Patient information

Anterior Shoulder Stabilisation

You will be admitted for surgery to your shoulder because of an instability of your shoulder joint.

Dislocations to the shoulder joint are not infrequent. They mainly occur as a result of trauma but in some patients they may arise as a result of a deficiency of the ligaments. Normally the shoulder dislocates out in front (an anterior dislocation) but approximately 10% of shoulders dislocate out the back (posterior instability).

If non-operative management (physiotherapy) is unsuccessful at dealing with the shoulder instability, surgery is required. It should be noted that non-operative management is less successful when a shoulder is unstable as a result of trauma.

Surgery

Surgery is either performed under general anaesthetic or under sedation along with a nerve block of the area. Your anaesthetist will advise you about the most appropriate anaesthetic.

There are two main types of stabilisation:

- Anterior stabilisation which stabilises the shoulder at the front
- Posterior stabilisation which stabilises the shoulder from the back.

This leaflet concerns anterior stabilisations only. Your surgeon will have informed you which type of stabilisation you are having.

At surgery a 10-15cm long incision is normally made over the front shoulder. The shoulder joint is approached by releasing one of the major muscles running in front of the joint. The capsule is opened and either re-inserted if it has been found to be torn from its point of insertion or shortened if it is found to be lax. The shoulder muscle is then reinserted and the wound is closed.

Post-operative Care

Most patients are discharged on the day of surgery. If surgery has been performed using a nerve block, the operated area is usually numb for 12-18 hours after surgery.

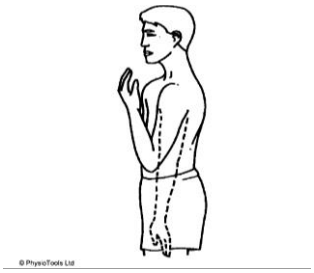
After surgery the arm is placed in a sling, and for the first 24 hours this may be supported by a body bandage which prevents the arm being moved away from the body. As a result of the release of the muscles running in front of the shoulder it is very important these muscles are not stretched by rotating the arm outwards.

The sling should be worn for 4-6 weeks, mainly for comfort. The sling should be worn at night with a tee-shirt over the top of the shoulder to prevent the arm from rotating away from the body. During the day-time the sling may be removed for exercises.

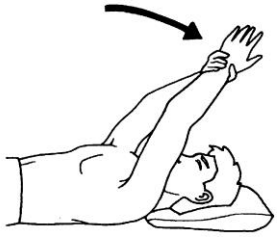
For the first 6 weeks movements of the shoulder must be restricted to protect the repair.

Rehabilitation

You should wear your sling for 4-6 weeks and only remove it for bathing and exercises. You should start the following exercises 24 hours after your surgery, once you have regained feeling and muscle function in your shoulder and arm after the anaesthetic.



Bend elbow towards shoulder and straighten out fully.
Repeat 10 times.



Lying on your back with elbows straight. Use the un-operated arm to lift the operated arm up, keeping it as close to the ear as possible.
Repeat 10 times.

Sit or stand.
Roll your shoulders in both directions.
Repeat 10 times.

- It is important that your repaired shoulder is not stressed for 4-6 weeks after your operation. Do not take your arm behind your back or too far away from your side.
- In bed, always rest your arm on a pillow to prevent it dropping behind your body.
- You may use your arm below shoulder level.

- You will be referred for outpatient physiotherapy at your local hospital or clinic.

If you have any questions about the exercises, please speak to your physiotherapist or the West Suffolk Hospital Physiotherapy Department on 01284 713300.

You should not return to driving for 6 weeks or until your surgeon has allowed you to.

Outcome of surgery

In general the results from stabilisation to the shoulder are good. Provided the arm is protected for the first three months and that heavy overhead lifts or contact sports are avoided for six months re-dislocations are rarely seen.

Complications

Wound seepage: Following surgery a certain amount of bloody seepage may be seen from the wound. This normally settles down within 24-48 hours. If bloody leakage should continue you should contact your General Practitioner or the Orthopaedic Department.

Infection: Infections around the shoulder are rare. If the wound should become red, hot and tender or you should develop a temperature in association with shoulder pain you should contact your General Practitioner or the Orthopaedic Department.

Pain: You will experience some pain and discomfort following surgery. The painkillers prescribed by your surgeon should be taken as prescribed. You may also place a bag of ice cubes or frozen peas over the shoulder to ease the swelling. You should furthermore rest the arm in a splint. Should this not settle your discomfort, you should contact your General Practitioner or the Orthopaedic Department.

Nerve damage: Nerve damage is rarely seen following shoulder stabilisation. Temporary nerve irritation may be seen as the result of post-operative swelling. If the shoulder has previously been operated on the risk of nerve damage is greater but the likelihood of damage to one of the nerves to the shoulder muscles is still small. Should damage to the nerve which innervates the larger shoulder muscle (the deltoid) occur irreversible loss of shoulder function may be seen. This is as stated a very rare occurrence.

Recurrent instability: This is a rare occurrence following shoulder stabilisation. Further trauma to the shoulder may however result in instability recurring.

Stiffness: As a result of the tightening procedure to the shoulder a certain amount of stiffness is always seen for the first 3-6 months. This normally subsides with exercises but a lack of full external rotation may be seen following surgery.

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http://www.disabledgo.com/organisations/west-suffolk-nhs-foundation-trust/main