

Six Months Before Surgical Consideration in Degenerative Rotator Cuff Tears: Was Adequate Conservative Care Received?

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DEAR EDITOR,

In July 2026, the French National Authority for Health (Haute Autorité de Santé, HAS) recommended that a surgical indication for symptomatic degenerative rotator cuff tears be discussed only after at least six months of well-conducted medico-functional treatment [1]. The recommendation is clinically reasonable: degenerative tears are clinically heterogeneous, and the need for surgery cannot be inferred from imaging findings alone. However, the six-month threshold is based on expert consensus (“accord d’experts”, AE), rather than being supported by a graded level of scientific evidence. The recommendation identifies persistent clinical domains of pain, function, arm use and strength derived from the Constant score, without specifying quantitative thresholds or a required combination of domains. The issue is therefore not whether six months is an appropriate duration, but how the recommendation’s requirement for well-conducted medico-functional treatment is established in practice.

These domains are not linked to documentation of the treatment actually received. A patient who has had little or no rehabilitation does not meet the well-conducted condition, yet this is not apparent from the clinical domains used to judge treatment failure: at six months, such a patient may show similar pain, functional limitation and weakness as one who has completed a structured programme without sufficient improvement. On these clinical criteria alone, the two are therefore indistinguishable, although only the latter has actually

undergone the treatment whose failure is being considered.

These differences are not incidental to rehabilitation; they are central to its assessment. Delayed access to a first appointment, intermittent attendance, treatment interrupted because of financial, transport or occupational constraints, and limited local rehabilitation capacity can all be understood within the International Classification of Functioning, Disability and Health as environmental barriers that may influence functioning and care [2]. HAS itself requires a global assessment of the patient, with particular attention to the psycho-socio-occupational and biopsychosocial context, before a surgical indication is made [1]. What the recommendation does not specify is how this contextual assessment should establish, before treatment failure is invoked, that rehabilitation was accessible and adequately delivered.

HAS’s own nationwide analysis illustrates substantial heterogeneity in preoperative care [3]. Among 26,059 adults undergoing rotator cuff repair in France in the second half of 2022, 30.1% had no recorded physiotherapy during the preceding 18 months and only 30.4% received what the analysis defined as complete medico-functional management (combining physiotherapy and corticosteroid injection). Among those receiving physiotherapy, the median number of sessions was 22 (IQR 11–43), and the first recorded session occurred a median of 10.5 months before surgery (IQR 4.8–16.9) [3]. These figures show substantial variation in recorded preoperative physiotherapy use. Low recorded use has also been reported elsewhere: in a

United States claims cohort, documented physiotherapy before repair fell from 12.1% in 2010 to 7.8% in 2015 [4].

These data carry important limitations, which HAS itself sets out. The national claims system does not provide the clinical detail needed to reliably distinguish traumatic from degenerative tears — a critical distinction, because a traumatic tear on a healthy tendon warrants surgical assessment without delay rather than a conservative trial [1]. Some patients without recorded physiotherapy therefore had a legitimate indication for early surgery, although traumatic codes accounted for 6.8% of index admissions, compared with 90.2% coded as non-traumatic shoulder lesions [3]. Claims data record reimbursed healthcare utilisation, but not the content or quality of rehabilitation, nor patient adherence. They therefore cannot distinguish treatment never prescribed, treatment prescribed but inaccessible, treatment available but incompletely undertaken, and treatment adequately delivered without sufficient clinical response. Only the last situation can reasonably be interpreted as genuine non-response to an adequate course of conservative care.

Specialist physical and rehabilitation medicine (PRM) involvement was uncommon in these pathways: 3.2% of patients had a PRM consultation during the 18 preoperative months, while PRM physicians accounted for 0.8% of recorded physiotherapy prescriptions, compared with 68.9% for general practitioners [3]. These figures describe patterns of involvement rather than causes of outcome. Nevertheless, they show that specialist PRM assessment was rarely part of the preoperative pathway, despite the relevance of rehabilitation expertise to the design, dosing and progression of rehabilitation.

The importance of a structured treatment trial is illustrated by the multicentre prospective MOON cohort. Patients with symptomatic atraumatic full-thickness tears underwent a standardised 6- to 12-week physiotherapy programme. Patient-reported outcomes improved beyond clinically meaningful thresholds, and more than 70% had not undergone surgery at 10 years. Among those who ultimately underwent surgery, 56.5% did so within the first six months; notably, low expectations regarding the effectiveness of physiotherapy were the strongest predictor of early surgery [5]. These findings reinforce the value of evaluating response within a defined treatment pathway, provided that the programme has actually been delivered.

Even when physiotherapy is available, the treatment prescribed may differ substantially from the treatment actually performed. In a prospective cohort, Burns *et al.*, used wearable monitoring to measure physiotherapy exercise objectively. Patients with symptomatic rotator cuff pathology exercised on only 41% of assigned treatment days, and greater cumulative participation was associated with greater improvement in

pain and disability at 8 and 12 weeks [6]. This gap between prescription and performance is not confined to routine care; even in controlled trial settings, reporting is poor. A 2024 scoping review of 13 randomised trials involving imaging-confirmed rotator cuff tears found poor reporting of exercise interventions, with a mean Template for Intervention Description and Replication (TIDieR) score of 10.4/24; adherence was reported in only two studies, and the overall implementation fidelity score was 27.4% [7].

This convergence of findings suggests why simply recording “six months of physiotherapy” provides limited information about the treatment actually received unless supervised exercise, home exercise, continuity and adherence are also documented. This is not an argument for imposing an arbitrary number of sessions, but for distinguishing treatment duration from treatment received.

A pragmatic record could document when physiotherapy actually started, the frequency of supervised sessions, whether treatment included an active exercise programme, adherence to home exercise, relevant interruptions and their reasons, and changes in pain, function and strength over time. This would help distinguish three situations: failure of access or delivery, incomplete adherence despite available care, and genuine non-response despite adequately delivered treatment. Such documentation need not delay or restrict surgical referral. It would simply make the well-conducted requirement verifiable at the point where it carries the most clinical weight.

We do not contest the six-month threshold. The recommendation already requires that this period consist of well-conducted medico-functional treatment; our concern is that it does not specify how this should be verified in practice. The distinction between treatment that has genuinely failed and treatment that was never adequately delivered rests largely on that qualifier. Yet these situations have different clinical implications: one may justify surgical consideration, whereas the other may call first for completion or optimisation of conservative care. Documenting what treatment was actually received — its initiation, content, continuity, adherence and clinical response — would make this distinction clinically assessable. Establishing it is not an administrative formality; it is part of the rehabilitation diagnosis.

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