Patient Information

SHOULDER ARTHROSCOPY
&
ANTERIOR STABILISATION

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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 the relevant 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.
PA at St. George's Hospital: 0208 725 2032
PA (Private Patients): 01737 352494
SWLEOC: 01372 735800
St. Anthony's Hospital: 0208 337 6691
Parkside Hospital: 0208 971 8000

We would like to thank the Nuffield Orthopaedic Centre (Upper Limb Clinic) for allowing us to reproduce some of the information contained in this booklet.

Patient information sheet
Arthroscopic Anterior Stabilisation of the shoulder

What happens in shoulder dislocation

In a shoulder dislocation the ball comes out of the socket. About 95% of shoulder dislocations are anterior meaning the ball is pushed out it front of the socket. In patients who sustain this type of shoulder dislocation, the most common injury in the shoulder is called a **Bankart lesion**. The "Bankart lesion" means that ligaments that help to hold the shoulder in proper position have been damaged and the shoulder is not held as tightly in position.

The Bankart lesion occurs in over 90% of patients with an anterior shoulder dislocation.

Treatment of a shoulder dislocation depends on a number of factors, and some patients may require surgery. When a patient dislocates their shoulder from a traumatic event they are at-risk for developing recurrent dislocations in the future. The chance of shoulder dislocations becoming a recurring problem depends most significantly on the age of the patient. The percentage of redislocations are about:

- Less than 20 years old: **90%**
- 20-30 years old: **75%**
- 30-40 years old: **30%**

These are ballpark figures, and other factors contribute to an individual patient's risk of redislocating their shoulder.

Treatment options

The usual treatment of an anterior shoulder dislocation is to place the patient in a sling for a few weeks to allow the swelling and inflammation around the shoulder to subside. Thereafter, progressive exercises are started until the patient is able to resume their usual activities. This results in the redislocation

rates shown above and there is no benefit to immobilization for any but the first dislocation.
Research from Japan has shed light on the treatment of first time shoulder dislocations with the shoulder held in *external rotation.* When the shoulder is held in external rotation the ligament is brought into a more normal position, and may heal in this proper position. The idea behind immobilization in external rotation is that if the ligament heals in the proper position, then repeat shoulder dislocations will be less likely.

- **Pros of External Rotation Immobilization**
    - Nonoperative, and therefore no complications that are seen with surgery.
    - Repeat shoulder dislocations may be less likely, as has been shown in some early studies.
- **Cons of External Rotation Immobilization**
    - Very awkward position to hold the arm--can be difficult to manage with normal daily activities.

It is unclear if the ligament heals with the proper tension--we know it is in a better position, but it still may not function normally.

Is surgery necessary for the treatment of a shoulder dislocation?
Most orthopedic surgeons would not choose to operate on a patient after a first dislocation. After a brief period of immobilization, followed by physiotherapy, the patient would gradually resume their normal activities. If the patient sustained a second, or recurrent, dislocation, then surgery is considered.

It is important to remember that stabilisation is significant surgery, and recovery is not easy.

The decision is also clouded by age. As patients reach their 30s and later, the chance of repeat dislocation begins to drop quickly. Patients over 30 generally do not need surgery unless repeat dislocations become a problem.

Purpose of the operation
To stop the shoulder from dislocating

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.

3 incisions will be made in the shoulder, one at the back and 2 at the front. Each is less than 1cm long
Occasionally it is necessary to convert the 2 front incisions into one longer incision if it is not possible to complete the operation arthroscopically.
The incisions will be closed with paper stitches "Steristrips" with a small dressing over the top. A nappy (Pampers, Huggies) will be applied over the top to soak up excess fluid from the surgery (arthroscopy uses a lot of water to irrigate the joint during the procedure).
The arm will be in an immobilizer sling which will have to be worn continuously for 3 weeks.

As result of the scalene block the arm will be numb and "dead" for up to six hours after surgery. This is entirely normal and most people go home with the arm still numb as it makes travel easier.
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 dislocation: 10%

If the shoulder does dislocate again it is usually possible to repeat the operation

Infection: less than 0.1%

If an infection does occur it is usually superficial in the wounds and is easily treated with antibiotics

Rarely the infection can be deep inside the joint and this requires surgery to wash the joint out.

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.

Stiffness: 1%

The shoulder will often become stiff after surgery and this usually settles with physiotherapy. Rarely the shoulder can become very stiff and require manipulation or arthroscopic release surgery.

What is going to happen?

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 anaethetist 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. As soon as you feel comfortable you may go home. You will need to have an adult with you at home as you will still be slightly under the effect of the anesthetic even if you feel fine.

1st Postop week

Leave the dressings alone

You may shower but do not soak the dressings

You may remove the sling for showering but keep the hand on the stomach if it is out of the sling.

You may have the sling over your clothes but the hand must remain on the stomach at all times.

1st 3 weeks

You can remove the dressings 2 weeks after surgery. The wounds will have been closed with paper stitches so no sutures need to be removed.

You will be seen in the clinic 3 weeks after surgery. The operation and next stage of the recovery plan will be discussed. You will be referred to physiotherapy at this point but it is not to start until 6 weeks after the operation.

2nd 3 weeks

You may remove the sling during the day but you are limited to "keyboard" range (place your hands on the desk in front of you. Do not turn the hands out any wider than a standard keyboard. You can now start some gentle exercises as shown.

You must continue to wear the sling at night until 6 weeks post surgery.

Frequently asked Questions

When can I shower?

Immediately after the surgery

When can I take the sling off?

The sling needs to be worn all the time for the first 3 weeks. It may be removed for dressing / showering but the hand must be kept against the stomach if the sling is off.

When will I be seen in clinic after the operation?

You will be seen at 3 and 9 weeks post surgery. Later appointments will be determined by your progress

When can I drive?

After the sling comes off and all movements are unrestricted. 6 weeks

When can I return to sports?

Non-contact sports (running, swimming) 6 weeks

Contact sports (including squash, soccer) 6 months

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 the week. Physical jobs will require at least 6-8 weeks.

How will I know if the operation has worked?

Once the shoulder has been rehabilitated (about 3 months post surgery) you should lose the feeling of apprehension (that the shoulder is going to dislocate) and have confidence with the shoulder. Beyond this it is difficult to be certain.