

For Everyday Shoulder Pain, Less Treatment Is Often More

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Shoulder pain is a ubiquitous complaint in primary care, often leading to a cascade of investigations and interventions that may not always serve the patient's best interest. Clinicians frequently face pressure to "do something" for patients presenting with persistent discomfort, but the evidence base for many common treatments suggests a more restrained approach is often superior.

The prevailing clinical wisdom, increasingly supported by observational data and guideline recommendations, points towards less aggressive management as the optimal strategy for many forms of everyday shoulder pain, particularly when structural damage is not the primary driver of symptoms. This shift challenges the traditional inclination towards immediate imaging, injections, or surgical referrals.

KEY TAKEAWAYS

- **The Pivot:** The focus for common shoulder pain has shifted from rapid intervention to conservative, patient-centered strategies.
- **The Data:** General clinical experience indicates that education, activity modification, and targeted physical therapy often yield comparable or better long-term outcomes than more invasive options.
- **The Action:** Clinicians should prioritize patient education, reassurance, and a structured exercise program before considering injections or surgical consultations for most non-traumatic shoulder pain.

Shoulder pain, encompassing a broad spectrum of conditions from rotator cuff tendinopathy to adhesive capsulitis, represents a significant burden on healthcare systems and patient quality of life. The shoulder joint's complex anatomy, involving the glenohumeral, acromioclavicular, sternoclavicular, and scapulothoracic articulations, allows for an extensive range of motion but also predisposes it to various pathologies. Many of these conditions, particularly those without acute traumatic onset, are often self-limiting or respond well to non-pharmacological interventions. The challenge for clinicians lies in differentiating conditions requiring specific, aggressive treatment from those that benefit from a more conservative, watchful approach.

Patients presenting with shoulder pain typically describe symptoms ranging from dull aches to sharp, debilitating pain, often exacerbated by movement or specific activities. Common diagnoses include rotator cuff tendinopathy, subacromial pain syndrome, impingement syndrome, biceps tendinopathy, and mild osteoarthritis. These conditions frequently overlap in their clinical presentation, making precise diagnosis challenging without advanced imaging, which itself can lead to over-diagnosis of incidental findings that may not correlate with symptoms. The natural history of many of these conditions involves spontaneous improvement over weeks to months, a factor often overlooked in the rush to intervene.

Understanding the Pathophysiology of Common Shoulder Pain

The majority of non-traumatic shoulder pain arises from issues within the rotator cuff and the subacromial space. Rotator cuff tendinopathy, for instance, involves degenerative changes in the tendons of the supraspinatus, infraspinatus, teres minor, and subscapularis muscles. These changes can range from inflammation to micro-tears, often without a clear inciting event. The subacromial space, located between the humeral head and the acromion, houses the rotator cuff tendons and the subacromial bursa. Compression or irritation of these structures, often termed subacromial pain syndrome or impingement, is a common source of discomfort. This can be due to anatomical variations, altered scapular kinematics, or overuse. The pain is typically worse with overhead activities and may radiate down the arm. Adhesive capsulitis, or frozen shoulder, presents with a distinct pattern of progressive pain and loss of both active and passive range of motion. While its exact etiology remains unclear, it involves inflammation and fibrosis of the glenohumeral joint capsule. This condition typically progresses through painful, freezing, and thawing stages, often resolving spontaneously over 1 to 3 years. Biceps tendinopathy, involving the long head of the biceps tendon, can also contribute to anterior shoulder pain, often coexisting with rotator cuff pathology. Degenerative changes in the acromioclavicular joint, particularly in older adults, can also cause localized pain, especially with cross-body adduction.

The Case for Conservative Management

For many years, the default approach to persistent shoulder pain involved a stepped escalation of interventions: rest, NSAIDs, physical therapy, corticosteroid injections, and ultimately, surgical consultation. But this linear progression often bypasses the fundamental understanding that the body possesses significant capacity for self-repair and adaptation. A growing body of clinical experience, supported by numerous observational studies and meta-analyses, suggests that a less interventional approach is often equally, if not more, effective for many patients. The efficacy of various recovery modalities, including passive ones, is frequently debated, but active rehabilitation remains paramount.

Patient education forms the cornerstone of conservative management. Explaining the benign nature of many shoulder conditions, reassuring patients that not all pain signifies serious damage, and setting realistic expectations for recovery can significantly reduce anxiety and improve adherence to rehabilitation programs. Many patients fear movement will worsen their condition, leading to activity avoidance and deconditioning. Countering this fear with evidence-based information about safe movement and progressive loading is critical. This approach empowers patients to take an active role in their recovery, rather than passively receiving treatments.

Structured physical therapy, focusing on strengthening the rotator cuff and scapular stabilizers, improving posture, and restoring normal shoulder kinematics, is a key component. The goal is not merely to reduce pain but to improve function and prevent recurrence. This often involves a progressive exercise program tailored to the individual's specific deficits and pain tolerance. Manual therapy techniques, such as joint mobilizations and soft tissue release, can be used as adjuncts to address stiffness and improve range of motion, but they are rarely sufficient on their own. The role of specific exercise modalities, like Pilates, is still being defined, but the principles of progressive overload and functional movement remain central.

When Less is More: Avoiding Over-Intervention

Corticosteroid injections into the subacromial space are a common intervention, offering short-term pain relief. But the evidence for their long-term benefit is often underwhelming, and repeated injections carry risks, including tendon

weakening, skin atrophy, and potential systemic effects. For some conditions, such as adhesive capsulitis, injections may provide a window for more effective physical therapy, but they are not a standalone solution. The transient nature of the relief can also create a cycle of dependence, where patients return for repeated injections without addressing the underlying biomechanical issues.

Imaging, particularly MRI, is frequently ordered early in the diagnostic process. While MRI can reveal structural abnormalities like rotator cuff tears, labral tears, or osteoarthritis, these findings often do not correlate perfectly with a patient's symptoms. Many asymptomatic individuals, especially older adults, have rotator cuff tears or degenerative changes on MRI. Identifying such findings in a symptomatic patient can lead to unnecessary anxiety and a focus on structural pathology that may not be the primary driver of their pain. This can then lead to surgical referrals for conditions that might have resolved with conservative care. The search for non-opioid pain management strategies is ongoing, but often simpler approaches are overlooked.

Surgical intervention, such as arthroscopic subacromial decompression or rotator cuff repair, is certainly indicated for specific conditions, including acute, full-thickness rotator cuff tears in active individuals, or severe, intractable impingement that has failed extensive conservative management. But for many common presentations of shoulder pain, particularly those involving tendinopathy or mild impingement, surgery has not consistently demonstrated superior outcomes compared to well-executed physical therapy. The recovery from shoulder surgery is often prolonged and requires intensive rehabilitation, carrying its own set of risks, including infection, stiffness, and persistent pain. For a comprehensive understanding of musculoskeletal conditions, the Oxford Handbook of Rheumatology serves as an excellent concise reference.

The Role of Shared Decision-Making

The principle of shared decision-making is particularly relevant in managing common shoulder pain. Clinicians should present patients with all viable treatment options, including the option of watchful waiting and conservative management, along with their respective benefits, risks, and expected outcomes. This transparent discussion allows patients to make informed choices that align with their values and preferences. For instance, a patient with a small, partial rotator cuff tear who is not highly active might opt for physical therapy, understanding that surgery may not offer a significantly better outcome and carries greater immediate risks.

But the system itself often incentivizes intervention. Reimbursement models, patient expectations shaped by media, and the perceived need for a definitive diagnosis can push clinicians towards more aggressive pathways. Resisting this pressure requires confidence in the evidence for conservative care and a commitment to patient-centered communication. It also requires adequate time for patient education and follow-up, which can be a challenge in busy primary care settings. The pressures on clinicians are significant, often leading to less time for comprehensive patient discussions.

The shift towards less treatment for common shoulder pain is not about doing nothing. It is about doing the right thing, which often means prioritizing education, reassurance, and active rehabilitation over potentially unnecessary or harmful interventions. It acknowledges the body's inherent healing capacity and the importance of patient empowerment in managing chronic conditions. This approach requires a paradigm shift in both clinical practice and patient expectations, moving away from a quick fix mentality towards a more holistic, long-term view of musculoskeletal health, specifically by shifting from an intervention-first approach to one that prioritizes conservative management and patient education.

The next step in this evolution will involve better tools for identifying which patients truly benefit from early, aggressive intervention versus those who thrive with a more minimalist approach.

CLINICAL IMPLICATIONS

GPs and specialists alike should reconsider the default pathway for non-traumatic shoulder pain. The reflex to order an MRI or refer for an injection often serves to escalate care unnecessarily, rather than genuinely improving long-term outcomes for most patients. A thorough clinical history and examination, coupled with patient education, should be the primary intervention.

The data consistently shows that for many common shoulder complaints, a well-structured physical therapy program, focused on active rehabilitation and progressive loading, is as effective as, if not superior to, corticosteroid injections or early surgical intervention. Clinicians must be confident in communicating this to patients, managing expectations, and resisting the urge to over-medicalize what are often self-limiting conditions.

This conservative approach not only benefits patients by avoiding unnecessary procedures and their associated risks but also reduces the burden on specialist services and healthcare costs. It requires a commitment to shared decision-making, ensuring patients understand the natural history of their condition and the evidence for less invasive options. The challenge lies in changing ingrained habits within the medical community and among patients who often expect a quick fix.

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