ORTHO SPORTS

Dr Matthew Brick Dr Warren Leigh

ARTHROSCOPIC SHOULDER STABILISATION-POST OPERATIVE

This is a procedure which aims to restore the anatomy of the shoulder to as near normal as possible. As you are aware, the reason that a shoulder dislocates has to do with the capsule that surrounds the joint. This capsule is a bag like structure which attaches to the edges of the joint and keeps the ball part of the joint in the socket. It contains thickenings or folds which represent the stronger part of the capsule and these are the so called ligament of the shoulder. When a shoulder subluxes (partly dislocates) or dislocates it does so because the capsule is no longer tight enough to keep in joint. The commonest cause for this is a tear in the front of the joint where the capsule attaches to the edge of the socket. This occurs when the shoulder comes out of joint for the first time and essentially it never heals. To fix this problem the rear has to be repaired by re-attaching the capsule to the bone. In addition however, any loose damaged capsule will need to be tightened. When the repair is done therefore, any redundancy in the capsule is removed by pulling this area in more tightly.

In some cases no obvious tear in the capsule can be found. In this instance the cause of the problem is usually an over large capsule which may have been stretched just enough to allow symptomatic subluxation to occur. In this instance because there is no tear to repair, the capsule is tightened over a wide area to create a smaller tighter structure that will keep the shoulder in joint. This is called a capsular plication and it represents the arthroscopic equivalent of the capsular shift procedure of open surgery. In effect there is very little difference in these procedures, that difference occurring in the location of the tightening and not really the end result. The advantage of doing this arthroscopically, however, is that the tightness can be more accurately judged than it can be at open surgery. Whilst this is not generally a problem for surgery at the front of the shoulder, it is a big problem for surgery at the back of the shoulder which traditionally has not done all that well.

With these newer techniques the results for a wide range of procedures are starting to appear better than some of the open operations. Despite this however, there are some problems that are best managed in an open fashion. In your case, however, it was felt that this was not the situation and hence an arthroscopic procedure was performed.

Arthroscopic Bankart Repair

The tear of the capsule and ligaments off the socket is called Bankart tear. When present this needs to be repaired. To do this, the capsule is freed up and further detached from the bone. The bone is then roughened with a burr in order to freshen it up and make it bleed. Anchors, (like a tiny plastic peg) are then

inserted into the edge of the socket and these have sutures attached to them. The other ends of these sutures are then passed through the capsule so that the capsule can be tied down onto the anchor and therefore onto the bleeding bone. In this way, using three or four anchors, the tear can be repaired.

The sutures are non absorbable so that they act as a permanent reinforcement to the repair. One of the problems with previous methods of arthroscopic stabilisation of the shoulder was the use of absorbable sutures. This lead to a higher than expected rate of failure in the longer term and it is felt that this is because the scar tissue of the repair is not sufficient to provide long term strength in some cases.

Capsular plication

In this procedure the capsule is pleated upon itself to remove redundancy. Again, non absorbable sutures are used where possible. As there is no tear in this situation, no anchors are required. Nevertheless, the strength of the repair is similar to a Bankart style of repair in that it relies on the same stitches being placed through the capsule. The same restrictions to post operative mobility therefore apply.

Your surgery

This has been done arthroscopically. In general therefore there should be one small wound at the back of the shoulder and two at the front. Occasionally there are more than three wounds, but this is unusual for standard repairs.

The wounds need to be kept dry for at least five days. If they do get wet before then, please dry them and, if necessary, reapply a clean dressing to them. Often a band aid will suffice.

The stitches can be removed at 7-10 days. This will be done at your first post operative appointment.

Post operative program

The single most important thing is to allow the repair to heal without placing excessive stress on it. This means that the shoulder should not be moved excessively or used to do heavy things. A sling is provided which needs to be worn for four weeks. It needs to be on most of the time and particularly when in bed and when walking out of the house. It may however, be taken off for eating, showering and when sitting quietly.
The hand can still be used to operate a keyboard, write or to eat, as long as the elbow is kept at your side and the hand is somewhere directly in front of you. (not rotated out to the side).

At the four weeks mark the arm can be taken through a full range of motion or as near to it as possible. The sling is no longer used and physiotherapy can begin.

At the three month mark, if all is going well, some people can return to non-contact sport. This does not apply to everyone however, and clearly some people are not ready to participate in those sort of activities at that time. If your shoulder feels good enough by then however, and if it is strong enough, then some training can be commence with a view to subsequent return to full sport.

Collision sport like rugby is a different story. Often we recommend 5-6 months before full contact is allowed.

It is expected that you will be in hospital for one night post surgery. Sometimes, however, the shoulder is good enough to allow an earlier discharge and if you feel up to leaving hospital on the day of surgery then this is certainly allowed. Independent of the time of your departure from hospital, please remember that you have had a significant sized procedure done to your shoulder. The fact that it was able to be done through the scope without the need to open the whole shoulder up does not change the actual procedure performed. It is recommended therefore, that you rest for a few days post surgery and do not try to push the recovery along faster than nature had intended.

Problems

Bruising
This is inevitable to some degree, especially around the area of the incisions. The shoulder is an area with a very large blood supply and thus has a tendency to bleed more than other areas. Some bruising is therefore to be expected and this will be reabsorbed over about two weeks. Very occasionally excessive bleeding does occur after a shoulder procedure. This is usually after open surgery however and rarely after arthroscopic surgery. If you have any concerns in this regard, please contact me or my staff.

Infection
Superficial wound infection is not very common. It generally means a little redness around the wound and usually relates to the stitches. Generally this resolves with removal of the stitches and antibiotics are rarely required.

Deep infection in the actual shoulder is very rare, partly because antibiotics and other precautions are used at the time of surgery. If it happens however, the shoulder needs to be washed out immediately and high does antibiotics commenced. By doing this the repair can usually be saved and long term sequelae avoided. Increasing swelling of the whole shoulder associated by increasingly uncontrollable pain and inability to tolerate even very small movement of the shoulder, may herald such an event. If concerned contact me directly.

Re-injury
If you are careful, early re-injury should not occur. Nevertheless accidents do happen and if in doubt the shoulder should be checked. Fortunately, the repair is reasonably strong and will survive a small injury. It is best, however, not to put this to the test.

Re-dislocation
Short of a further major re-injury, this is uncommon in the first six months. Subsequent to that however there is a small failure rate which is thought to be around 10%. Some of these are associated with a further injury, some are associated with gradual stretch out and failure of the repair and some are the result of only partially controlling the instability. With regard to that, some shoulders are unstable in more than one direction. It is sometime difficult to determine exactly which is the major direction of instability and hence where the repair should be done. In some cases the joint may be normally loose in several directions but only symptomatic in one. In that case only the symptomatic area needs treatment to return it to normal. In other cases however the joint is symptomatic in more than one area and hence a second area of repair is required. This other repair cannot always be done at the same time as the primary repair is performed and the shoulder is then reassessed through the recovery phase to see whether other intervention is necessary.

Who to contact

If you are having problems with your shoulder do not hesitate to contact the office or myself. I can generally be reached on one of the listed numbers and if not immediately available I will try to get back to you as soon as possible. If for some reason I am unable to be reached, then you may be able to seek advice from the hospital ward or from your general practitioner.