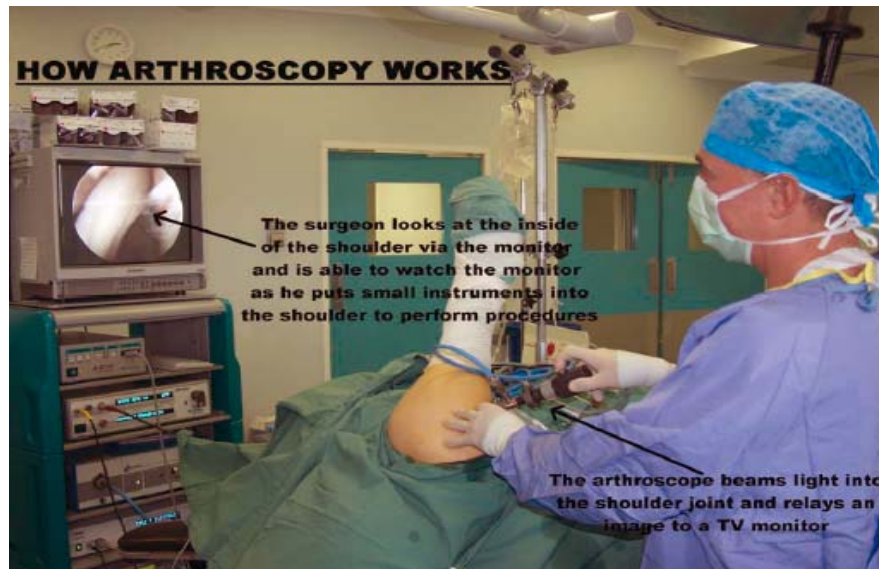




PATIENT NOTES – ARTHROSCOPIC SHOULDER SURGERY

I have suggested that you consider an Arthroscopic (keyhole) procedure to diagnose and treat your shoulder condition. Arthroscopy (Minimally Invasive Surgery) allows me to look into your shoulder joint to confirm your diagnosis and, in most cases, treat the condition with an operation that requires very small skin incisions. I am able to use specially made instruments that fit through the small skin incisions, disturbing the shoulder joint less than open surgery. This allows you to have a shorter hospital stay and a smoother recovery than with “open surgery”.



Prior to considering surgery you will almost certainly have had a CT scan or MRI arthrogram to help accurately diagnose your condition. Despite the sophistication of these tests there are times that when I look into the joint I discover something unexpected. The benefit of the arthroscopic treatment is that I can fix most of these problems immediately.

There are several conditions that can be treated arthroscopically

1. Impingement or inflammation of the Rotator Cuff
2. Some types of Instabilities or dislocations
3. Small Rotator Cuff tears
4. Labral or cartilage tears
5. Chronic Frozen Shoulders
6. Calcific Tendonitis
7. Early arthritis
8. Loose bodies
9. Infections

If you have certain medical problems you may require some preoperative tests to ensure that you are fit for a general anaesthetic. These will be organised through my office and you may need to see a physician. One week prior to surgery, you will need to wash your shoulder girdle with PHISOHEX antiseptic solution (available from your chemist). If you get an allergic reaction to the PhisoHex then stop using it immediately and inform my office. You are to avoid getting sunburnt.

If you are on Anti inflammatory tablets or Aspirin, please check with your GP and if he or she says it is safe, stop the tablets 10 days prior to surgery.

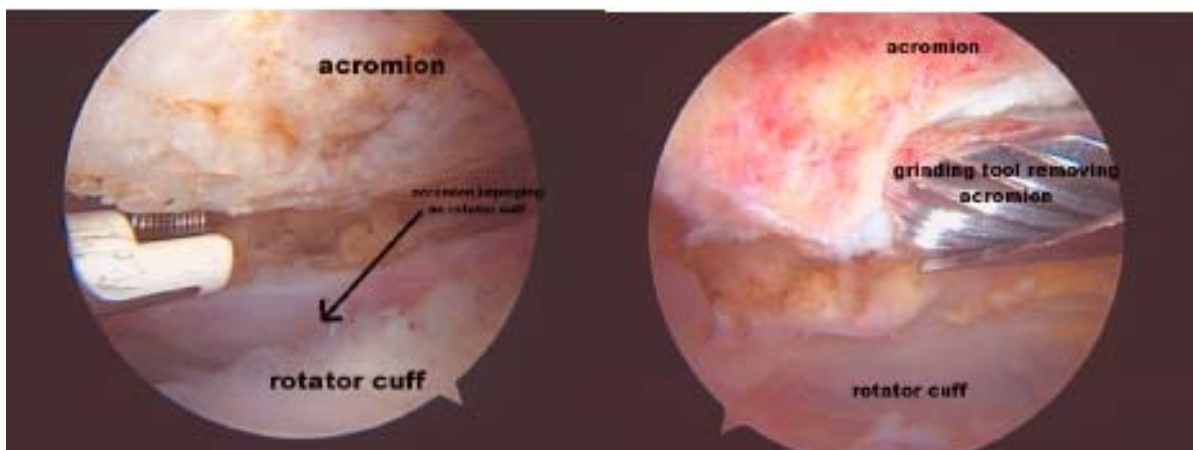
You will be admitted to the hospital on the morning of surgery and you will be visited by the anaesthetist who will examine you and make sure you are fully fit to undergo a general anaesthetic. In many cases the anaesthetist will explain to you the option of having a “block” which is an injection in and around the neck which will reduce pain for 12 to 18 hours post operatively. The nursing staff will also explain the use of “patient controlled analgesia” (or PCA) where you regulate the amount of pain relieving medication that you use. You must remove all rings from your hand prior to surgery.

The operation takes about 90 minutes, depending on exactly what procedure is done. There will be 2 or 3 small incisions about the shoulder. The exact operation done will depend on what is found when I look in the joint. Sometimes people have 2 or even 3 pathological processes going on at once and all of these can usually be addressed during the one procedure. Very occasionally a different diagnosis is found to what was expected and you may need to return for an ‘open’ operation a few weeks later, once the swelling has settled.

Listed in the following pages are the most commonly performed procedures:

ARTHROSCOPIC ACROMIOPLASTY

The acromion is the top part of the shoulder blade which can be felt at the point of the shoulder. Between this bone and the ball of the humeral head run the rotator cuff tendons which connect important muscles from the scapula (wing bone) to the shoulder joint (humeral head). If you have inflammation or a partial tear of the Rotator Cuff you can get “impingement” symptoms with pain and catching in the shoulder with reaching or overhead activities. These pains result from the Rotator Cuff rubbing on the Acromion bone and can be alleviated by giving the Rotator Cuff more room to move and ultimately allowing it to heal. This is achieved by ‘shaving’ the partially torn Rotator Cuff and trimming the protruding acromion bone and its ligament. **Arthroscopic subacromial decompression is an operation designed to provide more room for your rotator cuff tendons to move.**



Maintaining motion prevents scarring in the subacromial space from taking place. In effect, this prevents stiffness from setting in and it is important to achieve a full range of motion as early as possible after the operation. If the shoulder does get stiff in the early post operative period it usually does recover but may take a period of months rather than weeks to do so

After surgery you stay in hospital overnight and commence physiotherapy the day after surgery. Use of a sling is required for about a week but sometimes longer if the surgery involves any labral repair or capsular surgery (see other sections). Each individual will find a different method of shoulder exercises easier. It does not matter whether you are sitting up or lying down, helping your arm with your other hand or having someone else do this for you. As long as a full range of motion is achieved 5 to 6 times a day the same end result will be achieved. It often takes several weeks for the ache in the shoulder to settle even if you have regained full motion. There is often a clicking or burning sensation in the shoulder and this only subsides when the swelling of the tendons diminishes after approximately 2 months. The shoulder will continue to improve for up to 12 months and you should be patient with this recovery period. You will be taught the range of motion exercises before you leave hospital and should plan to start formal physiotherapy a week or 2 later. If the Rotator Cuff muscles are not too badly damaged the success rate of surgery is about 90%. **The surgery works by removing the bone that rubs on the Rotator Cuff muscle and relies on the ability of the muscle to heal.** I cannot give you a new Rotator Cuff and unfortunately in about 10% of patients the muscle does not heal and the surgery does not work.

ARTHROSCOPIC EXCISION OF THE END OF THE COLLAR BONE

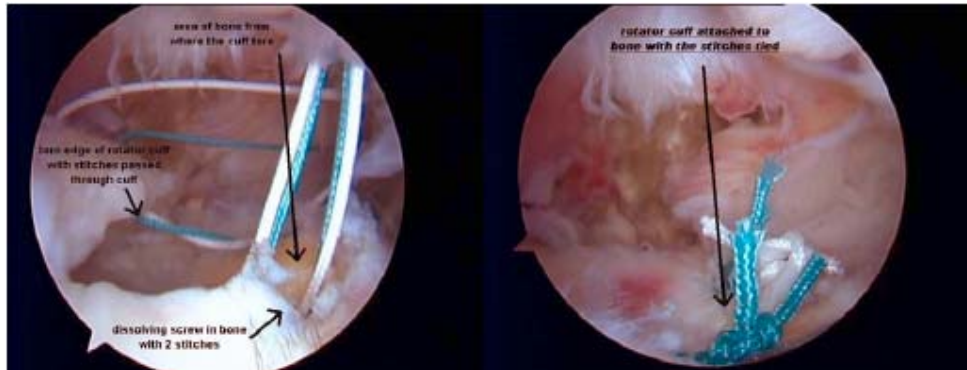
People with pain from arthritis of the Acromioclavicular joint can benefit from the worn out outer end (about 1/2cm) of the collar bone being removed. The joint remains stable because the surrounding ligaments are not interfered with and normal shoulder function can be achieved in most cases. This procedure is often combined with an acromioplasty (see above) if you have impingement as well as arthritis of the acromioclavicular joint.

After surgery you are in hospital overnight and commence physiotherapy the day after surgery. Use of a sling is required for about 2 weeks. Most people are back to normal within 3 months and the surgery has a 90% success rate.

ARTHROSCOPIC ROTATOR CUFF REPAIR

When the Rotator Cuff muscle has a complete or full thickness tear it is usually possible to repair the Rotator Cuff with 'keyhole surgery' using dissolving screws or small metal screws with stitches attached to them. This procedure is usually only successful in small to medium size tears. When the tears are large I recommend "open surgery" as the success rate is much higher.

In most cases the repair is combined with an Arthroscopic Acromioplasty (see above)



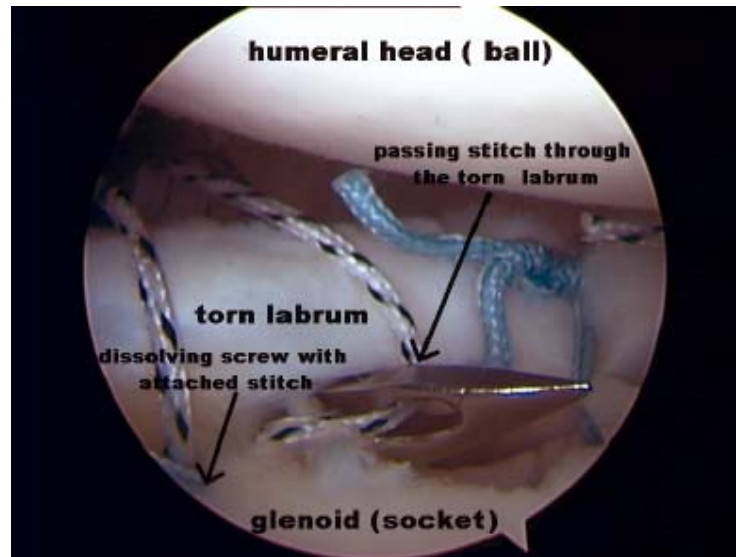
After surgery you will stay in hospital overnight and commence physiotherapy the day after surgery. Use of a sling and binder is required for 4 to 6 weeks, depending on the size and position of the tear. The sling is worn day and night to protect the repair and the arm must not be moved without the aid of the normal arm.

Rehabilitation and physiotherapy are required for 12 months and lifting is limited to between 2 kg to 5 kg for 6 months and 10kg for a further 6 months. It often takes 9 to 12 months for the pain to settle completely.

The success rate for small and medium size tears is in the vicinity of 80%. Large tears have lower success rates and for these tears I recommend an "open operation" which has a 90% success rate.

ARTHROSCOPIC STABILISATION AND LABRAL REPAIRS

When patients have recurrent dislocations, subluxations (half dislocations) or labral tears (also known as SLAP lesions) there is an option of repairing these arthroscopically. When the labrum tears off the bone it can be reattached using a screw with a stitch attached to the end. The back and top of the labrum which cannot be reached using can be repaired traditional open techniques can be repaired arthroscopically. In cases where the capsule (or lining of the shoulder) has stretched there is the added option of stitching the capsule. The capsular tightening part of the procedure is not as effective as if it was performed 'open' so some patients are not suitable for an 'arthroscopic stabilisation'.



You will stay in hospital overnight and be in a sling for 4 – 6 weeks (24 hours a day). After that an exercise program is commenced and physiotherapy may be required for 6 months. Sport and heavy lifting must be avoided for 6 months.

The success rate of the surgery is lower if you have had multiple dislocations or if the labrum is not torn (the dislocation happens because the capsule is very stretched). I recommend an “open” stabilization which has a 95% success rate for patients that are likely to resume contact sports. Surgery for a SLAP lesion is about 90% successful.

If you have a “hyper mobile” shoulder with evidence of generalised ligamentous laxity, arthroscopic surgery is rarely successful.

CHRONIC ADHESIVE CAPSULITIS OR FROZEN SHOULDER

On the rare occasion that the symptoms have not settled after 18 months the contracted and inflamed lining of the joint can be released. A special device is used to remove part of the capsule which allows the movement to be restored. If there is inflammation and impingement of the Rotator Cuff then an acromioplasty (see above) may be combined with the capsular release.

You are in hospital overnight and in a sling for about a week. Aggressive physiotherapy is commenced immediately after surgery and is required for at least 6 months. Surgery is successful in about 70% of patients but is moderately less successful in diabetics. Even with successful surgery restoration of full movement is unlikely (The general rule is that good movement is achieved).

CALCIFIC TENDONITIS

In this condition abnormal amounts of calcium are found within the Rotator Cuff. If this calcification does not spontaneously disappear over an extended period then surgery can help. The Calcium is cut out arthroscopically and in most cases the an acromioplasty (see above) is combined with the procedure.

You are in hospital overnight and in a sling for a week. Physiotherapy is required for 6 months and the shoulder can be a little stiff for up to 6 months. The Calcium can reform in 10% of cases.

ARTHRITIS

Arthroscopy can be helpful in this condition by removing loose fragments of bone, debriding the damaged articular cartilage and releasing part of the contracted capsule and acting as a general ‘spring cleaning’. The aim of such surgery is to give some pain relief and improve range of motion. This surgery is of limited value in that it will not cure the problem and the relief will be temporary only. It should be thought of as a ‘spring cleaning’ of the joint and does not cure the arthritis. Ultimately you may need a Shoulder Replacement.

You will be in hospital overnight and in a sling for 1 week. Physiotherapy may be required for 3 to 6 months and the level of improvement ranges from nothing to several years of relief.

AFTER SURGERY

You will wake up in the ward in a sling. You will be given enough pain killers to keep you comfortable.

The day after surgery I will see you and discuss the surgery with you. A waterproof dressing will be placed on the shoulder and you will be allowed to shower. When showering take the sling off but leave your arm adjacent to your body – **do not attempt to lift or rotate the arm** – and then put the sling back on after you are dry. Make sure the armpit is as dry as possible because of the risk of a sweat rash or an armpit infection. It is important to sit out of bed and walk around as soon as you are comfortable and able.

Depending on the exact procedure done you may commence physiotherapy the morning after surgery and you will be taught some exercises by the physiotherapist. You will need to do those exercises at home under your own supervision about 4 times a day. You will not be required to see a physiotherapist once you leave hospital, until after I see you in the office. If you have had a labral repair or stabilisation you must not have physiotherapy until I instruct you to do so, usually at about 4 to 6 weeks postoperatively.

You can be discharged from hospital the day after surgery if you are coping well with the pain level and are able to do your exercises yourself.

In the immediate post operative period you will experience pain about the shoulder. There will also be significant pain at night as a result of the surgery. On discharge from hospital you will be given pain killers which I would encourage you to use. Should you require extra tablets or tablets to help you sleep at night, either let my office know or see your family doctor. You will have a “see through” dressing over the wound made out of a substance called “duoderm” or “comfeel”. This is a waterproof dressing that allows you to shower without compromising the sterility of the wound. After a day or two you will notice a white material that looks like pus under the dressing. This is the perspiration of your skin reacting with the medication in the dressing and is nothing to worry about. The dressing should not be changed. It is common to get swelling about the arm, forearm, hand and fingers. **Please endeavour to keep the armpit as dry as possible** – once the wound has healed at about 7 days you can use talcum powder which will help.

The sling will need to remain on until I see you in the office at about 10 days postoperatively. **The sling must remain on 24 hours a day, including at night.** The sling only comes off to have a shower and get dressed and on those occasions the arm needs to be kept adjacent to the body. If you have been given an exercise program the sling is taken off to do the exercises. The Roads and Traffic Authority does not permit driving a vehicle while you are in a sling. I therefore recommend you do not drive until you are out of the sling.

When I see you in the office, I will remove the stitches and fully explain the surgery to you with the aid of a model. In most cases I photograph the shoulder during the surgery and these pictures help in explaining the procedure to you.

In most, but not all cases, I remove the sling at that stage and commence physiotherapy. I will allow you to use the arm as much as you want but I would recommend not lifting more than 2 kg and not doing overhead work. You can gradually start to resume normal activity as pain permits.

If you have had a labral repair or arthroscopic stabilisation I will be keeping you in a sling for about 4 weeks before starting exercises and physiotherapy.

I am comfortable with most people returning to light clerical work within 3 to 4 days of surgery. If your job requires heavy lifting or repetitive overhead work then it is unlikely you will be able to return to these duties for 6 months.

You should avoid contact and racquet sports and upper body weights for 6 months. Jogging, cycling and breaststroke swimming can be commenced within 6 to 12 weeks depending on the procedure that you have undergone (Check with me before doing so!).

I will review your progress every 4 to 6 weeks for about 6 months. During this time I will check your progress and upgrade your physiotherapy and exercise program.

Please note that many people have a misconception that arthroscopic shoulder surgery leads to a complete recovery within a few weeks. This is totally incorrect. Such surgery though minimally invasive, generally has a six month rehabilitation period and requires a patient committed to his or her post operative rehabilitation.

Complications are uncommon with this type of surgery but can occur. The common ones include but are not limited to wound infections, stiffness and occasionally some transient numbness around the shoulder. You should be aware that there is no operation that cannot make you permanently worse off than prior to surgery but I would like to emphasise that such complications are exceedingly rare.

Post operative stiffness can be a problem (especially if you have diabetes) but usually settles after about 4 months. Very occasionally we have to do a procedure called a Manipulation if stiffness remains a problem after 6 months.

When to contact me before I have removed your stitches:

- Fever above 38 degrees Celsius
- Increased pain unrelieved with pain medications
- Sudden, severe shoulder pain.
- Increased redness around the incision
- Increased swelling at the incision
- A bulge that can be felt at the shoulder
- Shoulder pain, tenderness or swelling.
- Numbness or tingling in the arm.
- Change in colour and temperature of the arm.
- Change in motion ability
- Drainage or odour from the incision
- Any significant concerns you have

If after reading this handout you have any questions, especially about the potential complications, please ring the office, leave a message for me and I will call you back to answer your questions.

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