



the LONDON SHOULDER PARTNERSHIP

Patient Information

SHOULDER REPLACEMENT

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This information booklet has been produced to help you obtain the maximum benefit from your operation. It is not a substitute for professional medical care and should be used in association with treatment at the orthopaedic clinic. Individual variations requiring specific instructions not mentioned here may be required.

If your wound changes appearance, weeps fluid or pus, or you feel unwell with a high temperature, during office hours please contact our PA. Alternatively contact the hospital where you had your operation in the first instance.

Who to contact if you are worried or require further information.

Main switchboard: 0203 318 5775

Mr Tennent's PA: 07702 641031

Mr Pearse's PA: 0207 881 4134

What happens in arthritis

Arthritis is the loss of the cartilage lining the joint surface (articular cartilage). Normally this is a soft glistening smooth white tissue which acts as a bearing surface to allow the joint to move freely. If the cartilage is damaged the surface becomes rough and no longer glides. This causes pain and stiffness within the joint. The most common need for shoulder replacement is in patients with rheumatoid arthritis. Less commonly it is performed in those with osteoarthritis.

Treatment Options

The initial treatment is conservative.

Activity Modification

Limiting activities which provoke pain may be necessary, and learning new exercise methods may be helpful.

Physiotherapy

Stretching and strengthening of the muscles around the shoulder joint may help decrease the burden on the shoulder. Preventing atrophy of the muscles is an important part of maintaining functional use of the shoulder.

Anti-Inflammatory Medications

Anti-inflammatory pain medications (NSAIDs) are prescription and nonprescription drugs that help treat pain and inflammation. While this will not cure shoulder arthritis, it may diminish the symptoms and help control pain.

Cortisone Injections

Cortisone injections may help decrease inflammation and reduce pain within a joint. While this will not cure shoulder arthritis, it may diminish the symptoms and help control pain.

Joint Supplements (Glucosamine & Chondroitin Sulphate) Glucosamine appears to be safe and **may** be effective for treatment of shoulder arthritis, but research into these supplements has been limited. Many patients **find moderate** relief with glucosamine for symptoms of shoulder arthritis.

When conservative treatment does not relieve pain, surgery may be recommended. The goal of surgery is to remove the pain.

Purpose of the operation

The aim of the surgery is to remove the arthritic joint surfaces and replace them to relieve pain. The aim is not to improve the range of motion although some gains are usually seen.

The procedure

The operation requires a general anaesthetic

An injection into the side of the neck called a scalene block is usually done to help with postoperative pain. This has risks associated with it which the anaesthetist will explain to you. An 8cm incision will be made in the front of the shoulder in the "deltopectoral groove". This runs from just below the clavicle "collar bone" straight down towards the axilla (armpit).

The head of the humerus (arm bone) will be shaped and the bone prepared to receive the implant. The face of the glenoid (the body side of the joint) may also be prepared to receive a new surface.

A sling will be applied before you wake up. This is purely to support the arm for the first few hours after surgery. You will be encouraged to start to use the arm as soon as possible.

As result of the scalene block the arm will be numb and "dead" for up to six hours after surgery, this is entirely normal. As soon as you feel any pain you should start the painkillers you have been prescribed.

Risks

All surgical procedures have some element of risk attached. The risks outlined below are the most common or most significant that have been reported.

Continued pain: 5%

Sometimes it is not possible to relieve all the pain even if the operation has been performed technically well.

Infection: 1%

If an infection does occur it is usually superficial in the wounds and is easily treated with antibiotics. Infection around joint replacement is potentially very serious and hard to eradicate. In the worst case scenario the implant has to be removed and replaced after a period of several months on antibiotics.

Nerve damage: less than 0.1%

The axillary nerve runs close to the bottom of the joint and, if damaged causes weakness of the deltoid muscle and difficulty in raising the arm.

Blood vessel damage: less than 0.1%

There are a number of large blood vessels close to the shoulder. It is very rare to damage these and if they are damaged they will be repaired before the end of the operation.

Stiffness: 1%

The shoulder is usually stiff before surgery and, whilst the operation will often improve the range of motion, there is no promise of improved motion. Occasionally the shoulder can become more stiff after the surgery.

Dislocation/Instability: 1%

Because of the ball-and-socket design of the implanted joint, it is important that the surgeon balance the soft-tissues around the shoulder to ensure it is not pulled out of position.

Loosening of the Implant

Over time, implanted joints may loosen. Developments are constantly being made to produce longer-lasting implanted joints, but this has not been perfected. If an implant loosens to the point where patients are having significant problems, a revision surgery may need to be performed (a replacement of a joint replacement).

What is going to happen?

Before admission to hospital

Up to date X-rays of the shoulder will be taken

Blood tests, an ECG (heart tracing) and sometimes a chest X-ray will be taken to ensure that you are fit for surgery.

The day of surgery

You will be asked not to eat or drink anything for 6 hours prior to surgery.

You will be admitted to the hospital a couple of hours before the operation and the nurse will ensure that you are fit and prepared. The surgeon will go over the operation again with you and ask you to sign a consent form (see above for consent).

The arm to be operated on will then be marked with an indelible marker.

The anaesthetist will then come and discuss the anaesthetic. When it is time for surgery you will be taken on the trolley round to the operating theatre.

After the surgery you will be taken to a recovery ward where the nurses will observe you while you wake up from the anaesthetic. Once you are fully awake you will be taken back to the ward.

On the day following surgery the drips and monitoring will be removed and the physiotherapists will see you. Hospital stays vary from one to three days for most patients and you can go home as soon as you are comfortable.

Your First Day at Home

You may need help with your daily activities, so it is a good idea to have family and friends prepared to help you. With their help, you will need to do the exercises you learned while in the hospital, four to six times daily. These exercises gradually increase the movement in your joint, so it is important to do them as scheduled.

Never use your arm to push yourself up in bed or from a chair. The added weight on your shoulder may cause you to re-injure the joint.

1st Postop week

Leave the dressings alone

Remove the sling as soon as possible and start to use the arm You may shower but do not soak the dressings

Start the exercises as described on the separate sheet

2nd Week

You will be seen in the clinic 2-3 weeks following surgery. The dressings will be removed and the wounds inspected. X-rays will be taken to ensure that the implant is stable.

You should continue doing the gentle exercises and more active physiotherapy will start at 6 weeks after surgery.

What happens after the surgery?

For the first 6 weeks you may gently use the arm and start the stretching exercises on the following sheets

After this stage you will start physiotherapy which will have been arranged previously. The physiotherapy has three phases.

Phase 1 is a continuation of what you will have already have started to regain the passive range of motion. This means that during this phase you will simply be stretching the shoulder out. There must not be any strengthening (Theraband) work during this phase.

Duration: Approximately 1-2 months

Phase 2 is to regain control of the shoulder blade and to start to develop strength enough to raise the arm alone against gravity. Gentle resistance may used during this phase but should be stopped if any pain is experienced.

Duration: Approximately 1-2 months.

Phase 3 is strengthening. During this phase resistance techniques and weights are used.

Duration: Approximately 3 months.

The exercises on the following pages are designed to help you through phase one which is the most important period. Strength can always be developed later but if the shoulder is stiff it is very hard to regain this at a later date.

Frequently asked Questions

When can I shower?

Immediately after the surgery

When will I be seen in clinic after the operation?

You will be seen at 2 and 8 weeks post surgery. Later appointments will be determined by your progress

When can I drive?

As soon as you feel comfortable. This is usually 6-8 weeks

When can I return to work?

Is the job physical?

Does the job require the operated arm?

Do I drive to get to work?

As a general rule if you can get to work you can resume a sedentary job within month week.

How will I know if the operation has worked?

The pain from the arthritis usually settles within days of the surgery however the discomfort from the operation often takes several weeks to settle. Improvements are seen for up to a year following the operation but most patients notice a significant improvement by 6 weeks to 3 months.