

Shoulder resurfacing arthroplasty

HealthTech guidance
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Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account, and specifically any special arrangements relating to the introduction of new interventional procedures. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties. Providers should ensure that governance structures are in place to review, authorise and monitor the introduction of new devices and procedures.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations wherever possible](#).

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This guidance replaces IPG354.

1 Recommendations

- 1.1 Current evidence on the safety and efficacy of shoulder resurfacing arthroplasty is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.

2 The procedure

2.1 Indications and current treatments

- 2.1.1 Patients with shoulder joint disease may have shoulder pain accompanied by functional limitation and a reduced quality of life. The humeral head may degenerate as a result of a range of conditions, most commonly osteoarthritis, rheumatoid arthritis or avascular necrosis. The whole or only part of the articular surface of the humeral head may be affected.
- 2.1.2 Depending on the underlying condition, conservative treatment may include physical therapy, pharmacological treatments (including pain relief and topical or oral non-steroidal anti-inflammatory drugs) and corticosteroid injections. Patients refractory to these treatments may need surgery: either shoulder arthroplasty using a stemmed humeral head prosthesis, or fusion of the joint.

2.2 Outline of the procedure

- 2.2.1 The aim of shoulder resurfacing arthroplasty is to replace only the damaged joint surfaces, with minimal bone resection.
- 2.2.2 The procedure is carried out with the patient in a semi-upright position and may be done using either general anaesthesia (sometimes accompanied by local anaesthesia), or local anaesthesia with or without sedation. Either a deltopectoral or anterosuperior approach may be used. The deltoid muscle is split to expose the surface of the humeral head, which is reamed to restore its shape. A hole is drilled for the central anchoring peg of the resurfacing prosthesis.
- 2.2.3 The peg of the prosthesis is inserted into the drilled hole and morcellised bone or cement is used to aid fixation of the articular prosthesis, which may cover the whole or part of the humeral head. A prosthesis may be used to cover the glenoid surface of the scapula if necessary. The shoulder joint is reduced and the wound is closed.

2.2.4 Various devices can be used for this procedure.

2.3 Efficacy

Sections 2.3 and 2.4 describe efficacy and safety outcomes from the published literature that the Committee considered as part of the evidence about this procedure. For more detailed information on the evidence, see the [overview](#).

2.3.1 A case series of 69 patients (79 shoulders: 37 treated by resurfacing, 42 treated by resurfacing plus glenoid component) reported that mean shoulder function (measured using the Constant–Murley shoulder scale [100-point scale; higher scores better]) improved from 40% of predicted at baseline to 91% at 4.4-year follow-up in patients treated by articular resurfacing only, and from 34% at baseline to 94% at 7.6-year follow-up in patients treated by resurfacing plus a glenoid component.

2.3.2 A non-randomised controlled trial of 44 patients reported no difference in the mean change in shoulder function (using the Constant–Murley shoulder scale) from baseline to 12-month follow-up in patients treated by shoulder resurfacing arthroplasty compared with patients treated by total shoulder arthroplasty (8.1 points versus 8.5 points; $p=0.356$). A case series of 94 patients (103 shoulders) reported that mean shoulder function (using the Constant–Murley shoulder scale) improved from 24% of predicted at baseline to 75% of predicted at 6.8-year follow-up ($p<0.001$).

2.3.3 Revision surgery for stemmed humeral prosthesis was reported in 6% (6 out of 98) of shoulders at 6.8-year follow-up in the case series of 94 patients (103 shoulders). Revision because of persistent pain was reported in 1 of 75 shoulders at a mean follow-up of 6.5 years in the case series of 62 patients (75 shoulders). Case series of 70 patients (84 shoulders) and 69 patients (79 shoulders) reported that no patient treated by shoulder resurfacing arthroplasty needed a revision procedure at follow-up of 4.2 and 4.4 years respectively.

2.3.4 The case series of 69 patients (79 shoulders) reported that mean shoulder pain improved from 3.9 points at baseline to 12 points at 4.4-year follow-up in patients treated by shoulder resurfacing arthroplasty, and from 2.1 points to 14 points at

7.6-year follow-up in patients treated by resurfacing plus glenoid component. A case series of 70 patients (84 shoulders) reported that, of 62 patients followed up, the percentage with severe pain reduced from 93% at baseline to 6% at a mean follow-up of 4.2 years.

- 2.3.5 A non-randomised controlled trial of 44 patients reported that, of the 22 patients treated by shoulder resurfacing arthroplasty, 2 needed conversion to total shoulder arthroplasty, 1 because of glenoidal erosion and 1 because of persistent pain, at 7 and 9 months respectively.
- 2.3.6 The case series of 62 patients (75 shoulders) reported that 96% of shoulders were rated as 'much better' or 'better' (not otherwise described; absolute figures not stated) at 6.5-year follow-up.
- 2.3.7 The Specialist Advisers listed key efficacy outcomes as relief of pain, range of motion, quality of life, and the rate of revision procedures.

2.4 Safety

- 2.4.1 Infection requiring removal of the prosthesis and fusion was reported in 1 patient at 6.8-year follow-up in the case series of 94 patients (103 shoulders).
- 2.4.2 Prosthesis instability requiring removal and fusion was reported in 1 patient at 6.8-year follow-up in the case series of 94 patients (103 shoulders).
- 2.4.3 Myositis ossificans causing almost complete ankylosis was reported in 1 patient in a case series of 94 patients (103 shoulders) at 6.8-year follow-up. The patient had an initial diagnosis of septic arthritis and extensive previous surgery.
- 2.4.4 The Specialist Advisers listed adverse events seen or reported in the literature to include loosening of the prosthesis, impingement and overstressing during implant if the prosthesis had been incorrectly sized. They considered theoretical adverse events to include infection, nerve injury, deep vein thrombosis, fracture, failure needing revision, and stiffness.

Update information

Minor changes since publication

January 2026: Interventional procedures guidance 354 has been migrated to HealthTech guidance 227. The recommendations and accompanying content remain unchanged.

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Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.