NHS
Royal Cornwall Hospitals
NHS Trust

Arthroscopic shoulder stabilisation

affix patient label

Including repair of the labrum, tightening of the capsule (plication) or 'SLAP' repair

What is the problem with my shoulder?

When the shoulder is injured or dislocated, the structures that help to keep it stable can be damaged. The most important of these is a cartilage rim around the edge of the shoulder socket known as the labrum: normally, the body can tell when the head of the arm bone moves out of place as it passes over the labrum. This prompts it to fire the control muscles that pull the head of the arm back into position.

Damage to the labrum can therefore affect the body's ability to keep the head of the arm bone in position against the socket. In some people the shoulder is stable enough to work normally despite this. In others, the damage causes problems of instability such as:

- repeated dislocation, often requiring less and less force each time
- an unpleasant feeling that the joint is coming out of position (subluxation)
- pain in certain positions or with certain activities.

Other structures that can be damaged, resulting in continued pain or instability are the:

- bone of the socket or head of the arm bone
- lining (capsule) of the joint and the ligaments within it
- control muscles of the shoulder (rotator cuff muscles) or their tendons
- attachment of the biceps tendon to the top of the labrum (a 'SLAP' tear)
- nerves around the shoulder

or any combination of the above.

There are many websites that include pictures and descriptions of shoulder anatomy, the causes of instability and the process of repair. One of the best is www.shoulderdoc.co.uk. You should feel free to use these sites, and to ask your surgeon if you have any questions.

Why do I need a repair?

Your surgeon suspects that the problems you have with your shoulder are caused by damage to the joint as described above. It is expected that repair of these structures will improve or get rid of your symptoms completely. Damage to your shoulder may have been confirmed with special investigations such as X-rays, ultrasound, MRI or CT scans.

Are there any alternatives?

A skilled physiotherapist may be able to improve the stability of your shoulder by balancing the muscles acting around it. In young patients, especially if there has already been more than one dislocation, your surgeon or physiotherapist may advise you that this is unlikely to be successful.

If you feel that you have not had a sufficient trial of physiotherapy you should discuss this with your surgeon.

If there is significant bony damage to the edge of the socket an open operation may be recommended. This involves fixing additional bone to the front of the socket, for example in a 'Latarjet' procedure. It is a more invasive procedure with higher risks. However, the risk of dislocating again after surgery is lower. Feel free to discuss this operation with your surgeon if you think it might be more appropriate for you.

How do I prepare for my operation?

You must **not** eat anything for at least **6 hours** before your operation. This is to make sure that your stomach is empty when you have your anaesthetic. Drinks containing fats (eg tea or coffee with milk) and sweets all count as food. You **can** drink water without fats in it (eg black coffee) until **2 hours** before your operation. You may also have small sips of water to take tablets. There is a hospital leaflet about having an anaesthetic. Ask the staff for a copy if you would like one.

A member of the surgical team will also see you on the ward. Usually it will be the surgeon who will carry out your operation. Feel free to ask them any question you have about the operation or what will happen to you afterwards. The surgeon may examine you again. They will also draw an arrow on the arm to be operated on and check that this consent form has been completed.

The anaesthetic

You will be given a general anaesthetic for the operation (you will be asleep). In addition we often use a local anaesthetic 'block' to numb your arm. This involves an injection around the nerves at the base of your neck which can be done awake or asleep. It reduces the quantity of pain killers you need during and immediately after your operation. It will generally keep your arm comfortable for some hours after the operation and can reduce problems such as sickness.

You may not be able to feel or move your arm for some hours after surgery due to the block. This can be irritating but it does mean that the repair is protected while you are waking up. It carries a very small risk of injury to the nerves supplying your arm. You will have the opportunity to ask the anaesthetists questions about the anaesthetic before your surgery. You may choose not to have the block if you prefer.

What does the surgery involve?

Your surgeon is expecting to be able to carry out the repair to your shoulder as a 'keyhole' operation (arthroscopy). This will involve making 3 or 4 small cuts (ports) around your shoulder each about 1cm long. Special instruments and cameras are used to carry out your surgery through these ports.

First your surgeon will examine your shoulder with you asleep. Especially in muscular patients, instability may be much easier to assess when the muscles are relaxed during an anaesthetic.

Your skin will be cleaned with antiseptic and nearby areas covered with sterile drapes. You will usually lie on your side for the operation with your arm held out on a support. Occasionally you may be in a sitting position.

The surgeon will first put a camera on a thin tube (cannula) into your shoulder from the back. Important structures will be checked including the joint surface, bones and tendons. A second tube will be slid into your shoulder joint from the front to allow access to the damaged parts. A third smaller tube may be slid into your shoulder from the side.

Working through these tubes the damaged surfaces are prepared and stitches are fixed in place around the damaged edge of the socket. Special devices are then used to pass the stitches through the damaged structures to repair them. The surgery usually takes about 90 minutes. Any other damage identified during the surgery will then be repaired. If a tendon repair is required this may involve a larger cut over the side of your shoulder of around 5-6cm.

The wound may be closed with stitches that are buried or absorb with time or with clips. Very small cuts may be closed with strips of suture tape. Skin glue may also be used and further local anaesthetic will usually be injected into the shoulder itself. Your arm will be put into a sling. This is for your comfort but also to protect the repair. You will then be taken to the recovery area for observation.

What happens afterwards?

If you have had a local anaesthetic injection into your neck before your operation, you may feel no pain at all when you wake up. You may also not be able to move your arm. Gradually, over the next few hours, the feeling will come back and you will be able to use your arm again. This is normal.

If you have not had a local anaesthetic injection into your neck, or if the local anaesthetic has not been effective, you may feel discomfort or pain in your arm when you wake up. It is important at every stage to let the staff know if you have pain and to ask for painkillers if you need them.

You will usually spend the night of your operation in hospital, especially if your operation is later in the day. This is to make sure that you are safe and that your pain is well controlled, especially if you have had a block. The nursing staff and physiotherapists will want to be sure that you are safe before you go. Note that for the first few days your shoulder may be very sore, even when you are not using it.

Getting moving

Your surgeon will decide at the time of surgery what movements will be safe afterwards. As a general rule **you must not turn your arm out beyond neutral, extend the arm backwards or lift it forwards more than 45 degrees** for the first six weeks.

You should use the sling provided at all times during the first six weeks, except while exercising. The physiotherapists will show you movements that you can and can't do. They will also give advice about exercises to perform. It is very important to follow these instructions.

How long will it take to recover?

It is difficult to predict exactly how long it will take to recover after your operation. The extent of the damage, the length of time since it happened, the amount of pain you had before the operation and the work you do will all affect the rate at which you get back to normal. When you come out of the sling at six weeks your arm will be weak and stiff. It may be a few weeks before you can comfortably drive. By about 12 weeks you will usually be able to use your arm above shoulder height. This is the point at which many people get back to work. The arm will still be weaker and stiffer than normal, and may still be uncomfortable in certain positions. Somewhere between 4 and 6 months most people would feel they are getting back to normal.

Full recovery can take 6-9 months or even longer. We will ask you not to return to activities with an unpredictable load on your shoulder such as rugby or surfing until 9 months after surgery. The timings may be different for professional sportsmen and women. The strength of your arm may continue to improve for 12-18 months after your operation.

Is there anything else that might need to be done during the operation?

- **ASD** – smoothing of bone edges above the shoulder that may be contributing to your symptoms.
- **Biceps 'tenodesis'** (reattaching the biceps tendon outside the joint) – sometimes a 'SLAP' tear of the biceps attachment to the top of the socket can't be repaired. In this situation the part of the tendon inside the joint is removed and the tendon reconnected outside the joint. This may be done through an extra cut of 5cm or so over the front of the shoulder. This could change the shape of your biceps muscle.

Neither of these affect what happens to you after your operation or the likely recovery times.

Are there any risks or complications?

As with all procedures there are risks from having this operation.

Common (Happens in 2-5% of patients)
Pain: The pain from the operation should settle quickly but in some patients this may take longer than expected. Occasionally scars can continue to cause an unpleasant pain long after the operation. This can be difficult to treat.

Bleeding: There will inevitably be some bleeding but it is usually only a small amount. There may be some leak of blood from your wounds but this should be dealt with on the ward. It is rare to need a blood transfusion after this operation.

Stiffness: Some stiffness that settles with use and physiotherapy is normal after shoulder surgery. Occasionally a very stiff or 'frozen' shoulder develops. It can be painful and may slow your progress after the operation. Extra physiotherapy, injections and sometimes further surgery may be needed to treat this.

Recurrence of symptoms/Re-dislocation: However well the repair is done the shoulder can be injured or dislocate again. This might be because of a fall during the recovery period or a further injury. If this happens your surgeon will discuss with you whether or not to repeat this operation or whether a different operation may be more appropriate.

Less common (Happens in 1-2% of patients)
Infection: This is a serious complication as it prevents the repair from healing. **Infection may appear as redness, oozing, warmth and/or worsening pain around your shoulder. It is vital that you tell medical staff if you think you have an infection at any stage.** Further surgery may be necessary to wash the joint out and remove the stitches (sutures) used in the repair. A prolonged course of antibiotics may be necessary. Every step is taken to avoid infection including IV (intravenous) antibiotics at the time of the operation but it can still happen.

Rare (Happens to fewer than 1% of patients)
Blood clots: These are rare after shoulder surgery but can form in the arms or legs. They can cause painful swelling of the limb and rarely, put your life at risk by affecting your lungs. If you are known to be at risk of forming blood clots we will give you medicine to reduce this risk.

Thickened or keloid scar: Some people naturally develop scars which become thickened with time. They can sometimes be helped with surgery or steroid injections.

Fat necrosis: Fat beneath the skin of your wounds can die away, leaving an uneven scar.

Nerve damage: Close to the area of your operation are the important nerves that supply your arm and hand. Very rarely these can be damaged during surgery. This could cause temporary or sometimes permanent weakness and numbness in the arm or hand.

Tendon damage: The tendons around the joint may also be damaged during the operation.

Major bleeding: Extremely rarely a large artery or vein may be damaged. This might need a further operation to stop the bleeding including a large wound over the front of the shoulder.

Risk of a general anaesthetic: The risk to a healthy patient of problems arising from an anaesthetic is very small. However, each year in the UK several healthy people will die or suffer serious heart, lung or brain injury following an anaesthetic. This can be from problems or mistakes made during the anaesthetic or because of patient health problems.We will take every possible step to keep you safe during your operation.

If you would like this leaflet in large print, Braille, audio version or in another language, please contact the General Office on 01872 252690

CONSENT FORM 1
PROCEDURE SPECIFIC PATIENT AGREEMENT

NHS
Royal Cornwall Hospitals
NHS Trust

NHS number: .....
Name of patient: .....
Address: .....
Date of birth: .....
CR number: .....

AFFIX PATIENT LABEL

_____ **side**

Arthroscopic shoulder stabilisation

Including repair of the labrum, tightening of the capsule (plication) or SLAP repair

Keyhole surgery to repair damage to the shoulder joint from dislocation or injury to the shoulder including injury to the attachment of the biceps tendon within the shoulder (SLAP tear)

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:

- *We hope to stop most, if not all, of the pain in your shoulder and to improve your function as much as possible*

Significant, unavoidable or frequently occurring risks:

- *Pain, bleeding, stiffness*
- *Recurrence of instability symptoms or re-discolation (if shoulder has dislocated previously)*

Uncommon but more serious risks:

- *Infection sometimes requiring further surgery, strong IV or long term antibiotics*
- *Need to convert to an open operation*
- *Change in biceps muscle shape*

Rare but serious risks:

- *Blood clot, nerve damage, tendon damage, major bleeding, altered wound healing*
- *Anaesthetic risk which includes a very small risk to life or limb from complications such as heart attack and stroke*

Any extra procedures which may become necessary during the procedure:

- *Blood transfusion (rarely necessary)*
- *Other (please specify):*

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust's approved patient information leaflet for this procedure: Arthroscopic shoulder stabilisation CHA3357 which forms part of this document.

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve: ☐ General and/or regional anaesthesia ☐ Local anaesthesia ☐ Sedation

Health Professional signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: ..... Name (PRINT): ..... Date: .....

Arthroscopic shoulder stabilisation consent

affix patient label

STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have a copy of the patient information leaflet which describes the benefits and risks of the proposed treatment. If not, you will be given a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand that tissue samples will only be taken in relation to the procedure explained to me. No samples will be taken for quality control, clinical education or research purposes.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

I have received a copy of the Consent Form and Patient Information leaflet: Arthroscopic shoulder stabilisation CHA3357 which forms part of this document.

Patient signature: ..... Name (PRINT): ..... Date: .....

A **witness** should sign below if this patient is unable to sign but has indicated his or her consent.
Young people / children may also like a parent to sign here (see guidance notes).

Witness signature: ..... Name (PRINT): ..... Date: .....

CONFIRMATION OF CONSENT (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

Important notes (tick if applicable):

☐ See advance decision to refuse treatment ☐ Patient has withdrawn consent (ask patient to sign/date here)

Patient signature: ..... Name (PRINT): ..... Date: .....

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