OrthTeamCentre

Orthopaedics · Spine · Neuro · Sports Med

Working with Spire Manchester Hospital

Patient Information Leaflet

Arthroscopic (Keyhole) Shoulder Surgery

How to find us:

The OrthTeam Centre

The Ohm Buiding (Unit 1)

Didsbury Technology Park

168 Barlow Moor Road

Manchester

M20 2AF

For more detailed directions, please visit

www.orthteamcentre.co.uk

OrthTeamCentre@spirehealthcare.com

Shoulder arthroscopy

What is arthroscopic ('keyhole') surgery?

Keyhole surgery is the technique of performing surgery through small (0.5-2cm) incisions rather than the larger incisions of conventional 'open' surgery.

The operation uses cameras to see inside the shoulder joint so that the surgeon can carry out the necessary procedure.

The advantages of key-hole surgery can include:

- Less pain after the operation
- Smaller scars
- Lower risk of complications
- A faster return to normal activities.

Why do I need the surgery?

There are many conditions that may potentially require surgery. Your surgeon will explain your diagnosis, the reasons for doing surgery , and any alternatives.

Whilst occasionally arthroscopy is used to help with the investigation of a shoulder condition, the diagnosis has usually been made by pre-operative examination and investigations.

The conditions commonly treated by shoulder arthroscopy include:

- Subacromial impingement
- Acromioclavicular joint (ACJ) arthritis
- Calcific tendonitis
- Frozen shoulder (adhesive capsulitis)
- Instability
- Rotator cuff tear

Is surgery the best decision?

Will the surgery definitely make my shoulder better?

No surgery is guaranteed to cure a condition. The outcome rates vary depending on the specific surgical procedure you have had.

As a rough rule of thumb in shoulder surgery we expect our patients to be 75% better at three months after surgery, and to continue to improve for up to a year-to-18 months after surgery.

This is quicker for the more minor procedures, and longer for the major procedures. Overall we expect eight-out-of-ten of our patients to have a good-to-excellent outcome.

What are the potential risks of surgery?

Any surgical procedure carries certain risks that will potentially harm you. These are thankfully rare in shoulder arthroscopy. Again the specific risks differ according to the particular surgery you will be having, but the overall risks we would like to warn you occur in less than 1% of cases are:

- Infection
- Bleeding
- Failure/recurrence

Shoulder stiffness after surgery is not uncommon, occurring in up to 10% of cases. More rarely this stiffness is excessive, known as post-operative frozen shoulder.

There is also a small risk of temporary or permanent nerve damage due to traction on your arm during surgery, or due to the interscalene block, leaving part of the arm numb or weak.

Risks specific to a particular procedure are detailed in the next section.

OrthTeamCentre
Orthopaedics · Spine · Neuro · Sports Med

What happens now?

Will I be seen before my operation?

You will have been seen in the outpatient clinic by your consultant. During this consultation, the risks and benefits of the surgical procedure will have been detailed and you would have consented to undergoing the procedure by signing a consent form.

Most patients will also undergo a separate pre-operative assessment. This may be in person, or a telephone interview. You will need to inform us of any other medical conditions, including any medications which you make take and any issues such as the need to stop any medications prior to your surgery .

You will also have swabs taken to ensure that you are not a carrier of infections such as MRSA. By doing this, we will help protect not only you, but also other patients from the risk of surgical infections.

What exercises should I be doing prior to my operation ?

If appropriate you will have undergone a course of physiotherapy prior to being listed for surgery. If this is the case, please simply continue with your exercises as directed by your physiotherapist.

Will I be asleep?

Shoulder arthroscopy is almost always carried out under a general anaesthetic, meaning you will be asleep.

The anaesthetic is often supplemented with a nerve block (interscalene block) which involves an injection into the side of your neck that numbs the whole shoulder and most of your arm. This can be helpful for controlling pain after the operation, but is not always possible or suitable.

Your anaesthetist will discuss the block with you on the day of your surgery if appropriate.

What will the operation involve?

Once under anaesthetic your shoulder will be re-examined. You will have between two and four small incisions made (0.5 – 1cm long) at the back, side and front of the shoulder. Sometimes additional Incisions need to be made. Your shoulder is then filled with fluid.

An instrument known as an arthroscope is passed into the shoulder. This contains the camera which allows your surgeon to look around your shoulder and using other specialised instruments to carry out your surgical procedure. The small incisions do not usually require stitches, but heal on their own. You will have a dressing applied and a sling as appropriate.

Further details of this can be found in the specific conditions section of this leaflet.

How long will I be in hospital?

The majority of shoulder arthroscopy is performed as a day-case procedure, meaning you will go home the same day. This is usually by the early evening, but this will depend on the time of your operation.

More complicated surgery can require overnight admission. You will not be able to drive immediately after your surgery and will require someone at home to look after you for the first 24 hours.

OrthTeamCentre
Orthopaedics · Spine · Neuro · Sports Med

The day of your operation

What happens on the day of surgery?

You will have received a letter from our admissions team explaining which ward to attend and at what time. You will have been asked not to eat or drink anything for 6 hours prior to your admission time.

Please be aware that the operating lists often last all day and there will be several other patients on the same list and we are unable to guarantee what time of day you will have your operation.

You will be seen by a member of the ward staff who will go through your admission paperwork and perform measurements such as your pulse rate and blood pressure. You will also be seen by a member of the surgical team who will ensure you have signed a consent form and mark the shoulder you are having operated on with an arrow.

Any final questions about the surgery can be answered at this stage. You will also see your anaesthetist who will ensure you are fit for the anaesthetic and discuss options such as a nerve block with you.

You will usually see a physiotherapist before your operation who will detail the rehabilitation exercises which will be carried out for the first few post-operative weeks.

After your operation

What can I expect after my operation?

You will have a dressing and a sling as described. In the hours after key-hole surgery to the shoulder, it is very common to experience a substantial amount of blood-stained discharge form the incision sites. Your dressings will therefore usually be changed on the ward prior to your discharge.

In order to minimise delay in your discharge home, we operate a nurse-led discharge policy, meaning you will have been discharged prior to the end of the surgeon's operating list. It is customary that the surgical team carry out a ward-round at the end of the day and as such it is possible that you will be seen by a member of the surgical team after your operation to explain exactly what was found and what procedure was performed. Otherwise, this will be done at the post-operation rehabilitation clinic.

You may, if appropriate be seen by a physiotherapist either before, or after your operation and be given specific exercises to perform. If required, you will be given painkillers to take home with you. It is important that you start to take these at the prescribed times as soon as you get home in order to keep your pain controlled, to maximize the benefits of your sur-gery.

After discharge, you will be seen by one of our specialist shoulder physiotherapists in the rehabilitation clinic approximately 1 week following your surgery. Your specific rehabilitation programme will depend on exactly what was found and done during your operation and the recommendations of your surgeon.

OrthTeamCentre
Orthopaedics · Spine · Neuro · Sports Med

Returning to normal activity

Returning to normal activities depends on the procedure and your job.
Specific answers can be provided by your surgeon, but as a rough guide:

	Minor procedures • Subacromial decompression • AC Joint excision • Excision of Calcific Deposits • Capsular release	**Major procedures** • Rotator cuff repair • SLAP repair/ biceps tenodesis • Stabilization
Driving	Usually 2-3 weeks post-surgery When pain allows sufficient control of steering wheel and to perform emergency stop.	Usually 6-10 weeks post-surgery When pain allows sufficient control of steering wheel and to perform emergency stop.
Return to work	As pain allows: Sedentary work - usually 3 weeks Manual work - usually 6 weeks	Sedentary work - usually 6 weeks Manual work - usually 3-6 months
Return to sport	Swimming: 2-3 weeks Golf: 3 weeks Contact sports: 6 weeks	Swimming: 6-12 weeks Golf: 3 months Contact sports: 3-6 months

OrthTeamCentre
Orthopaedics · Spine · Neuro · Sports Med

Acromio-clavicular joint excision

The joint between the collar bone (clavicle) and the bony tip of the shoulder (acromion) is known as the acromio-clavicular joint (ACJ). This is a very common site for osteoarthritis, where the protective cartilage wears away and allows the bones to rub against each other, causing pain. This pain is typically felt on the top of the shoulder and is worst reaching high above the head, or when crossing the arm across the chest.

Again, treatment initially includes local anaesthetic and steroid (cortisone) injections, but occasionally these do not fully relieve the symptoms. This is when surgery is considered.

The ACJ excision shaves away the end of the collar bone to allow more space between the collar bone and the shoulder tip. The space then fills in with scar tissue. This stops the bones rubbing, relieving the pain.

Capsular release

Frozen shoulder is a painful condition in which the flexible lining capsule of the shoulder joint thickens, becoming stiff and stuck to the other muscles and ligaments of the shoulder. It is not fully understood why this happens, but it can be associated with diabetes and injuries to the shoulder (including surgery).

Frozen shoulder usually settles of its own accord, but this can take up to two years. In the early stages, injecting the shoulder joint with local anaesthetic and steroid (cortisone) and physiotherapy are used to relieve the pain and improve the range of movement. In cases which worsen in spite of this, or in very severe cases, surgery is considered.

The surgery involves freeing up all the scarred, stuck portions of the capsule and manipulating the shoulder to ensure a full range of movement can be achieved. After the surgery, early mobilization of the shoulder is essential to maintain this movement.

Subacromial decompression

Roughness of the under-surface of the bone which makes up the tip of the shoulder has caused rubbing and irritation to the soft tissues and tendons which pass under the bone. This typically causes pain at the outer part of the shoulder and upper-arm, especially when lifting the arm above the head.

Treatment initially includes local anaesthetic and steroid (cortisone) injections, but occasionally these do not fully relieve the symptoms. This is when surgery is considered. The subacromial decompression smooths the bone allowing the soft tissues to move freely, relieving the pain.

Stabilisation

Shoulder instability refers to the ball-and-socket joint not remaining securely in place. This can cause the shoulder to feel like it is coming out of joint either partially (subluxing) or fully (dislocating). This often happens after an injury.

In many cases, physiotherapy can train the muscles around the shoulder to balance the shoulder joint meaning it becomes more stable. Occasionally however there is physical damage to the supporting structures in the shoulder (labrum, ligaments and capsule and bones) which mean the shoulder is at high risk of remaining unstable. In certain cir-cumstances surgery can be useful to repair those damaged structures.

After surgery, it is important to protect the repair and as such you will be in a sling for up-to six weeks.

OrthTeamCentre
Orthopaedics · Spine · Neuro · Sports Med

Contact us

Rotator cuff repair

The rotator cuff is a group of four tendons that (with the associated muscles) form a deep layer of the shoulder. They help to lift the arm above the head and also to rotate the arm. The tendons run under the bony tip of the shoulder blade (acromion), where they are vulnerable to harm. This can either be damage in the form of gradual wear-and-tear, or injury from a sudden trauma (or a combination of the two), both of which can cause a rotator cuff tear.

The symptoms of a torn rotator cuff include pain, typically down the side of the shoulder and arm. The pain is often worst at night and aggravated by lying on the affected side. The patient is also weaker in the affected shoulder, and often this means the arm cannot be lifted above the head.

The treatment for rotator cuff tears commences with painkillers and physiotherapy to keep the shoulder strong and supple. The strong outer layer of shoulder muscles can often be taught to compensate for the torn tendons, which brings symptoms under control.

Repairing the tendons is often possible, either by key-hole surgery, but occasionally full 'open' surgery is required. Either way, the aim of the surgery is to re-attach the torn tendon to the bone to allow the muscles to function properly once again. We use a system of small anchors with stitches attached to repair the torn cuff back to the bone.

There is a risk of the repair failing, or the tear recurring. This is usually because the tendon is of such poor quality that it cannot be securely repaired.

After surgery, it is important to protect the repair and as such you will be in a sling for up-to six weeks.

Before your surgery, please contact us via your consultant's admissions officer.

After your surgery, your first point of contact if there are any problems should be the ward on which you were staying or the physiotherapy department if your query relates to this. Alternatively please contact the relevant secretary for advice.

Hospital Switchboard

0161 447 6677

Physiotherapy

0161 447 6900

Consultant Secretaries Mr Morgan

Ann Hughes 0161 447 6864

Mr Peach

Julie Dennerly 0161 447 6865

Mr Phillips

Berghitta Denise 0161 447 6873

Mr Ravenscroft

Lorraine Clucas 0161 495 6803

OrthTeamCentre
Orthopaedics · Spine · Neuro · Sports Med