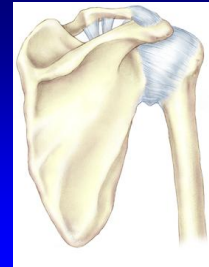




Dr. Benjamin Hewitt

Orthopaedic Surgeon



Shoulder Stabilisation

The shoulder is the most flexible joint in the body, allowing you to throw balls, lift heavy objects and reach in almost any direction. The shoulder is made up of bony and soft tissue parts which act as joint stabilisers.

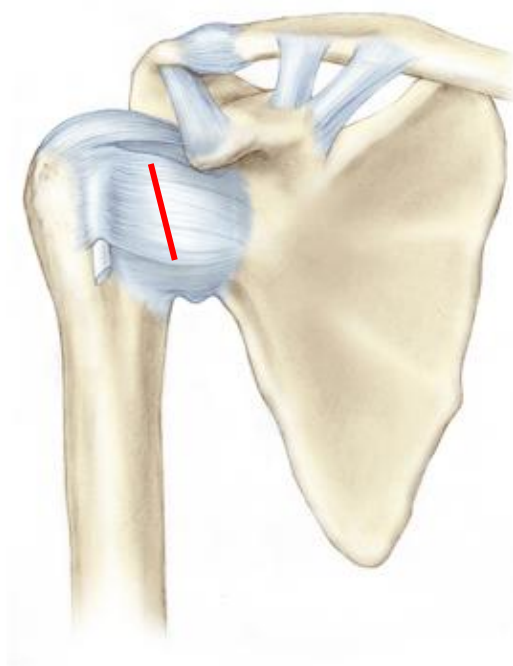
These include :

- **Capsule** : encloses the whole joint
- **Rotator cuff** : muscles and tendons
- **Labrum** : ring of fibrous tissue
- **Glenoid** and humeral head.

The most common cause of shoulder instability is a shoulder injury by falling or running into something. Once the shoulder has been dislocated it is very likely to slip out of the socket again and again. Repeated dislocations as well as being **painful** may predispose the shoulder to **arthritis**.

Dislocation

If the humeral head shifts completely off the glenoid then the shoulder is **dislocated** if it is only partially shifted then it is **subluxed**. When either of these happen the structures around the shoulder joint are stretched or torn. These injuries rarely heal perfectly. This means the shoulder remains unstable..



TREATMENT

Avoiding precipitators :

Most unstable shoulders usually are unstable in one direction. Eg anterior or posterior. As a result avoiding placing your arm in certain positions can avoid dislocations. Physiotherapists may use taping or braces to achieve this. This is often not a viable long term option in the sporting population.

PHYSIOTHERAPY

Physiotherapy can help restore stability, strength and control of your shoulder. It helps you regain control of your dynamic stabilisers - the rotator cuff and other shoulder. There are some types of instability where physiotherapy alone is enough to stabilise the shoulder. For most active people physiotherapy is only effective when used in conjunction with surgery.

SURGERY

In my practice I stabilize shoulders arthroscopically or perform an open Latarjet procedure.

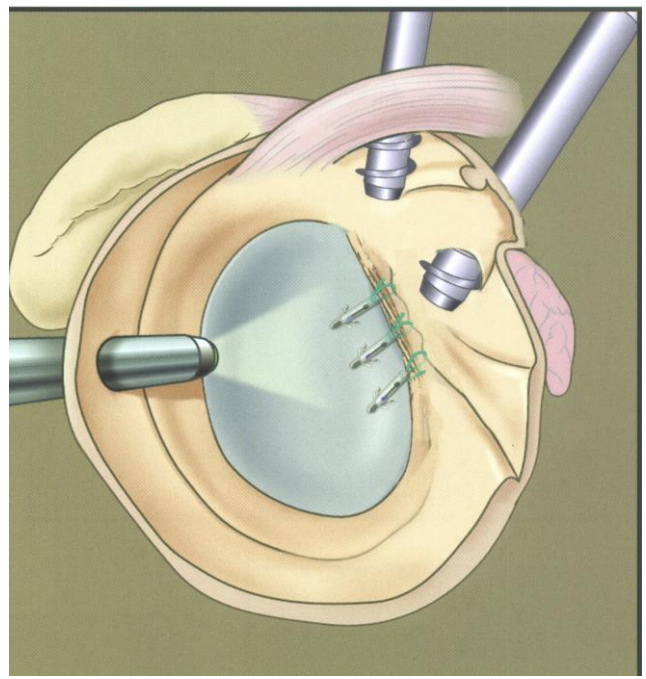
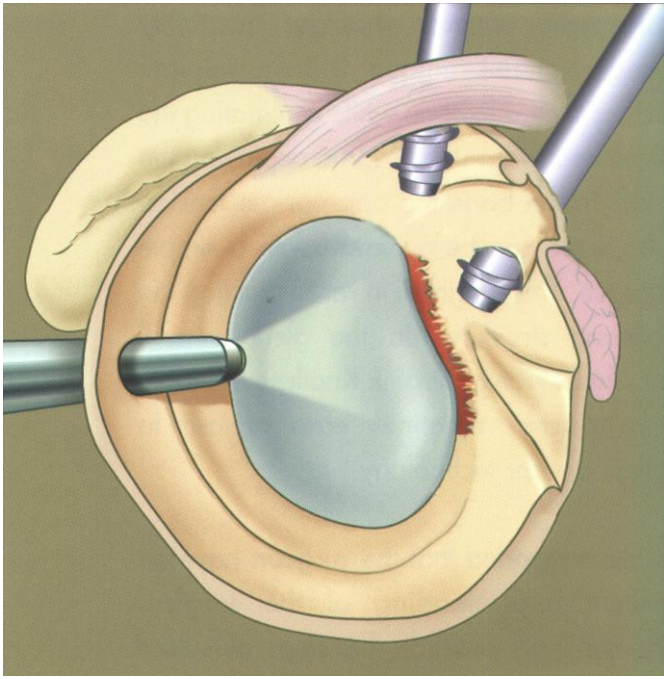
Arthroscopic surgery

Arthroscopic shoulder stabilization helps restore shoulder stability by tightening and repairing the shoulder's static stabilisers. The principles of the operation are to reduce the size of the stretched capsule of the shoulder joint and to reattach the torn labrum back to the bone.

The operation is performed under general anaesthesia. Two or three small stab incisions are made around the shoulder.

Through the arthroscope the entire shoulder joint is visualized and then the torn structures are repaired.

Arthroscopic stabilization is successful in 90 – 95% of cases. If following surgery you avoid high risk activities the success is even higher.



Open Latarjet Stabilisation :

Open stabilization is a very effective treatment in a number of patient groups.

I usually use this technique in the following :

- Significant bone loss
- Failed arthroscopic repair
- High risk sports.

It is an excellent technique that is gaining popularity in Perth.

The technique is complex .It involves a 7cm incision, and moving a small piece of bone onto the socket. This is held with 2 screws. The shoulder capsule is also repaired.

The advantages of this technique in my practice has been a reduced failure rate, and patients are allowed to rehab quickly.



RISKS

Pain, infection, bleeding, bruising, neurovascular damage and anaesthetic complications can occur with any kind of surgery. After stabilisation surgery there is particular concern with the following types of problems :

- redislocation : Usually 5% . This risk can be as high as 20% in very young patient or those people that continue high risk activities.
- stiffness ; everyone is slightly stiff. Usually only 5 –10 deg loss. A small number of patients (1%) end up very stiff with frozen shoulder.
- Infection : rare approx 0.5%. If occurs this will require antibiotics and possibly further surgery.

POST OPERATIVE RECOVERY

You will wake up in the ward in a sling. You will be given adequate pain killers to help control your pain.

The day after surgery 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. It is important to sit out of bed and walk around as soon as you are comfortable and

able.

Normally you will be able to go home the day following surgery. On discharge from hospital you will be given oral analgesics and written advice on exercises.

The sling will need to remain on for 6 weeks. The sling only comes off for showering and exercises

About 10 – 14 days following surgery you will have an appointment to see Dr Hewitt to review your wound and progress.

You will again be reviewed at 6 weeks to come out of the sling and begin your rehabilitation.

FREQUENTLY ASKED QUESTIONS

Driving : You can not drive with a sling therefore 6 weeks.

Working : Job dependant, office work 4-5 days.
No heavy labor for 3 months

Sport : If rehab progresses well 3 months

This protocol applies to most cases , some variations will occur depending on the injury and surgery. If you have any questions about the surgery or rehabilitation don't hesitate to ask Dr Hewitt.

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