NHS
Royal Cornwall Hospitals
NHS Trust

# Arthroscopic subacromial decompression (ASD) with or without AC joint removal

*affix patient label*

## What is an ASD?

- **Arthroscopic:** Using a camera and specially designed instruments we can work within the body through small cuts about 1cm long. This is also known as 'keyhole' surgery. It often takes less time to recover from operations carried out in this way.
- **Sub acromial:** The name of the bone that makes up the point of your shoulder is the acromion. It is part of your shoulder blade. Sub-acromial means working underneath the acromion, in the space between it and the shoulder joint.
- **Decompression:** You have a condition known as impingement. This happens when the head of the arm bone and the tendons attached to it catch on the under-side of the shoulder blade as you move your arm. Removing a thin layer of bone from the underside of the shoulder blade and smoothing it down can cure impingement and is called a decompression.
- **AC joint:** The joint between your collar bone and your shoulder blade. If it is damaged or arthritic it may be causing you pain or damage to the tendons that move below it. It can be removed without affecting the way your shoulder works.



## Why do I need it?

We hope that it will stop most, if not all, of the pain in your shoulder.

## Are there any alternatives?

Simple painkillers (such as paracetamol) and physiotherapy can be helpful in controlling the symptoms of impingement. Injections of steroid can also help. If you feel you have not had sufficient opportunity to try alternative treatments you should discuss this with your surgeon.

## How do I prepare for it?

You must **not** eat anything for at least **6 hours** before your operation. This is to make sure your stomach is empty when you have your anaesthetic. Drinks containing fats (e.g. tea or coffee with milk) and sweets all count as food.

You **can** drink water or a drink without fats in it (e.g. 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.

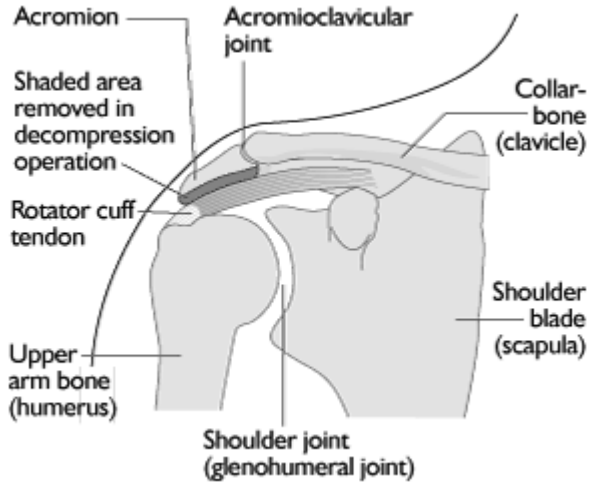
You may be given a general anaesthetic (where you will be asleep) or a local anaesthetic 'block' (where you are drowsy but awake and the area to be operated on is completely numb). Sometimes we will give both types of anaesthetic. The anaesthetist will come and see you before your operation to discuss this with you. You will be able to ask them questions about the anaesthetic.

A member of the surgical team will also see you on the ward. This is usually the surgeon who will perform your operation. Feel free to ask any questions you have about the operation or what will happen 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 and signed.

**What does it involve?**

The surgeon will examine your shoulder with you asleep. 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 make a small cut on the back of the shoulder and then pass a narrow telescope with the camera attached to it into the shoulder joint itself. Important structures will be checked including the joint surface, bones and tendons.




*(Image courtesy of the arthritis research campaign)*



The surgeon will then move the camera to look into the area underneath the acromion. A second small cut will be made on the outside of the arm, just beyond the tip of your shoulder Through these cuts, instruments will be used to remove a thin layer of bone from the underside of your acromion and smooth off any bony points that may be irritating the tendons. Fluid flows through this space constantly during the operation and washes out any debris. Other small cuts may need to be made to complete the procedure.

The wounds may be closed with buried stitches that absorb with time or with conventional stitches. Small cuts may be closed with strips of tape. Your arm may be put into a sling. This is mainly for your comfort. You will then go to the recovery area for observation.

**Biceps tenotomy**

One of the two tendons that come from the biceps muscle passes into the shoulder joint and can be affected by impingement. If the tendon is damaged at surgery and the surgeon is concerned that it may continue to cause pain or further damage, they may cut it (tenotomy). This often happens naturally and generally does not cause any loss of function. It can change the shape of the biceps muscle however and in lean muscular patients the change may be quite noticeable. For this reason alternative treatments are generally used in younger more muscular patients. You should ask your surgeon if you are concerned about this.

**Conversion to an open procedure:**

Sometimes if there is more damage than expected, the surgeon may decide during the operation that further work is necessary for the best chance of a good outcome. This can happen if there is damage to the tendons that help control your shoulder or the structures that stabilise it.

It might then be necessary to make a larger cut at the side of your shoulder for example to repair one of the important 'rotator cuff' tendons. The recovery process may then be longer and include a period of up to 6 weeks of immobilisation in a sling. Your surgeon will normally discuss this with you. If they are suspicious of a tear they may arrange other investigations such as ultrasound. Again you should ask your surgeon if you are concerned about this.

**What happens afterwards?**

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

It is not always necessary to have a local anaesthetic injection into the neck. In this case or if the local anaesthetic has not been effective, you may feel some discomfort or pain in the 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 should be able to go home on the day of your operation. However, the nursing staff and physiotherapists will want to be sure that you are well enough before you go. If you do go home on the day of surgery, there should be a responsible adult staying with you.

The physiotherapists will usually show you movements that you can and can't do following the operation and give advice about exercises to perform. It is important to follow these instructions. There is a separate sheet showing these exercises, to take with you.



**What should I look out for?**

For the first 2 weeks, your shoulder will be sore when you use it. Fairly quickly it should become comfortable to use with your arm by your side. It may be painful for some weeks after the operation to use your arm above shoulder height. You should not plan to do anything that needs this movement (e.g. painting a ceiling) for at least a couple of months after your operation. It is your responsibility to decide when your arm is comfortable enough for you to drive safely. Generally this would be at some point within the first few weeks after the operation but it may be more than this.

Full recovery can take 6-9 months or even longer. Most patients feel that they are more comfortable than before the operation at around 6-8 weeks but this does vary.

**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 procedure does involve cutting and pressing on the soft tissues around your shoulder. 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 be some bleeding but it is usually small during this operation. There may be some leak of blood from your wounds but this should be dealt with on the ward. It is very rare to need a blood transfusion after this operation.

Change in biceps shape: Dividing one of the biceps tendons can change the shape of the biceps muscle as explained above. It will only be done if the tendon is significantly damaged.

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.

Additional procedures requiring a longer recovery period: Sometimes the surgeon may decide during the operation that further work is necessary to have the best chance of a good outcome. It might then be necessary to make a larger cut around the shoulder. This might be to repair a tendon as described above or to repair damage to structures that help to stabilise the joint. The recovery process may be longer if this happens and may include a period of up to 6 weeks of immobilisation in a sling.

**Less common** (Happens in 1-2% of patients)
Infection: This may present as redness, oozing, warmth and worsening pain around your shoulder. A course of antibiotics may be necessary or very rarely another operation to wash out the joint. Infection can slow the healing of your wounds.

**It is vital that you tell medical staff if you think you have an infection at any stage.**

**Rare** (Happens to fewer than 1% of patients)
Blood clots: These are rare after shoulder surgery. They can cause painful swelling of the arm or leg and very rarely, put your life at risk by affecting your lungs. If you are at high risk of forming blood clots we will give you medicine to reduce this risk.

Thickened or keloid scar: Some people have a tendency to 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 important nerves that supply your arm and hand. These can be damaged during the surgery. If the damage is noted during the operation the surgeon may repair the nerve, but nerves do not always heal. This could cause temporary or sometimes permanent weakness and numbness in your arm or hand.

Fracture: Removing bone from the underside of the acromion does leave it slightly weaker for a while. Rarely in patients with thin bone it could break.

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 during 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

Patient copy

# CONSENT FORM 1
## PROCEDURE SPECIFIC PATIENT AGREEMENT

NHS
Royal Cornwall Hospitals
NHS Trust

NHS number: .....
Name of patient: .....
Address: .....
AFFIX PATIENT LABEL
Date of birth: .....
CR number: .....

_____ side

# Arthroscopic subacromial decompression (ASD) with or without AC joint removal

*Keyhole surgery to remove a thin layer of bone from the underside of the shoulder blade to cure impingement*

**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*

**Significant, unavoidable or frequently occurring risks**:

- *Pain, bleeding, stiffness, conversion to an open operation requiring more prolonged recovery, change in biceps shape*

**Uncommon but more serious risks:**

- *Infection sometimes requiring further surgery, strong IV or long term antibiotics*

**Rare but serious risks:**

- *Blood clot, nerve damage, fracture, 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 subacromial decompression (ASD) (CHA3240) 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: .....

*affix patient label*

**Arthroscopic subacromial decompression (ASD) with or without AC joint removal**

## 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 subacromial decompression (ASD) (CHA3240) 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)

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