



DR. TERRY HAMMOND

SHOULDER SURGEON

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SHOULDER SURGERY Information for Patients

SHOULDER DISLOCATION/INSTABILITY SLAP TEARS

This booklet has been prepared to help you better understand your shoulder problem and the surgery that may be required. It will also help explain what will happen after the surgery has been performed. Although this booklet aims to be relatively comprehensive, you will probably still have some questions and I would of course be happy to answer these at any time.

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SHOULDER DISLOCATIONS

The shoulder is a ball and socket joint and is illustrated in *figure 1*. The ball is known as the head of the humerus and the socket is known as the glenoid. As you can see in the diagram, the glenoid is quite a flat structure and this means that the shoulder is prone to dislocations where the head of the humerus slips off the glenoid. An example of this injury is shown in *figure 2*.

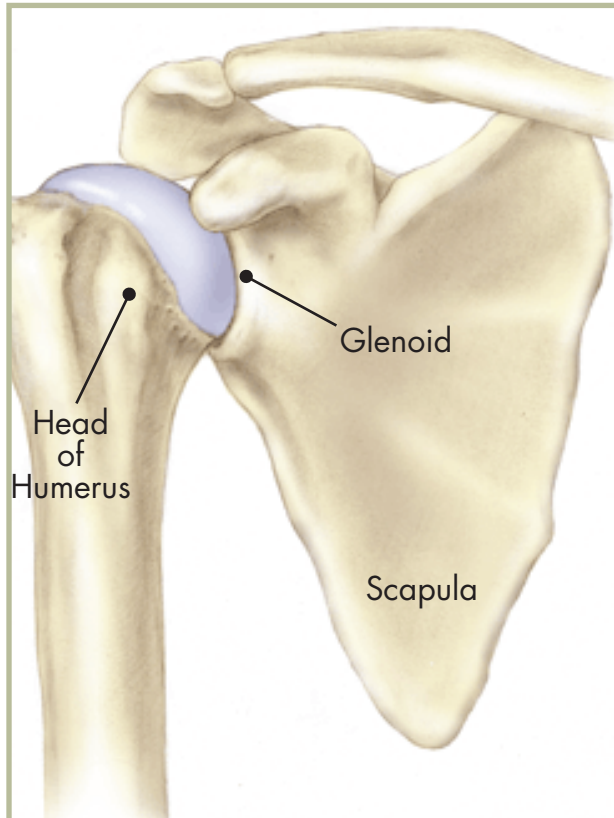


Figure 1. The bones of the shoulder

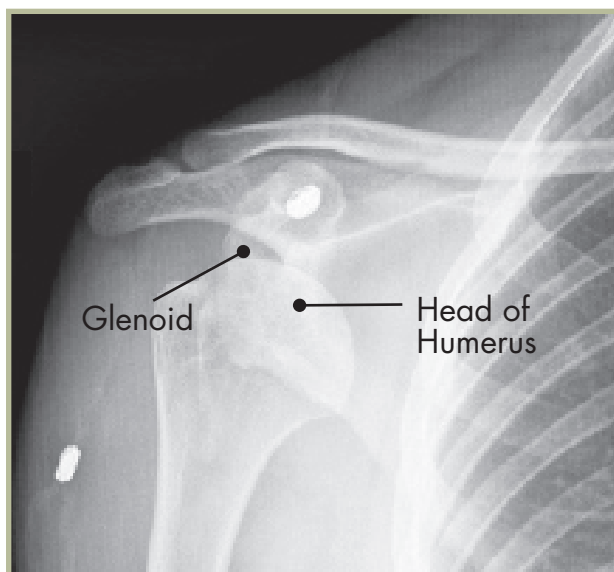


Figure 2. Shoulder dislocation. Note the head of the humerus is separated from the glenoid

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In order to stop this happening the shoulder is surrounded by sleeve of strong tissue called the capsule. This is illustrated in *figure 3*. When the shoulder dislocates, it tears a hole in the front of the capsule. This tear is shown in *figure 4*. As well as the tear in the capsule, the head of the humerus may sometimes knock a piece of bone off the front of the glenoid as it dislocates.

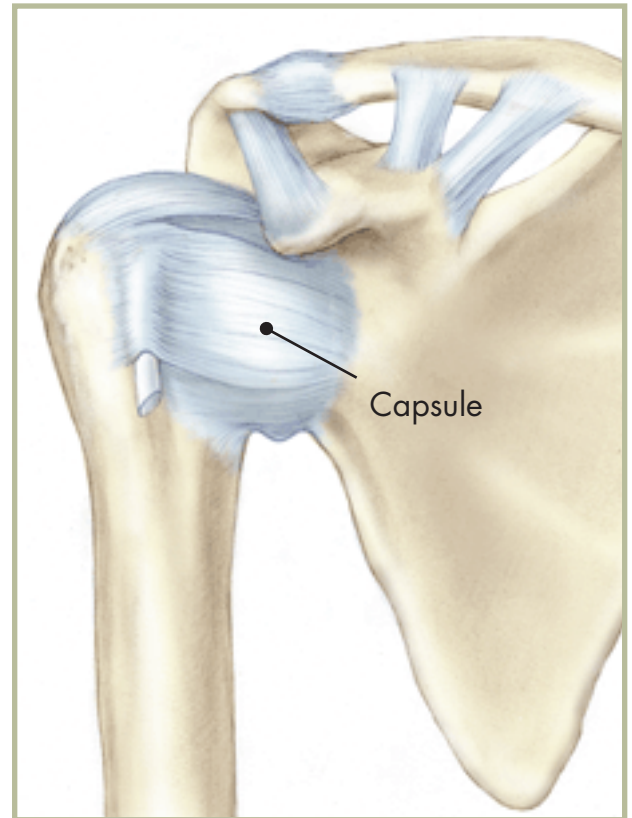


Figure 3. The capsule of the shoulder

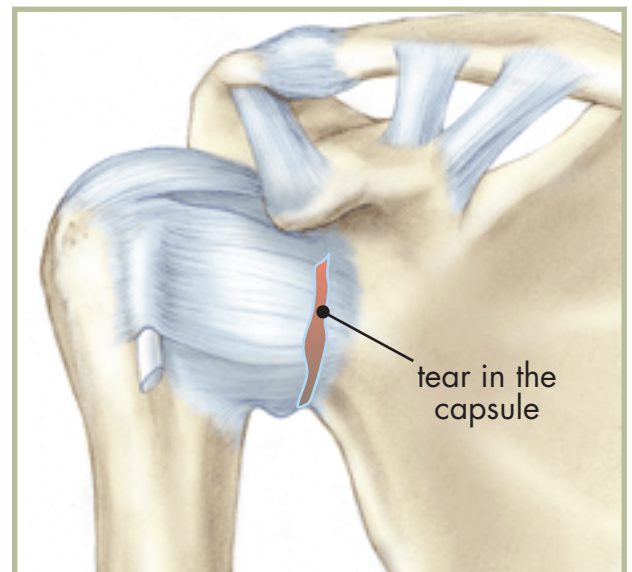


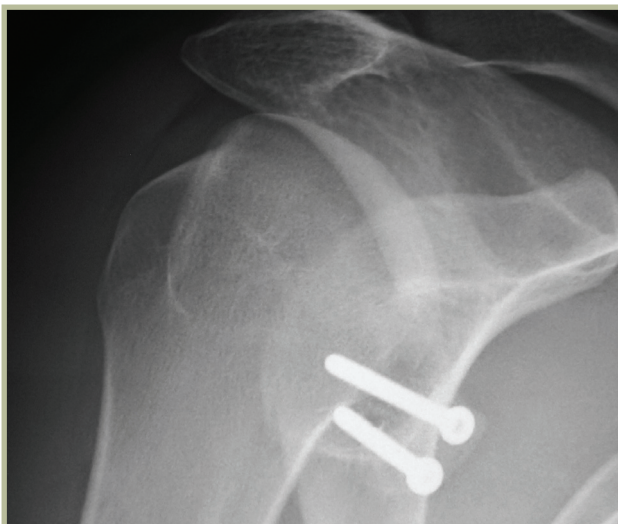
Figure 4. Bankart lesion. Note the hole in the capsule where it has been torn from the front of the glenoid.



SURGERY

In order to prevent further dislocations, the hole in the capsule must be repaired. This can usually be done by arthroscopic (keyhole) surgery. A number of small holes are made in the skin and a camera and surgical instruments introduced into the joint. Special stitches are used to repair the tear in the capsule.

In some cases however, it may not be possible to repair the damage by arthroscopic surgery. This is particularly true in cases where a piece of bone has been fractured off the front of the glenoid. In these cases an open (not arthroscopic) operation is required. One such procedure is known as a Latarjet operation. This involves an incision in the front of your shoulder; a piece of bone is then screwed to the front of the glenoid. This makes up for any bone that has been fractured off the edge of the glenoid. An example of this operation is shown in figure 5.



*Figure 5. Latarjet operation.
(The two screws shown in the photograph are used to hold the piece of bone onto the glenoid.)*

Although the surgery (either arthroscopic or open) gives a strong repair, it is possible to tear out the stitches if you move your shoulder the wrong way immediately after surgery. You must wait until your shoulder is fully healed before doing any activities such as heavy work or sport – this takes between 4-6 months.

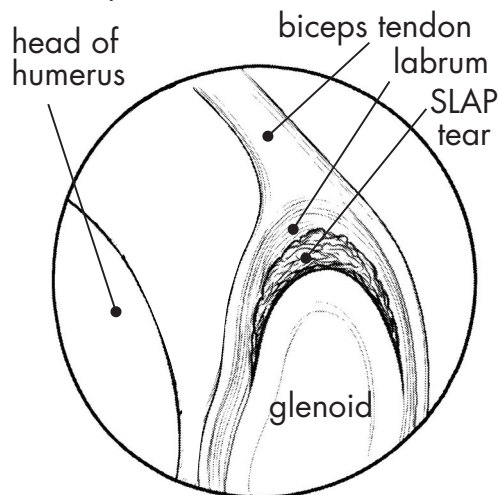
After either arthroscopic or open surgery, there will be some restriction in the range of motion of your shoulder. This is necessary to allow the capsule to heal. Gradually, the movement will return but in some cases we aim to produce a permanent restriction in the range of motion in your shoulder. This is usually a small restriction and does not affect the function of your arm.

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SLAP TEARS

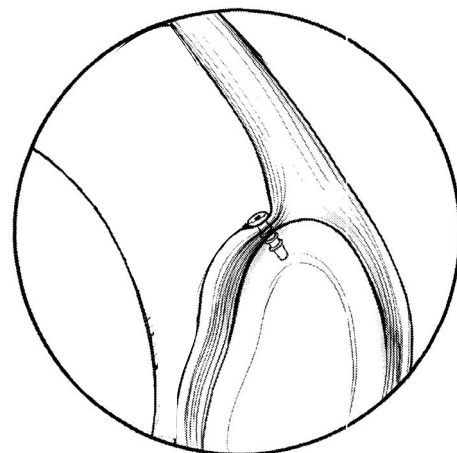
The glenoid is surrounded by a rim of strong flexible tissue known as the labrum. This is illustrated in figure 6.

The labrum may become torn or detached from the glenoid. This is known as a SLAP tear and is also shown in figure 6. This can result in pain or even repeated dislocations of the shoulder.



*Figure 6. SLAP tear
This is the inside view of the shoulder joint. The biceps tendon and the labrum should be firmly attached to the top of the glenoid. Here it has been pulled off. This is a SLAP tear.*

In order to treat this problem, surgery is usually required. Arthroscopic surgery is performed and the torn labrum is reattached to the glenoid. This is illustrated in figure 7.



*Figure 7. SLAP repair.
A special anchor has been used to re-attach the labrum to the glenoid.*



RISKS OF SURGERY

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Although shoulder surgery is generally very safe, there are a number of possible risks and complications that you should be aware of.

RE-DISLOCATION:

If you are having surgery for dislocation of your shoulder there is always a chance that the shoulder may re-dislocate after surgery. The only way to completely eliminate this risk would be to surgically stiffen the shoulder so that it has no movement whatsoever. Obviously this would be highly undesirable in most cases. If the shoulder does re-dislocate you may need another operation. It is important to understand this risk – you should not have surgery unless you are willing to accept the possibility of re-dislocation.

STIFFNESS:

Following surgery you will notice some stiffness in the shoulder joint. This is a desirable outcome as it allows the shoulder to heal and decrease the chance of re-dislocation. The shoulder will gradually stretch out with time, but it is common to have a very slight restriction in the range of motion that persists long term. Very occasionally there may be marked stiffness which persists for longer than usual. This is termed a “frozen shoulder”. It usually resolves completely and does not affect your outcome but it certainly prolongs your recovery period.

INFECTION:

Infection in the shoulder joint is rare following surgery, but if it does occur you will usually require another stay in hospital and possibly further surgery.

There are a number of minor complications that can occur following surgery. These usually settle completely and do not affect the outcome. These complications can include bruising, swelling, tingling of your fingers, nausea, vomiting, sore throat and bruising around the intravenous drip site.

MAJOR COMPLICATIONS:

Thankfully, major complications following shoulder surgery are very rare. Some of these complications can include damage to major arteries and nerves, sudden death from anaesthesia, heart attack or stroke, deep vein thrombosis and pulmonary embolus.

Obviously, it is possible that these complications can lead to either loss of your limb or your life, but this is an extremely uncommon occurrence. If you have any particular concerns, myself or my anaesthetist would be happy to discuss this with you at length.

The list of complications is not fully comprehensive but it does outline what are considered to be the major risks of surgery and those which have the most serious outcome.

Please feel free to discuss this with me at any time – you should not proceed with surgery until you are satisfied that any issues regarding the risks of surgery have been adequately discussed.

THE DAY OF YOUR SURGERY

You will usually be admitted on the morning of your surgery to either Pindara Main Hospital (Allchurch Ave) or the Day Procedure Centre (Pindara Place, ground floor). You will often be admitted some hours before your surgery. This time can be quite boring so it is a good idea to bring a book or magazine with you.

The nursing staff, my anaesthetist and I will see you before your surgery and go through a series of questions confirming your name, date of birth, what surgery you are having and what side we are operating on. In most cases you will have a general anaesthetic and be asleep during the whole procedure. You will then spend some time in the recovery unit before either being allowed home or staying overnight. You will have strong painkillers and therefore generally you will be reasonable comfortable immediately after your surgery.

You should tell your friends or relatives that this whole process is quite lengthy and will take some hours. I will see you immediately after your surgery but often it is difficult to remember what I say due to the anaesthetic drugs. I will therefore see you in the ward or contact you in the days following your surgery to give you information about your operation. Patients admitted to Pindara Main Hospital will often stay overnight but those in the Day Procedure Centre will be allowed home on the day of surgery.



AFTER YOUR SURGERY

Following your surgery, you will need to wear a sling. You must wear this for six weeks and keep it on at all times unless you are doing your exercises or showering. The strap around your back must be worn when you are asleep in bed but you can remove the strap when you are awake. If you have any problems with your sling contact your physiotherapist or my rooms - the nursing staff at my rooms can usually help.

You will need to be very careful not to stretch your shoulder too far or the stitches will tear out. If the shoulder feels like it has re-dislocated (popped out of joint) you will need to contact me through my rooms or directly on my mobile phone.

You should leave your dressings intact until I see you in my rooms. There may be some fluid or blood underneath them but this is quite normal. Obviously, if there is any sign of infection i.e. redness or a pusy discharge you will need to contact myself, my rooms or the Emergency department of Pindara Hospital.

CAN I USE MY HAND?

You can use your hand while your arm is in the sling- this can be quite useful for activities such as holding light things while you are using your other arm.

CAN I TAKE MY ARM OUT OF THE SLING FOR DAY-TO-DAY ACTIVITIES E.G. TYPING, WRITING, EATING AND TOILETING?

Although it may be tempting to do these things, I advise against it. The reason for this is that stitches inside your shoulder are quite small and can tear out if the shoulder is moved incorrectly. Although you may think you can be careful with your arm, most people inadvertently move their arm into the wrong position and this can tear the stitches.

WHEN CAN YOU SHOWER?

You can shower anytime after your surgery but you must avoid getting your incisions wet for two weeks following your surgery. Many patients prefer to have a bath during that time. When you are showering, you can take your arm out of the sling and straighten your elbow out to allow your arm to hang straight

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down; you can then lean forward a little to wash your armpit.

SHOULD I DO ANY PHYSIOTHERAPY OR SHOULDER EXERCISES?

In most cases you will not need any physiotherapy or shoulder exercises for at least the first six weeks. However you should do hand, wrist and elbow exercises. Take your arm out of the sling and bend and straighten out your elbow. Move your wrist around to make a circle. Spread your fingers out and then make a fist.

Do these exercises three times a day and then place your arm back in the sling. The only other time you should be out of your sling is when showering. Unless I instruct you otherwise you should do no exercises of your shoulder and in particular you must not lift up your arm.

WHAT SHOULD I DO AFTER SIX WEEKS?

After six weeks, you can discard your sling and use your arm for gentle day-to-day activities. However, even then you should not stretch the shoulder beyond its comfortable limit. It is normal at that stage to have significant stiffness but this should be allowed to resolve by itself. At no time after your surgery should you have any stretching – even many months after your surgery, stretching is not allowed.

WHEN CAN YOU DRIVE?

Legally you cannot drive while wearing a sling therefore you cannot drive for at least 6 weeks.

WHEN CAN I WORK?

As your arm will be in a sling for six weeks, you will usually need at least two months off work. You cannot do heavy work for at least three months.





PAIN RELIEF GUIDELINES

When your surgery is arranged we may give you prescriptions for pain killing medications. Most people prefer to get these tablets before their surgery so they are easily available if they are required. Alternatively, you can wait until after your surgery and only get those medications you require. If you haven't been given prescriptions before your surgery, the hospital will give you tablets when you are discharged. Some patients should avoid certain medications – please read the information below to see if there are any you should not take.

Please note that the description of the medications below use the generic ('official') name for the drug. The drug you get from the chemist often has the brand written in large letters on the box but the generic name is usually written as well – often in smaller writing. Please note carefully the dose of the drug; this may vary depending on your age.

Shoulder surgery can be very painful and it is therefore vital that you take enough medication to control your pain. The most common reasons for significant pain after surgery are using your arm too much and under-dosing your medication. I strongly recommend that you keep an accurate record of the exact time you take each medication. This allows you to know exactly when the next dose may be taken.

Although you should take enough pain-killers to control your pain, you do not necessarily need to take all the medication. Start with the Paracetamol and add the Celebrex if needed. If your pain is still not controlled add the Tramadol. Only take the Oxycontin or Oxycodone for severe pain – this may be helpful at night to help you sleep.

As your pain settles, decrease the number of tablets you take. Stop the Oxycontin and Oxycodone first, then the Tramadol. When your pain is improved further, stop the Celebrex and finally cease the Paracetamol.

The following guidelines provide further information regarding your medications.

PARACETAMOL

Take this regularly even if your pain is not severe. Take 1gm (usually two 500mgs tablets) four times a day if you are under 60 years old or take 1gm every six hours if you are over 60 years old.

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CELEBREX

Take 100mgs twice daily. Take this regularly even if your pain is not severe but this can be stopped in 5 days if your pain settles. **DO NOT TAKE** if you have ischemic heart disease i.e. a history of a heart attack or angina or if you have had a cardiac stent.

TRAMADOL SR

Take 150mgs three times a day if you are less than 60 years old or 100mgs three times a day if you are over 60 years old. **DO NOT TAKE** if you have had seizures or epilepsy. Occasionally tramadol can make you feel 'strange' or 'jittery'. If so stop taking it.

OXYCODONE

This is **NOT TO BE TAKEN REGULARLY**. It is a strong pain killer for use if the other medications are not completely controlling your pain. Take it if and when you need it – often this may be at night.

Take up to 10-20mgs every four hours as needed if you are less than 60 years old and 5-10mgs every four hours as needed if you are over 60 years old. If the medication makes you nauseated, stop taking it or decrease the dose.

OXYCONTIN

This is **NOT TO BE TAKEN REGULARLY**. It is a strong pain killer for use if the other medications are not completely controlling your pain. You should not take this if you are over 60 years of age. However, if you are younger than 60 you can take 20-40mgs twice a day. If the medication makes you nauseated, stop taking it or decrease the dose.





RECOVERY FROM SURGERY

I will generally see you in my rooms 1-2 weeks after your surgery. We will remove your dressings and check your wounds. I will ensure that your recovery is going as planned and I can answer any further questions that you may have at that stage.

When you have recovered from your surgery and are using your arm relatively normally, it is often helpful to return to your physiotherapist. At that stage they can begin a long-term rehabilitation programme that can reduce the chances of developing further shoulder problems.

It is important to realise that shoulder surgery has a very long recovery period. It often

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takes at least three months before you are really pleased you had the surgery. During that time, there may be periods when the shoulder is quite uncomfortable; you may think it is improving only to find it seems to get worse again. There may also be unusual sensations in the shoulder i.e. clicking, grinding or catching. All these findings are very common and generally do not indicate any problem. These symptoms will gradually improve with time. However, the full recovery often takes *a year or more*. This long recovery period can be very frustrating but luckily shoulder surgery is associated with very good results. Well over 90% of patients will achieve an excellent result.

ADVICE FOR YOUR PHYSIOTHERAPIST

The following information is provided for your physiotherapist. You can show them this section and it will assist them with your post operative care.

FIRST SIX WEEKS

During the first six weeks after surgery I prefer my patients not to have any formal physio. I like them to stay in the sling at all times except while showering or while doing hand, wrist and elbow exercises. In most cases they should not have any exercises involving the shoulder at all. They must keep the back strap on while asleep but can remove it during the day.

AFTER SIX WEEKS

After six weeks the sling can be discarded. They can continue their exercises but are now allowed to go to any range of motion that is comfortable. It is extremely important that they do not go beyond their comfortable limit. I do not want any stretching at any time after surgery. It is completely normal and in fact desirable to have some stiffness and I like this to gradually improve over the months following surgery.

Core strengthening and scapular stabilizing exercises can be gradually introduced six weeks after their surgery.

Rotator cuff strengthening should commence three months after surgery.

Further advice regarding such things driving, working, showering, dressings etc is contained in "After Your Surgery" section of this book.

Please feel free to contact me if you have any questions.

