Arthroscopic Subacromial Decompression

Including

Acromioclavicular joint excision
Excision calcific deposit
Long head of biceps tenotomy

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

It includes the following information:

- Key points
- About your shoulder
- About the operation
- Risks and alternative solutions
- Frequently asked questions
- Exercises
- Contact details
- Useful links

Key Points

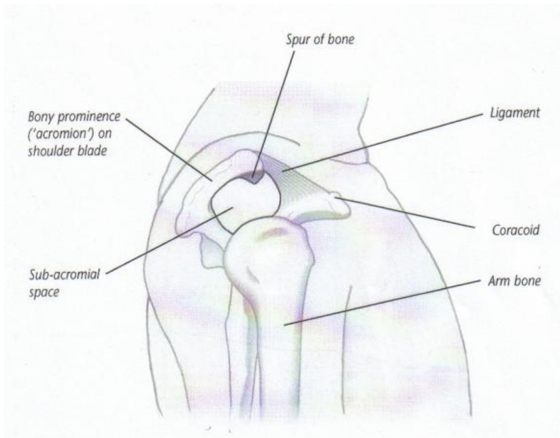
If you are considering having a shoulder operation remember these key points

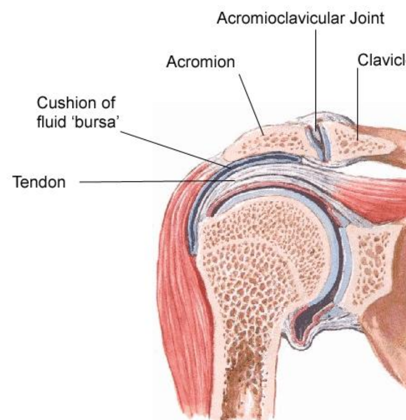
1. nearly all are done as day case surgery (home the same day)
2. you will have a general anaesthetic
3. you will not need a sling beyond 1 or 2 days
4. most people are driving within 1 to 2 weeks
5. most people return to work once they can drive although it may be considerably longer if you are a manual worker
6. you can return to sport as soon as you feel able to do so
7. this is a safe, reliable and effective operation for 90% of people
8. this is not a quick fix operation - improvement in symptoms take weeks and months to occur
9. www.shoulderdoc.co.uk is a reputable and useful British website for further information

About your shoulder

The shoulder is a ball and socket joint. A bone (acromion) and a ligament (coraco-acromial) above the shoulder together form an arch. The collar bone (clavicle) meets the shoulder blade (acromion) at a small joint (acromioclavicular joint) which lies above the main shoulder joint. The shoulder joint is surrounded by a deep layer of tendons (the rotator cuff) which pass under the arch in the subacromial space. One of these tendons (supraspinatus) sometimes swells and rubs on the bone and ligament above causing painful shoulder impingement. The bone (acromion) then may respond to the rubbing by forming a spur. The acromioclavicular joint can also be a source of shoulder pain after injury or arthritis. *See diagram below.*

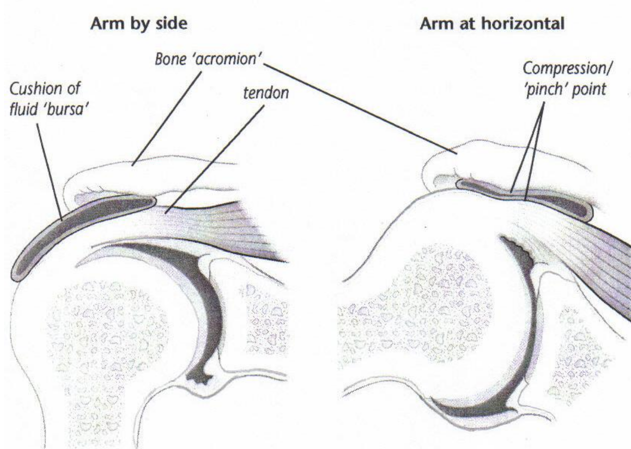
Right shoulder – viewed from the side ***and from the front***





When you lift your arm up it reduces the space under the arch. The rubbing causes further swelling of the tendon on the acromion bone, s*ee diagram below.* If the acromioclavicular joint is irritable then lifting your arm up high causes it to be squeezed and this too is painful.

If the cycle of rubbing and swelling is not broken by time, rest, physiotherapy and cortisone injections then surgery may be necessary.

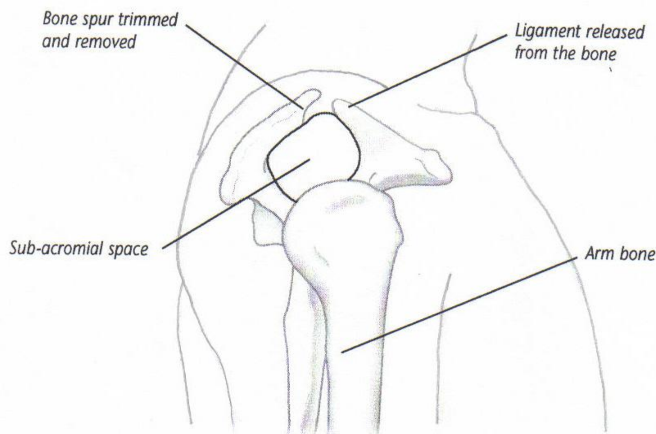


About the operations

The operation is done by keyhole surgery ('arthroscopy'). Most people are given a full general anaesthetic, i.e. you will be asleep. Two or three 5mm puncture wounds are made around the shoulder to allow entry of the arthroscopic instruments; one of these is a camera, which allows the surgeon to thoroughly inspect the inside of the shoulder joint. A burr (a surgical drill) is used in the shoulder to shave away part of the coraco-acromial ligament and any overhang of bone (acromial spur). This allows the tendons to move more freely and thus break the cycle of rubbing and swelling.

If necessary, the burr is also positioned into the acromioclavicular joint and a very thin slither of bone is removed from within the joint, leaving a gap of less than 1cm. This gap slowly fills in with scar tissue. The consistency of the scar tissue changes with time. For the first few months it is thin and weak, therefore, the bone ends can still move about and even clash into each other. This movement can cause feelings of clicking and sometimes pain. However, the scar tissue eventually stiffens to the consistency of a pencil rubber. This holds the bone ends in alignment and prevents them clashing, effectively acting as a new joint.

Right shoulder viewed from the side – after subacromial decompression



What are the risks?

All operations involve an element of risk. We do not wish to over-emphasise them but feel that you should be aware of them. 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 many months after the operation (rare; less than 1%).

c) Persistent **pain** and/or **stiffness** in/around the shoulder. 5-20% of patients will still have symptoms after the operation.
d) Damage to the **nerves** and **blood vessels** around the shoulder (rare; less than 1%).
e) A need to **re-do the surgery** is rare. In less than 5% of cases, further surgery is needed within 10 years.

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

What are the alternatives?

You probably have tried most of the alternative solutions for your shoulder pain before considering surgery. Not all these options are appropriate for all people.

They include:

- Modifying activity and sport to avoid the pain.
- Seeking the advice of a sports professional.
- Taking painkillers and/or anti-inflammatory tablets.
- Cortisone injections.
- Physiotherapy and other allied specialities such as acupuncture and osteopathy.

Questions that we are often asked about the operation

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.
- 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 use of ice packs (5 to 10 minutes per application) or heat may also help relieve pain in your shoulder
- The amount of pain you will experience will vary and each person is different. Therefore take whatever pain relief **you** need.

Do I need to wear a sling?

You will be wearing a sling when you leave theatre. This sling is for comfort only. You can take it on and off as you wish. Normally, it is discarded after a few days but you may find it helpful to wear the sling at night for the first few nights, particularly if you tend to lie on your side. Alternatively, you can rest your arm on pillows placed in front of you. If you are lying on your back to sleep you may find placing a thin pillow or small rolled towel under your upper arm will be comfortable.

When can I go home?

Often you can go home the same day.

Do I need to do exercises?

Yes (see at the end of this leaflet) you will be shown exercises by the physiotherapist and you will need to continue with the exercises once you go home. They aim to stop your shoulder getting stiff and to strengthen the muscles around your shoulder.

What do I do about the wound?

You will not have any stitches, only small sticking plaster strips over two or three small wounds. Keep the wounds dry until they are healed, which is normally within 5-7 days. You must keep them covered when showering or bathing for the first week.

When do I return to the outpatient clinic?

This is usually arranged for about 3 to 6 weeks after your operation to check on your progress. Please discuss any queries or worries you may have when you are at the clinic. Further clinic appointments are made after this as necessary.

Are there things that I should avoid?

Not really. The worst that can happen is to cause yourself pain, therefore, avoid heavy lifting for the first few weeks. However, **do not be frightened to start moving the arm as much as you can.** Gradually, the movements will become less painful.

How am I likely to progress?

It is important to recognise that improvement is slow and that this is not a quick fix operation. By 3 weeks after operation you will not have noticed much improvement and it is common for people to wonder whether they made the right decision about having the

operation done! However, you should have recovered nearly full movement. Getting your hand up your back usually takes a little longer. By 3 months after the operation most people are delighted and have noticed a great improvement in their symptoms. Everything continues to improve slowly and by 9 to 12 months after the operation your shoulder should be back to normal / feeling like the other shoulder.

When can I drive?

You can drive as soon as you feel able to comfortably control the vehicle. This is normally between one and two weeks. It is advisable to start with short journeys.

When can I return to work?

This will depend on the type of work you do and the extent of the surgery. If you have a job involving arm movements close to your body you may be able to return within a week. Most people return within a month of the operation but if you have a heavy lifting job or one with sustained overhead arm movement you may require a longer period of rehabilitation.

When can I participate in my leisure activities?

Your ability to start these activities will be dependent on pain, range of movement and strength that you have in your shoulder. **Nothing is forbidden**, but it is best to start with short sessions involving little effort and then gradually increase the effort or time for the activity. However, be aware that sustained or powerful overhead movements (e.g. trimming a hedge, some DIY, racket sports etc) will put stress on the subacromial area and may take longer to become comfortable.

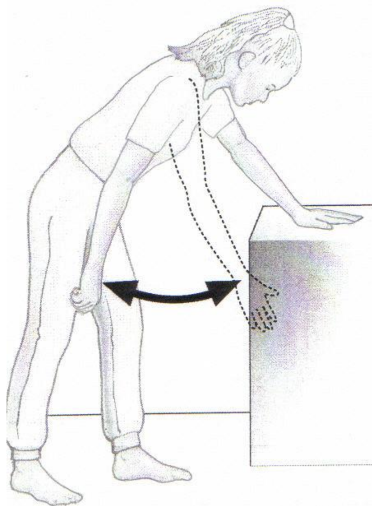
Exercises

Use painkillers and/or ice packs to reduce the pain before you exercise, if necessary.

Do short, frequent sessions (e.g. 5-10 minutes, 4 times a day) rather than one long session. It is normal for you to feel aching, discomfort or stretching sensations when doing these exercises. However, intense and lasting pain (e.g. for more than 30 minutes) is an indication to change the exercise by doing it less forcefully or often.

Pictures are shown for the right shoulder unless specified

1. Pendulum - lean forwards



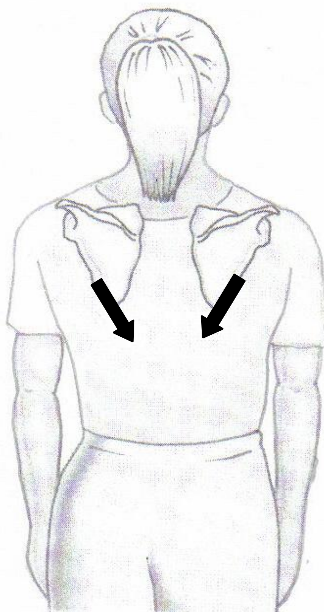
Let your arm hang freely.

Start with small movements.

Swing your arm:

- Forwards and backwards
- Side to side
- In circles

2. Lower trapezius – sitting or standing



Keep your arms relaxed.

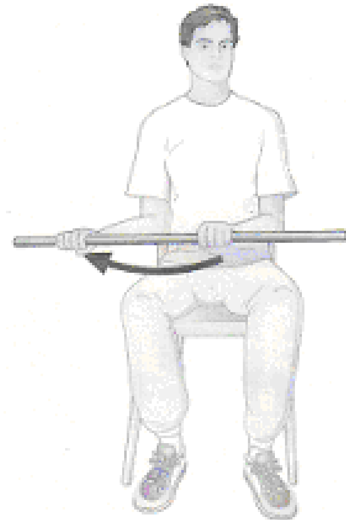
Square your shoulder blades (pull them back and slightly down).

Do not let your back arch.

Do not let your elbows move backwards (clasp your hands in front of you to discourage this).

Hold for 10 seconds.

3. External rotation – sitting or lying

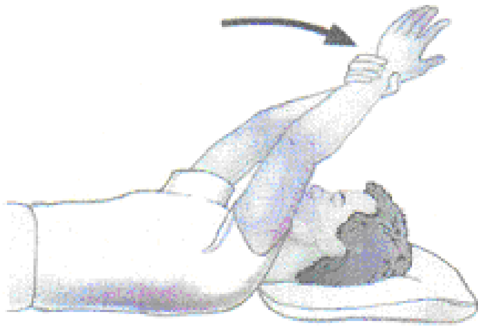


Keep your elbows into your side throughout.

Move hand outwards.

Can support/add pressure with a stick held between your hands if the movement is stiff.

4.Flexion in lying (left shoulder shown) - lying on your back on bed/floor

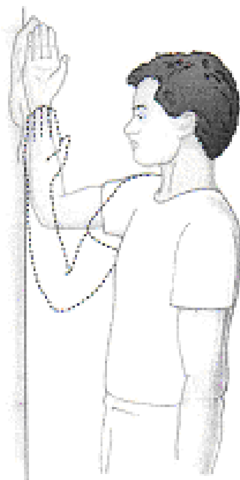


Support your operated arm and lift up overhead.
Try to get arm back towards pillow/bed.

Gradually remove the support.

Repeat 5-10 times.

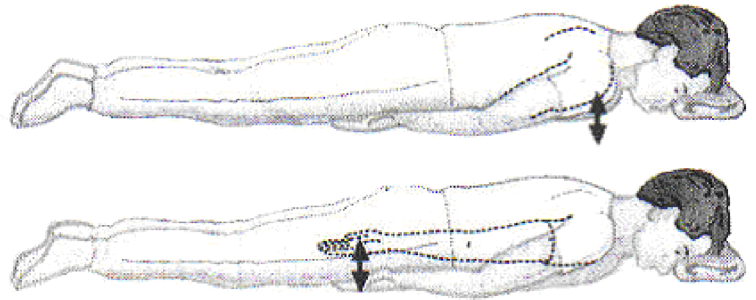
5.Flexion in standing - standing facing a wall



With elbow bend and hand resting against a wall **slide** your hand up the wall aiming to get a full stretch.
If necessary use a paper towel between your hand the wall to make it easier.

Repeat 10 times.

6. **Shoulder blade exercise – lying face down with head on a towel or turned towards shoulder**



Keep arm relaxed by side.

Lift shoulder straight up in the air. Try to keep a gap of about 5cm between shoulder and bed.

Hold shoulder up for 30 seconds and repeat 4 times.

Progress by lifting the arm up and down (elbow straight) but keeping the shoulder blade up all the time.

Aim to do this movement for 30

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Useful links

- www.readingorthopaediccentre.com
- www.shoulderdoc.co.uk
- www.orthogate.org/patient-education/shoulder/impingement-syndrome.html
- http://hcd2.bupa.co.uk/fact_sheets/html/subacromial_decompression.html
- http://www.gpnotebook.co.uk/simplepage.cfm?ID=765067278

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.