Treatment Guide for Case Managers
Rotator Cuff Tear

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Mechanism of Injury:	Can occur as a single traumatic event or following repetitive trauma often in combination with chronic impingement syndrome	
Subjective symptoms:	- Pain with forward elevation of the arm (overhead work) - Night pain - Inability to sleep on involved side - Profound weakness of rotator cuff	
Objective findings:	Physical Exam: - Subdeltoid pain - Painful arc of motion (60-120) + Neer's, Hawkin's sign + impingement test (injection into subacromial space reliefs pain) - Profound cuff weakness	Imaging: - Plain x-rays - MRI X-ray may show a high riding humerus in a massive tear. MRI can be helpful to assess the size, location and retraction of the torn rotator cuff
Natural History:	This depends on the size of the tear, the age and biology of the patient and the functional demand. A partial thickness or small full thickness tear may respond favorably to PT without loss of strength in low demand patients. High demand patients can feel significantly disabled even by partial thickness or small rotator cuff tears. Not treating a rotator cuff tear may lead to progression of symptoms and to an untreatable rotator cuff tear if fatty degeneration of the muscle occurs.	
Non-operative Treatment:	- Activity modification - NSAIDS - PT (RC strengthening, scapular strengthening, capsular stretching) - HEP - Cortisone injection (used carefully since this can cause further RC damage if used frequently)	
Operative Treatment:	Shoulder arthroscopy with subacromial decompression and rotator cuff repair. Postoperative PT required. In revision situations and very large tears an open rotator cuff repair may be necessary	
MMI:	**Non-operative:** 10-12 weeks	**Operative:** 3-6 months
Work status until MMI:	Limited overhead activities No repetitive pushing, pulling, lifting	Light duty for 1-2 weeks, no or limited overhead activities with weight restrictions. No repetitive pushing, pulling, lifting