

**Table 1. Description of studies**

Author, year, study register	Study design	Intervention	Control	Population (type of tears, N, age)	Relevant outcome measures	Relevant follow up	Notes
Cederqvist, 2021  NCT00695981 and NCT00637013.	RCT	<p>All patients first underwent a 3-months non-surgical treatment and MRI arthrography before randomized into the surgical or non-surgical treatment group.</p> <p>The non-surgical treatment before randomization consisted of:                      Physiotherapy: cold pack + exercises (3 times per week, with increasing load and decreasing repetitions over time) + stretching (glenohumeral joint), hanging exercises, manual therapy/cross-fiction massages (supraspinatus, e infraspinatus, subscapularis, teres minor, teres major muscles, trapezius, deltoid, long head of the triceps, and the biceps sulcus areas).</p>	<p>All patients first underwent a 3-months non-surgical treatment and MRI arthrography before randomized into the surgical or non-surgical treatment group.</p> <p>The non-surgical treatment before randomization consisted of:                      Physiotherapy: cold pack + exercises (3 times per week, with increasing load and decreasing repetitions over time) + stretching (glenohumeral joint), hanging exercises, manual therapy/cross-fiction massages (supraspinatus, e infraspinatus, subscapularis, teres minor, teres major muscles, trapezius, deltoid, long head of the triceps, and the biceps sulcus areas).</p> <p>Patients randomised to non-surgical treatment continued the previously initiated rehabilitation programme. It was not reported how long patients followed this program. Unsuccessful non-surgical treatment was defined as severe pain or poor subjective function in the shoulder</p>	<ul style="list-style-type: none"> <li>• Only full-thickness tears included in the current summary, of which 88% in the intervention group and 90% in the control group were solely in the supraspinatus tendon.</li> <li>• Exclusion of high-energy trauma patients</li> <li>• Full-thickness tear by MRA</li> <li>• N = 98 (50 vs. 48)</li> <li>• Mean age: 56 yr</li> </ul>	<p>Function: CS                      Pain: VAS                      Adverse events</p>	<p>Function: 2y                      Pain: 2y                      Adverse events: 2y</p>	<p>Group allocation (full-thickness or non-full-thickness tendon lesion) was based on written statement made by clinical radiologist. Of these, 95 shoulders were randomised to receive surgery (50 shoulders with full-thickness ruptures, of which 44 solely in the supraspinatus tendon) and 95 to non-surgical Treatments (48 with full-thickness ruptures, of which 44 were solely in the supraspinatus tendon). In the non-surgery group, 12 (13%) shoulders experienced severe pain and surgery was performed during the 2-year follow-up.</p>

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		<p>The surgical treatment consisted of: Arthroscopic or mini-open single-row surgical treatment of cuff repair.</p> <p>All patients underwent the same early post-surgery rehabilitation protocol.</p>	<p>during follow-up. These patients were offered a surgical intervention.</p> <p>All patients underwent the same early post-surgery rehabilitation protocol.</p>				<p>In the surgery group, 36 (38%) shoulders experienced pain relief before surgery and did not undergo surgery. Shoulders treated per protocol were 75%.</p>
<p>Kukkonen, 2014 Kukkonen, 2015 Kukkonen 2021  NCT01116518</p>	RCT	<p>Repair: surgical rotator cuff repair + acromioplasty + immobilization in a sling for 3 weeks postoperatively + physiotherapy</p>	<p>Physiotherapy: instructions + home exercises + 10 sessions of physiotherapy</p> <p>The first 6 weeks of the exercise protocol aimed at improving glenohumeral motion and active scapular retraction, after which static and dynamic exercises to improve scapular and glenohumeral muscle function were gradually increased until 12 weeks. Thereafter, the patient increased resistance and strength training up to 6 months. In addition to receiving written instructions, the patient was referred to undergo 10 sessions of physiotherapy at an outpatient health care facility.</p>	<ul style="list-style-type: none"> <li>• Atraumatic symptomatic supraspinatus tendon tear comprising &lt;75% of the tendon insertion and documented with MRI</li> <li>• N = 120 (60 vs. 60)</li> <li>• Mean age: 65 yr</li> </ul>	<p>Function: CS Pain: VAS Patient satisfaction: dichotomous question</p>	<p>Function: 1y, 2y, 5y Pain: 1y, 2y, 5y Patient satisfaction: 1y, 2y, 5y</p>	<p>There were eight cross-over cases in the physiotherapy group, and two cross-over cases in the acromioplasty and physiotherapy group.</p>
<p>Lambers Heerspink, 2015</p>	RCT	<p>Repair: Open surgical treatment / repair. 14/25 augmented with bone anchors</p>	<p>Conservative treatment:  Subacromial steroid infiltration, physiotherapy, and analgesic</p>	<ul style="list-style-type: none"> <li>• Degenerative, nontraumatic full-thickness</li> </ul>	<p>Function: CS Pain: VAS</p>	<p>Function: 1y Pain: 1y</p>	<p>Three patients were dissatisfied with the result of conservative treatment. A decision</p>

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<p>Netherlands Trial Registry (NTR TC 2343)</p>			<p>medication; further options: analgesic medication with NSAIDs, paracetamol, or tramadol). In weeks 4 to 6, exercises were gradually increased, and deltoid training was started. In weeks 6 to 12, rehabilitation was aimed at further optimization of mobility and strength regeneration of the remaining cuff and deltoid. Physical therapy was continued until patients reached an optimum range of motion and an improvement in strength was achieved.</p>	<p>rotator cuff tears</p> <ul style="list-style-type: none"> <li>• N = 56 (25 vs. 31)</li> <li>• Mean age = 61 yr</li> </ul>			<p>was made to perform rotator cuff repair and the patients discontinued their primary intervention</p>
<p>Moosmayer, 2010 Moosmayer, 2014 Moosmayer, 2019  NCT00852657</p>	<p>RCT</p>	<p>Repair: Surgical treatment of cuff repair (through a deltoid splitting approach, anteroinferior acromioplasty was performed).  Patients who were unsatisfied with their results after a minimum of 15 physiotherapy sessions and who had persistent clinical findings were offered a secondary surgical treatment.</p>	<p>Physiotherapy: physiotherapy and exercises. Treatment sessions of 40 minutes were given twice weekly for 12 weeks and with decreasing frequency during the following 6 to 12 weeks.  Patients who were unsatisfied with their results after a minimum of 15 physiotherapy sessions and who had persistent clinical findings were offered a secondary surgical treatment.</p>	<ul style="list-style-type: none"> <li>• Full-thickness tear by sonography and MRI (traumatic or atraumatic)</li> <li>• N = 103 (52 vs. 51)</li> <li>• Mean age = 60 yr</li> </ul>	<p>Function: CS, ASES Pain: VAS Patient satisfaction: VAS</p>	<p>Function: 1y, 2y, 5y, 10y Pain: 1y, 2y, 5y, 10y Patient satisfaction: 1y, 2y, 5y, 10y</p>	<p>Fourteen patients (27%) in the physiotherapy group reported an insufficient treatment result from physiotherapy and crossed over to secondary surgery (9 patients during the first year, 3 patients between 1 and 2 years, and 2 patients between 5 and 10 years). Treatment was by secondary tendon repair in 12</p>

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