



Anterior Stabilisation of the Shoulder Open and Arthroscopic

Information for patients

This information has been produced to help you gain the maximum benefit and understanding of your operation.

It includes the following information:

- About your shoulder and shoulder dislocation
- About the operation
- Risks and alternative solutions
- Frequently asked questions
- Exercises
- Contact details

The shoulder

The shoulder joint is extremely mobile because it is a 'loose' joint. It is formed between the ball shape of the humeral head and the nearly flat saucer/socket of the glenoid. There is a thick rim of gristle (labrum) attached around the rim of the glenoid which deepens the saucer into a bowl shape and so provides some stability. Attached all around the edges of the glenoid and humeral head is the capsule which contains all the shoulder joint like a strong 'bag'. Areas of the capsule are thickened to form ligaments. Blending with the capsule are the tendons of the 4 rotator cuff muscles which constantly control the movements between the glenoid and humeral head.

Therefore, there are several important structures which help to keep the joint in position:

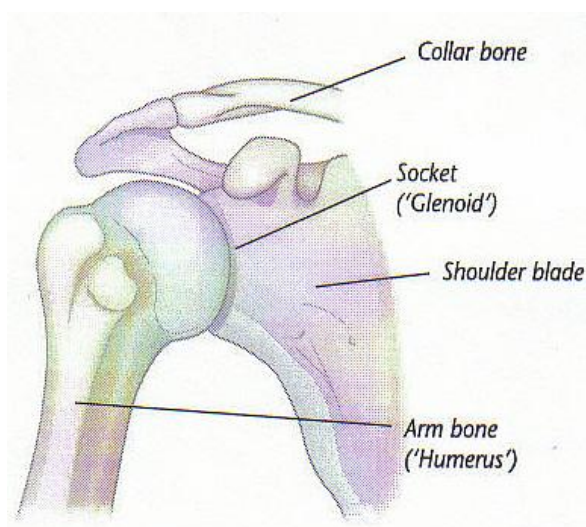
- a) A rim of cartilage (labrum); which deepens the socket
- b) Capsule; the 'bag' which contains the joint
- c) Ligaments; which hold the bones together
- d) Muscles; which keep the shoulder blade and joint in the correct position when moving or using the arm.

Shoulder dislocation

Most shoulders dislocate forwards and/or downwards (*see diagram below*). Sometimes the ball of the humerus bone only partly comes out of the socket of the shoulder blade (glenoid) and move back into place spontaneously. This is known as subluxation.

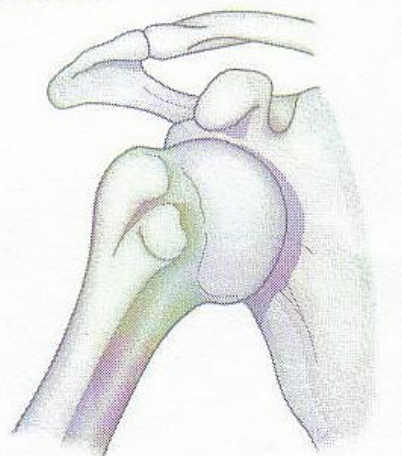
Right shoulder (from the front)

Normal alignment



Dislocated shoulder

The top of the arm bone is now in front of the socket



The commonest cause of dislocation is an injury. This may occur in anyone but is most frequently encountered in young adults. The shoulder dislocates for the first time because of a major injury such as during rugby, snow boarding, water skiing, car

crash etc. When the shoulder dislocates it knocks the lower-front labrum away from the rim of the glenoid and also stretches the capsule of the joint. The labrum always seems to heal into the wrong position and the capsule remains slightly stretched. This means that there is now a weak point around the circumference of the shoulder which allows the joint to dislocate with increasing ease. Physiotherapy cannot make the labrum heal in the correct position nor to tighten the capsule.

The treatment for recurrent traumatic dislocation depends on the age of the patient and their sporting involvement. Sportsmen/women under 30 years old usually need a shoulder stabilisation. More sedentary adults usually chose to modify their sport or lifestyle. Older patients frequently have an associated rotator cuff tear which needs to be repaired surgically. Therefore, if you are under 30 and enjoy sport then there is a chance you will continue to dislocate unless you have surgery.

About your shoulder stabilisation operation

You will have a full general anaesthetic, i.e. you will be asleep. Your shoulder will be examined to assess the extent and direction of instability (examination under anaesthesia = EUA). Next, an arthroscope (camera) will be passed into your shoulder from the back through a tiny incision (cut) in the skin. This will allow the surgeon to assess the extent of internal damage within the joint. Often, it is then possible to complete the whole stabilisation operation using only keyhole (arthroscopic) surgery via several more small skin incisions at the front of the shoulder. Otherwise, the main operation will be performed 'open' via a 5cm skin incision over the front of the shoulder in line with a bra strap. Both the open and arthroscopic versions of the operation involve finding the detached labrum (gristle) and fixing back into its correct position using stitches or anchors. The stretched capsule is also tightened.

Which is best, open or arthroscopic stabilisation?

Currently we do not know for sure. The open technique is tried and tested over many years with good but not perfect long-term results. The arthroscopic technique is only about 10 years old and the earliest sets of results were not as good as the open procedure. However, the development of modern techniques and equipment means that the results of arthroscopic stabilisation have improved and are now almost as reliable as the open technique. The benefits of the arthroscopic over the open procedure seem to be less pain and stiffness in the first few weeks after the operation (after that there is no difference), smaller scars, lower risk of infection, and, most importantly, the avoidance of having to cut then repair an important tendon (subscapularis) at the front of the shoulder.

What are the risks and complications?

All operations involve an element of risk. We do not wish to over-emphasise them but feel that you should be aware of them before and after your operation. The risks include:

- a) Complications relating to the **anaesthetic**, such as sickness, nausea or rarely cardiac, respiratory or neurological (less than 1% each, i.e. less than one person out of one hundred).
- b) **Infection**. These are usually superficial wound problems. Occasionally, deep infection may occur after the operation (less than 1%).
- c) Unwanted **stiffness** and/or **pain** in (and around) the shoulder (less than 1%).
- d) Damage to **nerves** and **blood vessels** around the shoulder (less than 1%).
- e) A need to **re-do** the surgery. The repair may fail and the shoulder become unstable again. This occurs in between 3-20% of cases.

Please discuss these issues with the doctors if you would like further information.

Alternative solutions

You do not have to have the operation.

Simply by changing your lifestyle and preferred sports you may be able to avoid further dislocations. Some people never have more than one dislocation even without changing their lifestyle.

Physiotherapy can help some people but not all.

Shoulder sports pads and harnesses can help reduce the number of dislocations on the playing field but at the expense of limiting movement and flexibility of the shoulder.

Questions that we are often asked

Will it be painful?

Please purchase packets of tablets such as paracetamol (painkillers) and anti-inflammatories (e.g. nurofen, ibuprofen, diclofenac) before coming into hospital.

- During the operation local anaesthetic will be put into your shoulder to help reduce the pain.
- The anaesthetist may discuss the option of numbing the whole arm for a few hours after the operation
- Be prepared to take your tablets as soon as you start to feel pain.
- If needed, take the tablets regularly for the first 2 weeks and after this time only as required.
- If stronger tablets are required or if you know you cannot take paracetamol or anti-inflammatories talk to your GP.

- The amount of pain you will experience will vary and each person is different. Therefore take whatever pain relief **you** need.

You may find ice packs over the area helpful. Use a packet of frozen peas, placing a piece of wet paper towel between your skin and the ice pack. Use a plastic bag to prevent the dressings getting wet until the wound is healed. Leave on for 10 to 15 minutes and you can repeat this several times a day.

Do I need to wear a sling?

Yes, your arm will be immobilised in a sling for about 6 weeks. This is to protect the surgery during the early phases of healing and to make your arm more comfortable. You will be shown how to get your arm in and out of the sling by a nurse or physiotherapist. You are advised to wear the body strap to keep your arm close to your body, under your clothes, for the first 3 weeks. **Only take the sling off** to wash, straighten your elbow or if sitting with your arm supported.

You may find your armpit becomes uncomfortable whilst you are wearing the sling for long periods of time. Try using a dry pad or cloth to absorb the moisture.

If you are lying on your back to sleep, you may find placing a thin pillow or rolled towel under your upper arm helpful.

When can I go home?

It all depends on whether you are comfortable. If the operation is done by keyhole surgery (arthroscopic stabilisation) many people chose to go home the same day. If the operation is done open (open stabilisation) then you will want to stay for one night in order to be able to receive strong painkillers.

When do I return to the clinic?

This is usually arranged for about 3 weeks after your discharge from hospital to check how you are progressing. Please discuss any queries or worries you have at this time. Appointments are made after this as necessary.

What do I do about the wound and the stitches?

Keep the wounds dry until they are healed which is normally for 10 to 14 days. You can shower/wash and use ice packs but to protect the wound with cling film or a plastic bag.

Avoid using spray deodorants, talcum powder or perfumes near or on the scar.

If you have any stitches they will be dissolving sutures and therefore will not need removing. The ends, which look like fishing line, will drop off on their own.

Do I need to do exercises?

For the first 3 weeks you will not be moving the shoulder joint. You will be shown exercises to maintain movement in your neck, elbow, wrist and hand and you will need to continue with these at home.

Outpatient physiotherapy will be arranged to start between 3 and 6 weeks after your operation. You will start an exercise programme to gradually regain movements and to strengthen your shoulder. The exercises will be changed as you progress.

You will need to get into the habit of doing regular daily exercises at home for several months. They will enable you to gain maximum benefit from your operation. Some of the early exercises are shown at the back of this booklet.

Are there things that I should avoid doing?

In the first 3 weeks:

Do not be tempted to remove your arm from the sling to use your arm for daily activities but only to do the correct exercises.

For 6-8 weeks:

Avoid moving your arm out to the side and twisting it backwards. For example; when putting on a shirt or coat, put your operated arm in **first**. Try not to reach up and behind you (e.g. seat belt in car).

Do not force movement for 12 weeks (3 months). These movements stretch the ligaments and muscles that have been tightened. Remember, this operation has been done because you had too much movement in your shoulder.

The ligaments and muscles need time to repair in their new, tightened position and it is advisable not to **over-stretch** them early on. They will benefit from gentle movements after 3 weeks.

How am I likely to progress?

This can be divided into 3 phases:

Phase 1. Sling on, no movement of the shoulder.

You will basically be one-handed, immediately after the operation for the first 3 weeks. This will affect your ability to do everyday activities, especially if your dominant hand (right if you are right handed) is the side of the operation.

Activities that are affected include dressing, shopping, eating, preparing meals and looking after small children. You will probably need someone else to help you. You may also find it easier to wear loose shirts and tops with front openings.

Phase 2. Regaining everyday movements.

After 3 weeks you can gradually wean yourself off using the sling and you will start outpatient physiotherapy. You will be encouraged to use your arm in front of you, but not to take it out to the side and twist it backwards (see 'things to avoid' above).

Exercises will help you regain muscle strength and control in your shoulder as the

movement returns. The arm can now be used for daily activities; initially, these will be possible at waist level but gradually you can return to light tasks with your arm away from your body. It may be 6-8 weeks after your operation before you can use your arm above shoulder height.

Phase 3. Regaining strength with movement.

After 8-12 weeks you will be able to progressively increase your activities, using your arm further away from your body and for heavier tasks. You can start doing more vigorous activities but contact sports are restricted for at least 6 months (see leisure activities section). You should regain the movement and strength in your shoulder within 6-8 months. Research has shown that after 2-5 years, about 90% of people have a stable shoulder with few limitations. Vigorous sports or those involving overhead throwing may require adaptation for some people, although many return to previous levels of activity.

When can I drive?

This is likely to be 6-8 weeks after your operation. Check you can manage all the controls and it is advisable to start with short journeys. Initially, the seat-belt may be uncomfortable but your shoulder will not be harmed by it. It is illegal to drive while you are still using your sling.

When can I return to work?

You may be off work between 2 and 8 weeks, depending on the type of job you have, which arm has been operated on, and if you need to drive. If you are involved in lifting, overhead activities or manual work you will not be able to do these for 8-12 weeks. Please discuss any queries with the physiotherapist or hospital doctor.

When can I participate in leisure activities?

Your ability to start these will be dependent on the range of movement and strength that you have in your shoulder following the operation. Please discuss activities in which you may be interested with your physiotherapist or consultant. Start with short sessions, involving little effort and gradually increase. General examples are:

Cycling – 4 to 6 weeks.

Swimming – gentle breast-stroke 8 weeks, freestyle 12 weeks.

Light sports/racquet sports using **non operated** arm – 10 weeks.

Racquet sports using operated arm – 16 weeks.

Contact or collision sports which includes horse riding, football, martial arts, rugby, racquet sports and rock climbing – 6 months.

The normal time frame of improvement

By 3 months after the operation you should have recovered a good range of movement, the pain will have settled and the shoulder will feel more solid and stable. The shoulder will continue to strengthen for up to 12 months after the operation.

Exercises

Use pain-killers and/or ice packs to reduce the pain before you exercise.

It is normal for you to feel aching, discomfort or stretching sensations when doing these exercises. However, if you experience intense and lasting pain (e.g. more than 30 minutes) reduce the exercises by doing them less forcefully or less often. If this does not help, discuss the problem with the physiotherapist.

Certain exercises may be changed or added for your particular shoulder.

Do short frequent sessions (e.g. 5-10 minutes, 4 times a day) rather than one long session.

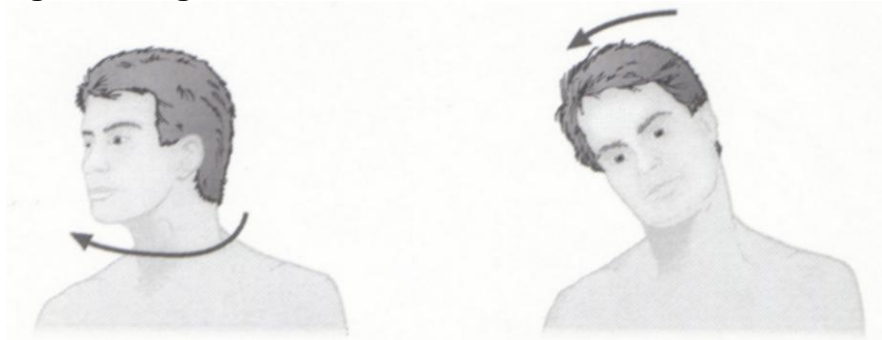
Gradually increase the number of repetitions you do. Aim for the repetitions that your therapist advises, the numbers states here are rough guidelines.

Please note: all pictures are shown for the right shoulder unless specified.

Phase 1 exercises - from operation day to 3 weeks after operation

Neck exercises

Standing or sitting



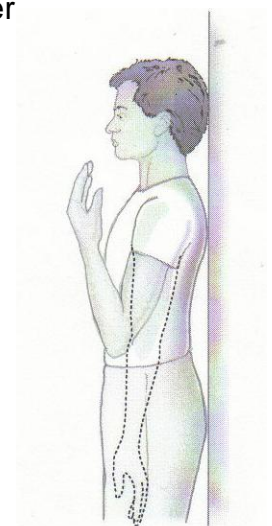
Tilt your head to one side.
Repeat 5 times.
Then turn your head to the other side and repeat 5 times.

Tilt your head towards one shoulder.
Repeat 5 times.
Then tilt your head to the other side and repeat 5 times.

Elbow exercises

Standing or lying

Straighten your elbow and then bend your elbow
Repeat 5 times.
(Shown for left arm)

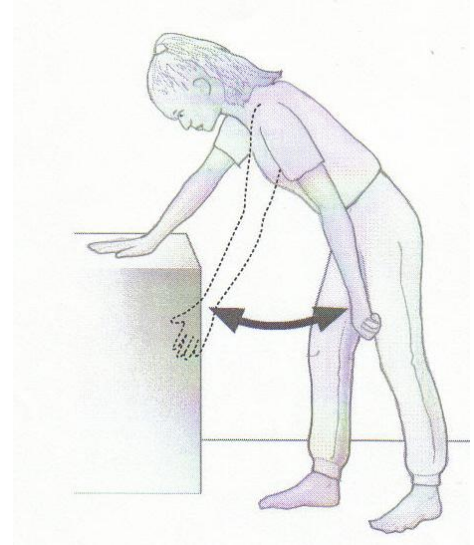


Phase 2 exercises - start these as advised by the hospital doctor or physiotherapist. Normally about 3 weeks after the operation.

Shoulder exercises

Stand leaning forwards

Let your arm hang down.
Swing the arm forwards and backwards.
Repeat 10 times.
(Shown for the left shoulder.)



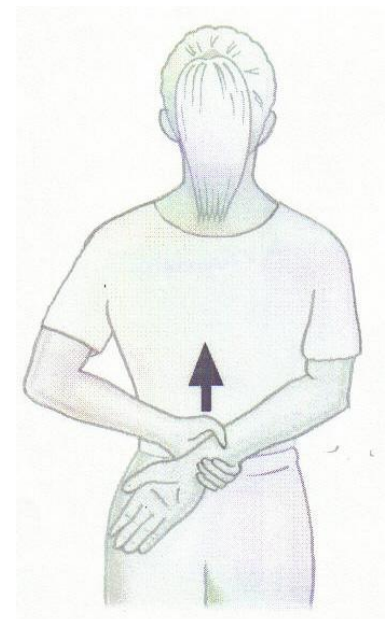
Lying on your back

Support your operated arm with the other arm and lift it up overhead.
Repeat 10 times.
(Shown for the left shoulder.)



Standing with arms behind your back

Grasp the wrist of your operated arm and gently stretch the hand towards the opposite buttock.
Then slide your hands up your back.
Repeat 5 times.



These additional exercises can be started 4 weeks after your operation

Stand with arm close to side and elbow bent

Push the palm of your hand into other hand but **do not let it move.**

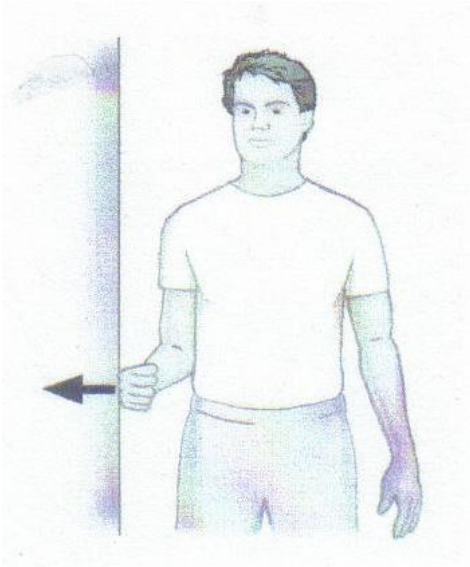
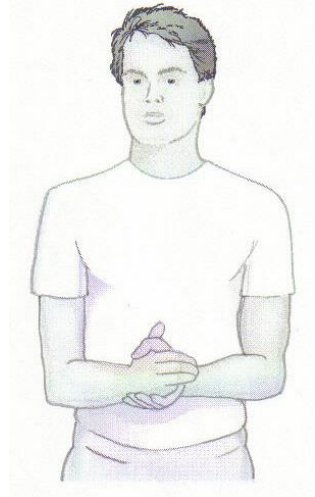
(This can be done against a wall or door-frame).

Do not shrug your shoulders

Hold for 10 seconds.

Repeat 10 times.

Build up to 30 repetitions.



Standing with your operated arm against a wall

Bend your elbow. Push your hand into the wall but do not let your arm move.

Do not shrug shoulders

Hold for 10 seconds

Repeat 10 times.

Build up to 30 repetitions.

Stand with your back against the wall

Keep your arm close to your side with the elbow bent.

Push the elbow back into the wall but do not let the arm move.

Hold for 10 seconds.

Do not shrug your shoulders.

Repeat 10 times.

Build up to 30 repetitions.

Stand sideways with operated arm against wall

Keep your arm close to your side with the elbow bent.

Push the elbow into the wall but do not let the arm move.

Hold for 10 seconds.

Do not shrug your shoulders.

Repeat 10 times.

Build up to 30 repetitions.

Stand facing a wall

Keep your arm close to your side with the elbow bent.

Push your fist into the wall but do not let the arm move.

Hold for 10 seconds.

Do not shrug your shoulders.

Repeat 10 times.

Build up to 30 repetitions.

The last few exercises work the muscles without moving the joint. These can be progressed to using elastic exercise bands so the muscles work with the joint moving. This can be done after 6 weeks.

Phase 3 exercises – from 8 weeks after your operation

These will concentrate on increasing the strength and mobility around your shoulder. The exercise will be selected for your individual shoulder and lifestyle.

Further information

Further useful information can be gained from the Internet at www.shoulderdoc.co.uk

Contact details

Contact details

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This information sheet is not a substitute for professional medical care and should be used in association with treatment at your hospital. Individual variations requiring specific instructions not mentioned here might be required. It was compiled by Mr Harry Brownlow (Consultant Orthopaedic Surgeon), Emma Lean and Catherine Anderson (Specialist Physiotherapists) and is based on the information sheet produced by Jane Moser (Superintendent Physiotherapist) and Professor Andrew Carr (Consultant Orthopaedic Surgeon) at the Nuffield Orthopaedic Centre in Oxford.



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