

Peter Campbell - Shoulder Surgeon



WESTERN
ORTHOPAEDIC
CLINIC

Shoulder Surgery

Information for Patients

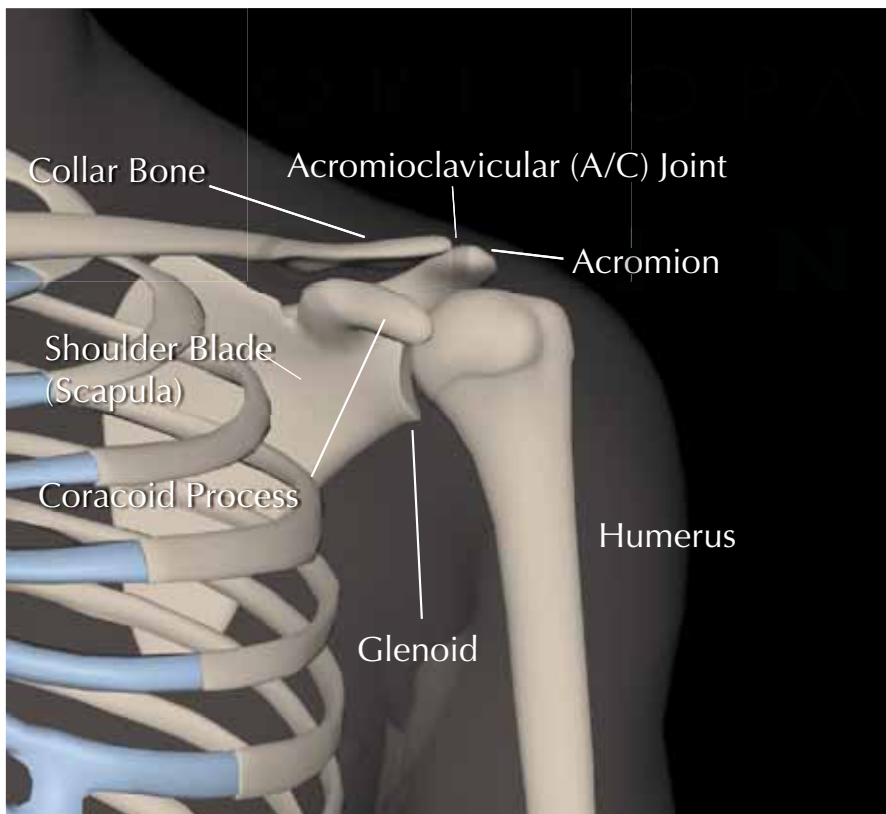


We have put this information booklet together for you to assist you in understanding your up coming operation. After you leave the office it is easy to be confused by all the information you have just received from Mr Campbell and his staff. There will be information that you have forgotten or questions that you forgot to ask. We hope this booklet helps you to better understand shoulder anatomy, what your operation involves, what to expect after your surgery, possible complications from having surgery and a general anaesthetic and an estimate of how much your surgery and hospital stay will cost. Please retain this booklet as it has relevant information for you for your post operative management. If after reading this booklet you wish to discuss any

aspects before making a decision, please arrange another appointment by ringing the office.

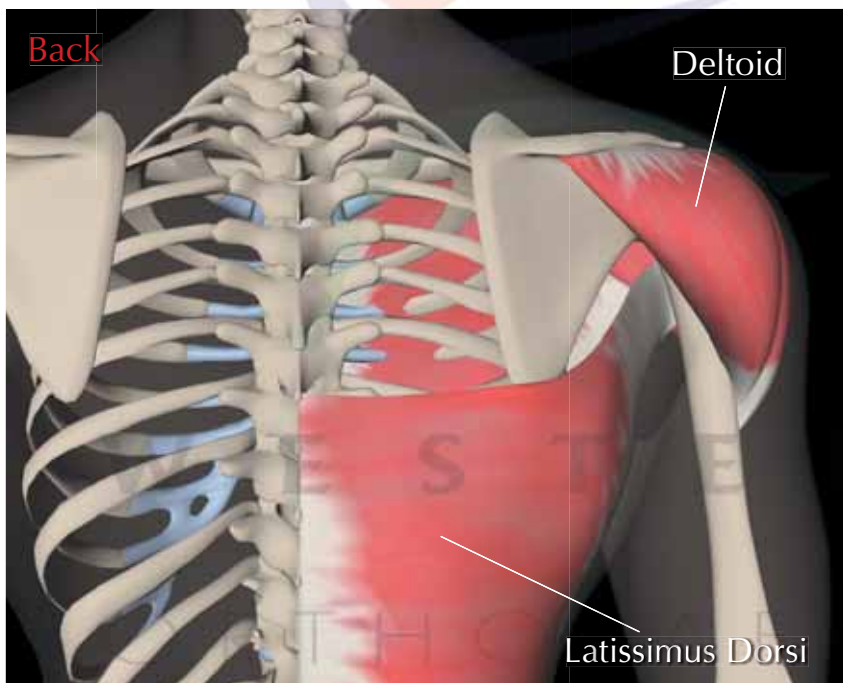
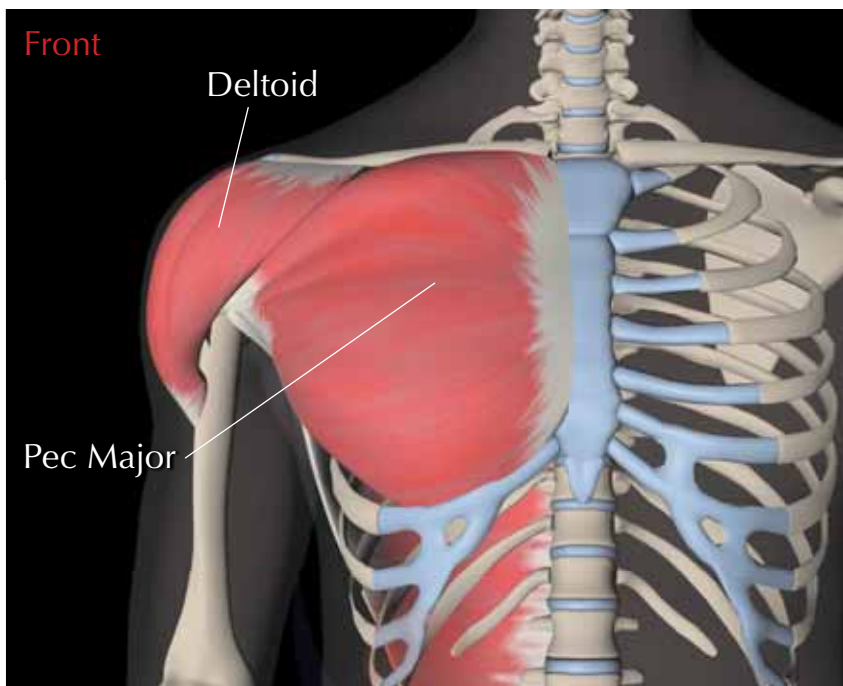


Shoulder Anatomy And Functions



The shoulder joint is the most mobile joint in the body. To enable this degree of mobility there is a large round ball (the head of the humerus) at the upper part of the arm and small flat socket (Glenoid) which is part of the shoulder blade. This is like a golf ball sitting on a golf tee. From a purely bony point of view this arrangement is inherently unstable. To confer stability to the shoulder the soft tissues that are attached around the shoulder joint have an integral function.

To move the shoulder joint there are two groups of muscles. The first group of muscles are the prime movers and these are the large muscles that are attached to and move the arm bone. As the arm bone moves another series of smaller muscles which all come from the shoulder blade act as guide ropes which hold the ball of the joint firmly against the socket no matter what position the arm is placed in.



All of these muscles and their attachments are named anatomically and most of these names are derived from Latin. These muscles will be named in the illustrations so that when you see their names written in x-ray reports or any other investigations or in operative reports you will understand what is being referred to. The large muscles which are the prime movers of the shoulder joint are the pectoral muscles at the front of the chest, deltoid

muscle which drapes over the shoulder joint and the latissimus dorsi which is the large muscle arising from the back which is the climbing muscle.

The muscles from the shoulder blade, are the pulleys and guide ropes which hold the ball against the socket are named according to which part of the shoulder blade they arise from.

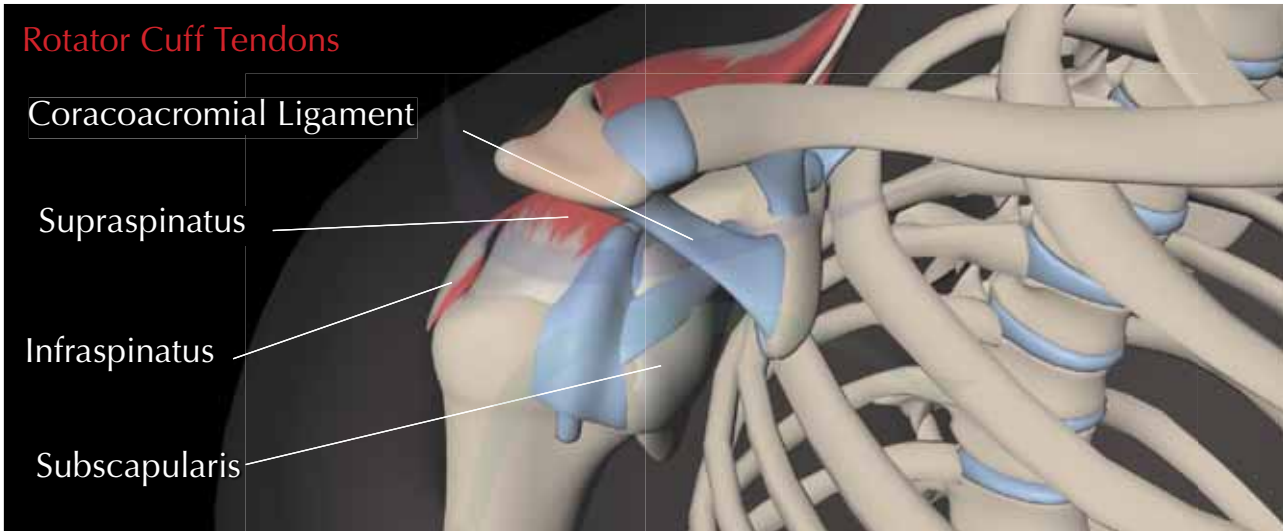
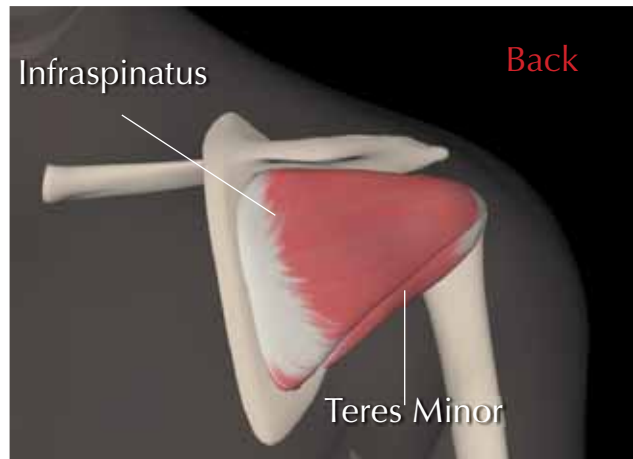
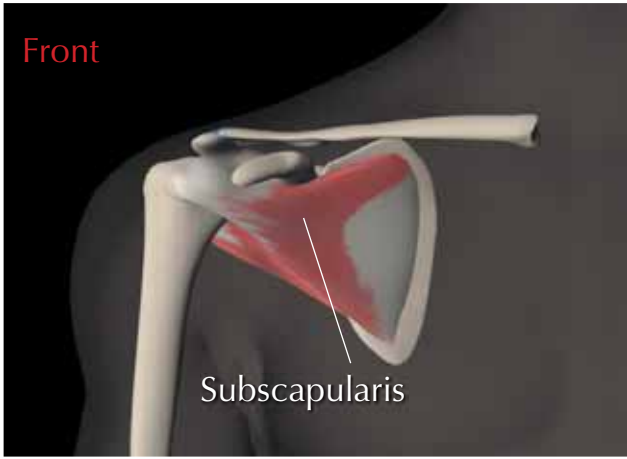
At the back of the shoulder blade

(scapula) arises a bony process which is called the spine of the shoulder blade or scapula and it curves around to form the bony overhang of the shoulder. This is called the acromion. The collarbone (clavicle) joins on to the acromion and this joint between the acromion and the collarbone is known as the AC joint.

The muscle arising from the deep surface of the shoulder blade is called the subscapularis and it inserts onto the front part of the arm bone just below the ball of the joint. The muscle that arises from above the spine is called the supraspinatus and the muscle that arises from below the spine is called the infraspinatus. All of these tendons tend to meld together as they attach to the bone around the ball of the shoulder joint. They form a cuff of tissue around the ball of the shoulder joint.

The anatomists who originally studied this part of the body thought that their main function was to rotate the arm so all of these muscles and tendons have been grouped together as the rotator cuff. As previously mentioned their main function though is not to rotate the arm but to maintain the ball firmly against the socket as the shoulder joint moves.

You will note on the diagrams that the tendons will have to move as the shoulder moves below the bony overhang of the shoulder called the acromion and beneath a ligament which connects the acromion to another bone at the front of the shoulder joint called the coracoid process. Between this bony arch and the tendon sits a lubricating sack called the bursa. This is a normal structure



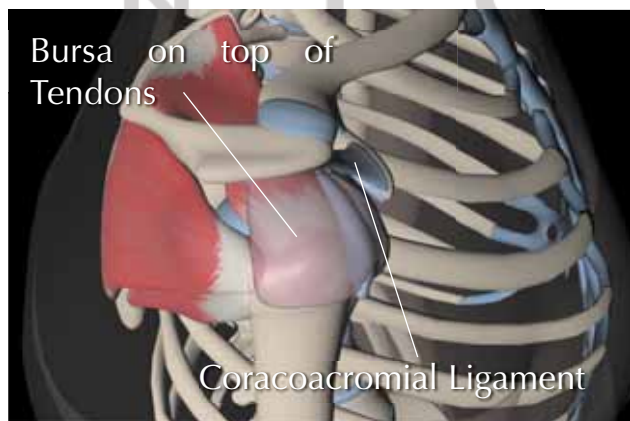
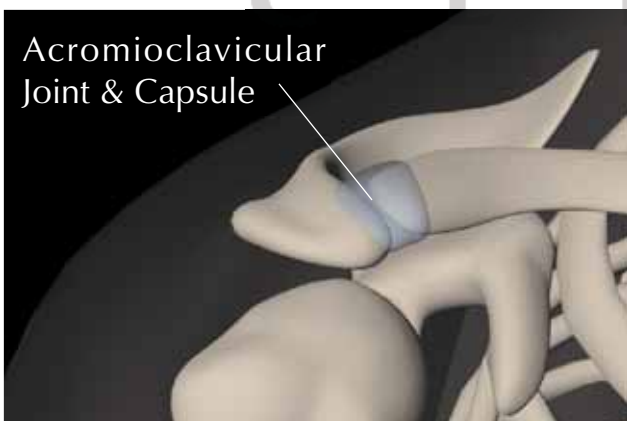
and it is present to allow the tendon to slide under this hard surface. This bursa is often injured or becomes thickened and inflamed with various problems of the shoulder and this is called bursitis.

There are two joints around the shoulder region. The first is the main joint which is the ball and socket joint which is otherwise known as the glenohumeral joint.

This is the joint which produces the movement of the arm. There is a second much smaller joint where the collarbone joins on to the bony overhang of the shoulder and this is called the AC joint. This joint also moves but nowhere near as much as the shoulder joint itself.

Every time you lift your arm the collarbone rotates and there is movement at this joint and

every time you bring your arm across your body or back behind your body the joint slides. The acromioclavicular joint can be injured and it also can suffer arthritis like any other joint. Disorders of the acromioclavicular joint are common and are a common cause of shoulder pain. They may occur in isolation or in combination with the other common shoulder conditions which are listed overleaf.



Shoulder Problems

Impingement

One of the rotator cuff tendons called supraspinatus tendon passes directly underneath the acromion and attaches to the top of the humerus. The space between the tendon and the acromion is called the subacromial space and contains a fluid filled sack called a bursa. This bursa acts as a lubricant for the tendon to move under the acromion when you move your arm. In some people the space between the tendon and the overhanging acromion is narrow. The rotator cuff tendons and the adherent bursa can catch or be pinched when you raise your arm. This can result in the bursal tissue becoming thickened and inflamed. This then places more pressure on the cuff tendons and

decreases the subacromial space causing more pain and catching when you use your arm.

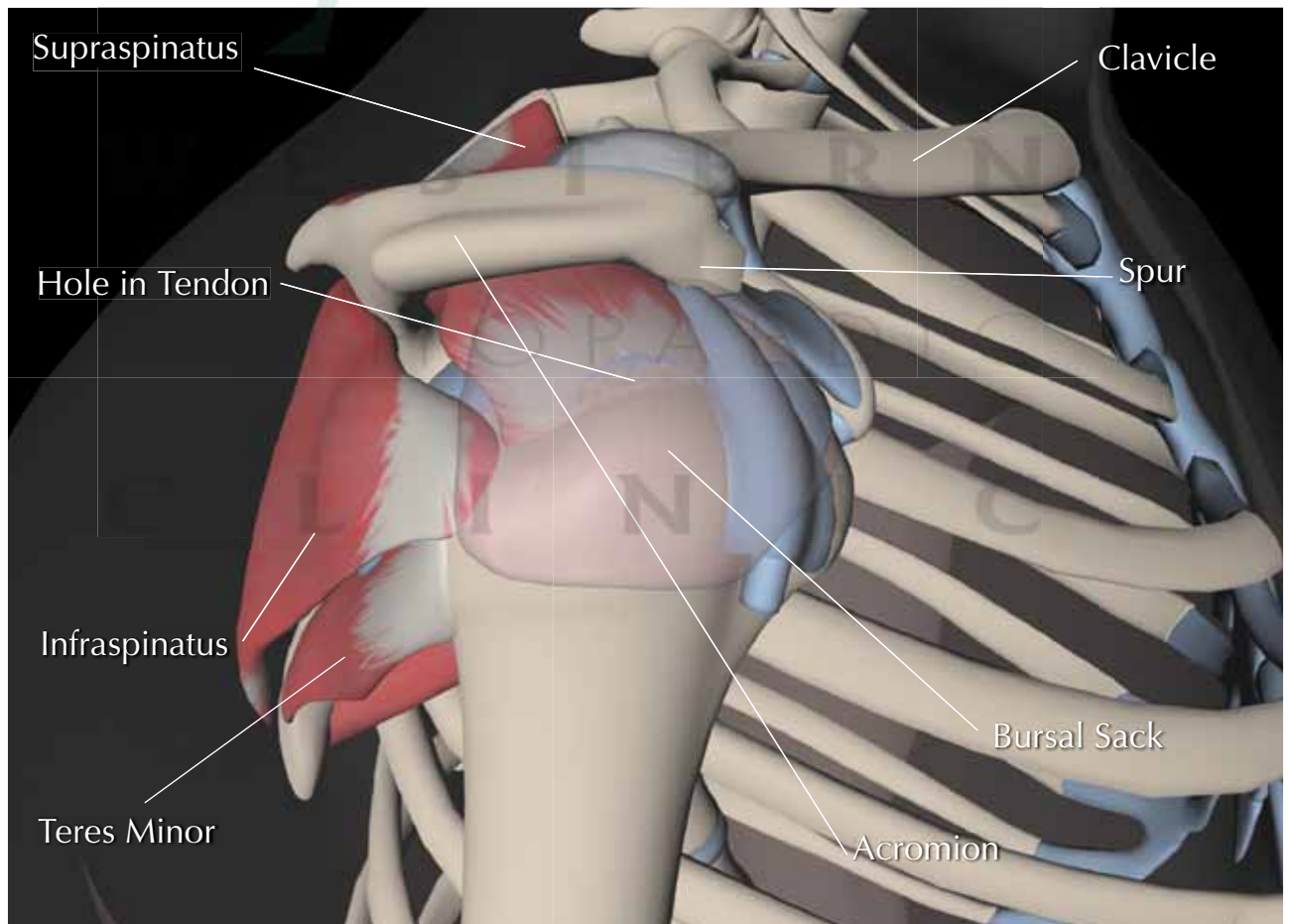
Bony spurs also form on the underside of the acromion. These spurs also causes catching and irritation of the tendon and bursal sack. Once again the end result is painful catching and decreasing range of motion of the shoulder in any above shoulder activities. The surgical solution for this problem is an operation called an ACROMIOPLASTY OR SUB ACROMIAL DECOMPRESSION.

Rotator Cuff Tear

Tears in one or more of the rotator cuff tendons are common and there are different types or degree of tears to the rotator cuff tendons. The three most

common ways of tearing the rotator cuff tendon are:

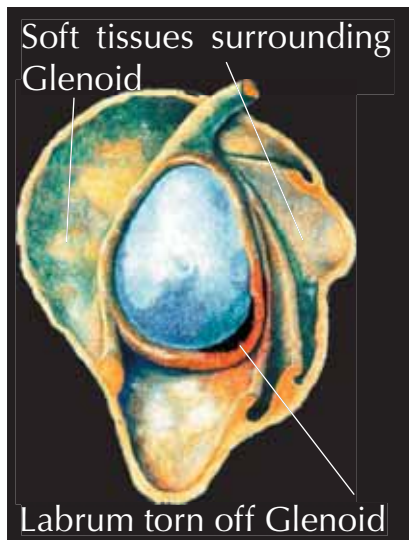
1. Frequent repetitive use of your arm above shoulder height. This is common in trades people and manual workers. Over time and with repetitive rubbing the tendon begins to weaken and eventually becomes worn. In some people this results in a partial or full thickness tear of one or more tendons.
2. A traumatic injury such as a fall onto your shoulder. The impact pulls the tendon off the insertion point at the top of the humerus.
3. A degenerate tear which occurs over time. As we get older so do our tendons and like many other areas in our body our



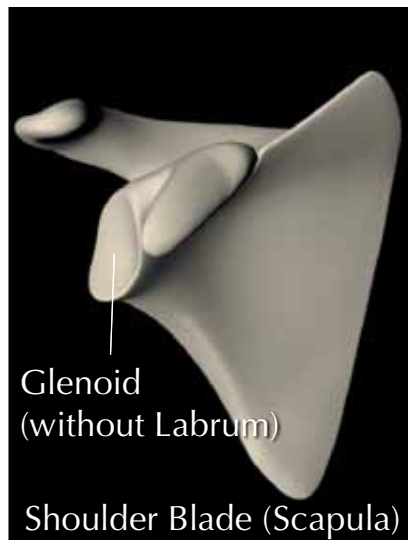
tendons lose their strength and flexibility. This natural process of wear and tear on the tendons can eventually lead to a partial or full thickness hole in the tendon.

Instability

An unstable shoulder is precisely that, a shoulder joint that is loose and dislocates either completely or partially. The capsule that surrounds the ball and socket joint and various ligaments help stabilise and keep the shoulder joint normally aligned. Shoulder instability is most commonly caused by two different problems. The first is post traumatic. This category includes people that have had excessive force applied to their shoulder such as a tackle in a football game resulting in a dislocated shoulder. This type of injury results in the ligaments becoming stretched and a stabilising structure called the labrum

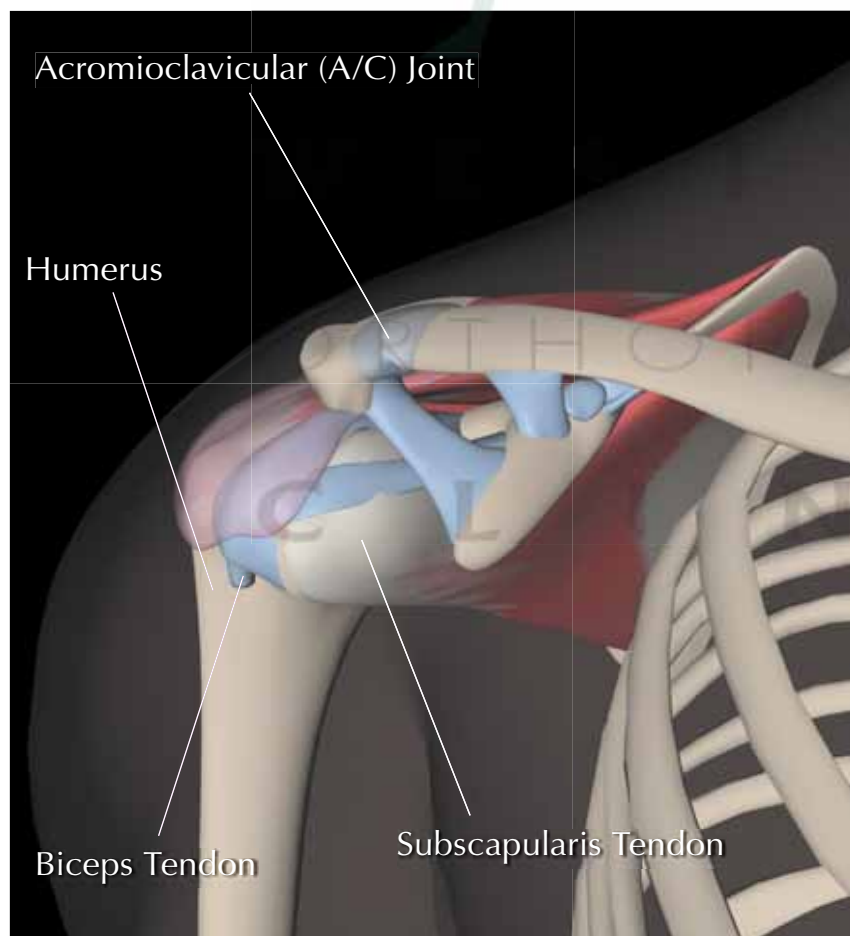


becoming detached from the socket or (glenoid). The second category of patients present with generalised looseness of the joint. These people have flexible joints throughout their body and have had this all their life. People with loose joints often develop problems with the shoulder where their shoulder starts to become excessively loose in one or more directions and starts to



produce pain and a feeling of instability.

In some patients when they repeatedly dislocate their shoulder they can damage the bone along the side of the glenoid, as well as tear off the labrum. To restore stability to this injury, surgery in the form of an open stabilisation or "laterjet" procedure needs to be performed.



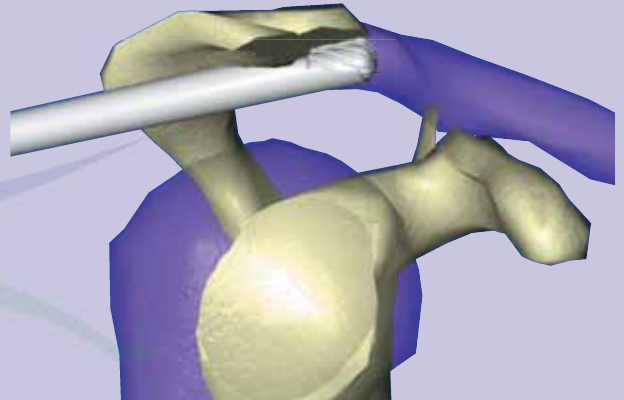
Acromioclavicular joint arthropathy

The acromioclavicular or A/C joint is where the end of the clavicle (collar bone) meets the acromion. Strong ligamentous tissue and a capsule surrounds the joint. The end of the clavicle and the acromion is covered in cartilage to enable the two bones to slide and rotate against each other. When you move your arm this joint always moves. It is common to experience pain and problems from this joint. Most of these problems occur from arthritis or wear and tear of the cartilage in the joint, dislocation of the joint or fractures of the clavicle.

Types of Shoulder Surgery

ACROMIOPLASTY & DECOMPRESSION

An acromioplasty is keyhole surgery and involves reshaping the under surface of the acromion to decompress the rotator cuff tendons below. This allows the tendons to move freely under the acromion and prevent the painful catching of the tendon. The inflamed bursal tissue will also be removed.



EXCISION AC JOINT

This is an arthroscopic operation in which the inflamed tissue between the bones is removed and a centimetre of bone from the end of the collar bone is removed. The stabilising capsule of the joint and the stabilising ligaments around the joint are left intact and there is no loss of strength of the shoulder. The gap is filled in with scar tissue and a centimetre is taken so that no matter what position the shoulder is placed in, in future the two bones will not rub against each other.



ARTHROSCOPIC STABILISATION

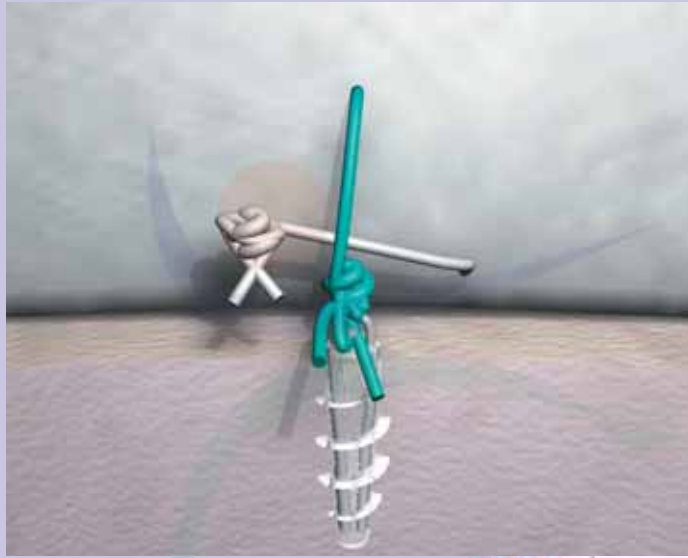
Stabilisation is an operation in which any of the injured structures in the shoulder joint are repaired back to bone and the joint which is stretched is tightened back to normal tension. In the vast majority of cases this is performed arthroscopically but in a few cases an open operation is necessary if there has been a fracture of the bones of the shoulder joint or if there is bone missing. Which type of surgery necessary will be determined by appropriate investigations pre-operatively.



Types of Shoulder Surgery

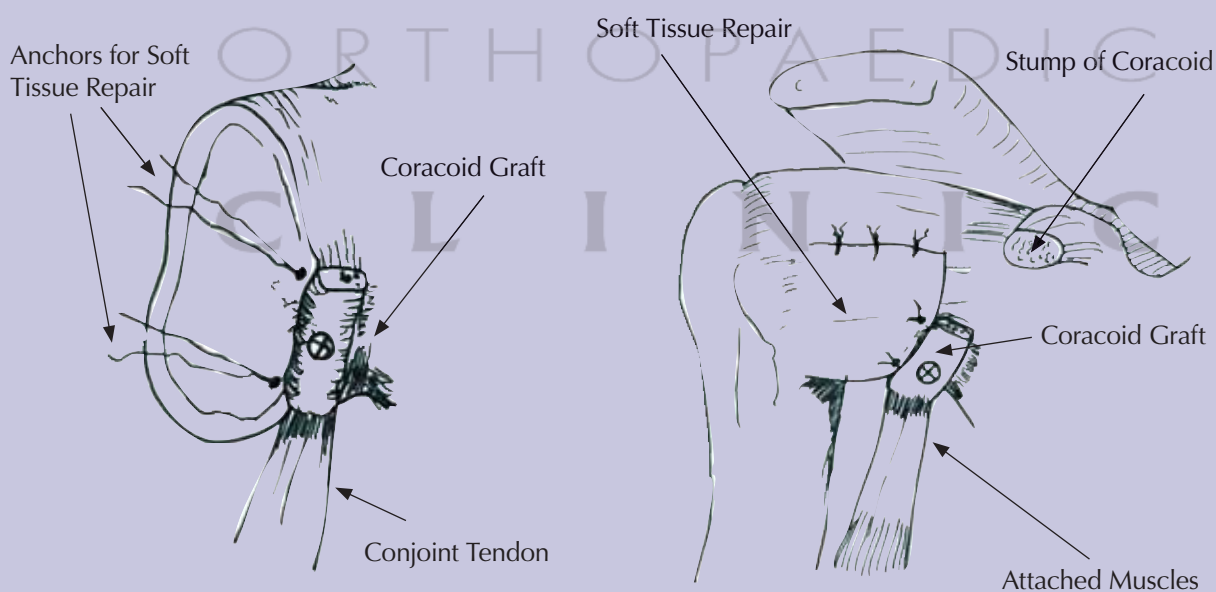
ROTATOR CUFF REPAIR

Involves reattaching the torn rotator cuff tendons back onto the bone. This is done by placing anchors with suture material into the bone and stitching the suture through the tendon and tying the tendon down onto the bone. The repair of the tendon is either done through a small key hole incision or is performed arthroscopically. At the same time an Acromioplasty will be performed to remove all inflammation tissue and reshape the under surface of the acromion.



LATARJET (OPEN STABILISATION)

This is an open operation, not keyhole surgery. It involves a piece of bone being removed from the coracoid process and transplanted to the glenoid to replace the bone that is deficient. The bone block is fixed to the glenoid with a metal screw.



Surgical Complications and Risks

Your shoulder condition is neither life nor limb threatening but the complications of surgery (albeit extremely rare) can be both life or limb threatening. The following lists outline the most frequent post operative events and the rare but possible complications of shoulder surgery. These lists are not totally inclusive but do discuss the most common adverse outcomes. If you decide to undertake shoulder surgery these adverse events and possible complications will be discussed with

you. At any time before your surgery if you wish to discuss further any of these potential complications before proceeding please do not hesitate to contact Mr Campbell's rooms and discussion will be undertaken. You are under no obligation at any time to proceed with surgery. Unless you are satisfied that any issues that you may have with the possible risks of surgery have been adequately discussed with you do not proceed.

Common risks and associated events:

In this list we have included a number of conditions which occur after any surgical operation and a number of common but usually short lived phenomenon that can also occur.

Pain.

Unfortunately all shoulder surgery is associated with a significant amount of post operative pain. The things that are done to try and minimise your pain in the post operative period are:

- At the time of surgery a local anaesthetic block is placed into the nerve which supplies most of the sensation to the shoulder joint.
- Local anaesthetic is instilled into the operative area and an external automatic pain pump device is attached which will run a constant flow of local anaesthetic for 24 to 48 hours post-surgery.
- Whilst an inpatient if injections are necessary for pain these will be administered.
- On discharge from hospital you will be supplied with strong oral pain killing medication to try and make you as comfortable as

possible. The most severe pain is for the first 48 hours after the surgery and most patients are comfortable at rest within a week of surgery. Pain on movement though can persist for many weeks following the surgery and the expected outcomes and course of these will be discussed with you.

Nausea and vomiting.

Nausea and vomiting are common after a general anaesthetic. It does vary from person to person and it also varies from operation to operation.

Leakage from wounds.

Large volumes of fluid are pumped into the shoulder during surgery to assist with vision using the arthroscope. As a result the shoulder becomes swollen with fluid. After the surgery this fluid leaks out of the skin punctures. I encourage my patients to spend the first post operative night in hospital so that this leakage is into hospital sheets and mattresses and pillows and not your own at home. Your wounds and dressings will usually have to be changed the following morning because of leakage. Once the wounds have been redressed the leakage does not tend to be an ongoing problem.

Sore throat.

The anaesthetists will place a breathing tube to control your airway during your operation. This can produce a sore throat which may persist for the first day after surgery.

Dental damage.

With the passage of an airway by the anaesthetist there is a possibility of damage to the teeth. Please discuss this with your anaesthetist on your pre-operative visit and he will explain the manoeuvres he will undertake to minimise this risk.

Pain and bruising at the intravenous site.

The anaesthetist will place an intravenous line into a vein in your opposite arm. This is to administer the various anaesthetic agents necessary to maintain the anaesthetic. A number of these agents from a chemical point of view are quite irritable to the surface of the vein. This may result in some inflammation and some superficial clotting in these veins. Once the intravenous catheter has been removed there may be an area of pain or bruising at the intravenous site. This will settle with time.

Bruising around the wound.

Although your surgery may be done predominantly arthroscopically there is usually bone reshaped internally. This will have some bleeding associated with it. This bleeding will track down with gravity and at five to seven days post-surgery bruising may actually come out at distant sites like the upper chest or the mid arm portion. This is a normal occurrence and will also be resorbed with time.

As a result of swelling around the shoulder because of the surgery there is a relative interference with blood coming back from the entire arm in the veins and from tissue fluid coming back from the arm in the lymphatic vessels. This will result in a generalised increase in the volume of the arm. This is not usually visually apparent but can produce transient problems or short-lived problems in the arm. These are:

Swelling and stiffness of fingers.

The fingers often become swollen and stiff and it is important to keep the fingers moving.

Carpal Tunnel Syndrome.

The nerve that supplies sensation to some of the fingers passes through the wrist and this is called a carpal tunnel. There is often a short-lived tingling and numbness in the thumb and index and middle fingers as a result of swelling in this area. If you have suffered any carpal tunnel syndrome before your shoulder surgery, this is to be expected in the post operative period. In most cases this is short lived and settles as the swelling

settles.

Ulnar nerve numbness.

The nerve that supplies the little finger and the finger beside it passes near the surface at the elbow. For the same reason because of swelling and also because of having the arm resting in a sling there is often temporary numbness and/or tingling in these fingers due to a degree of compression of the nerve at the elbow. Once again this usually settles with time.

Patches of numbness in the forearm.

There can be various patches of tingling and/or slight decrease in sensation in the forearm because of swelling and also the position of the arm at the time of surgery. This is usually a transient affair and does settle in the immediate post operative period.

Change in biceps appearance.

The next common possible sequelae after surgery is a change in the shape of the upper arm. The biceps muscle in the front of the arm comes from two tendons around the shoulder. One of the tendons arises from above the shoulder joint but passes through the shoulder joint before it enters into the arm. As it sits in the shoulder joint it can be damaged

and injured and it does often contribute to shoulder pain. If this is the case the tendon will be released inside the shoulder joint and it will slide out of the shoulder joint. In approximately one in ten people in which this is done there is a slight change in the shape of the muscles of the upper arm. This does not result in a loss of strength or function and is purely cosmetic.

The next list is of **RARE BUT POTENTIALLY SERIOUS** risks of surgery.

Infection.

Any operation where the skin is penetrated to enter a joint runs the risk of infection. This infection is usually caused by organisms that normally live on the skin. To reduce the risk of infection at the time of your shoulder surgery a number of things are done.

- The antiseptic solution that the skin is soaked in binds to the keratin protein in the skin and has a long acting action against the common skin organisms.
- At the time of your anaesthetic you will be given one dose of intravenous high dose antibiotics which are effective against the common skin organisms.
- The standard surgical sterile technique is employed to reduce the risk of infection. The infection rate for shoulder surgery in my practice is 0.04%. If an infection does occur this will have to be treated surgically. Infection always requires further surgery in the form of washing out the infection and removing



any foreign material. It often also requires the use of high dose intravenous antibiotics for up to six weeks after the onset of the infection. Once the infection is eradicated this then will require further surgery to repair the primary problem. As previously stated the infection rate following shoulder surgery in my practice is very low.

Stiffness of the shoulder.

Everybody who has shoulder surgery will have a relative degree of stiffness in the post operative period. This can persist up to two to three months post-surgery. In approximately 3% of patients having shoulder surgery this stiffness is much more severe and can result in a frozen shoulder. This does not last forever but it does prolong the recovery period. It makes what is already a frustrating period of time even more frustrating because of the time taken.

Failure of repair.

If the rotator cuff is repaired the success rate is approximately 90% to 92%. Failures usually occur when the tissue is of poor quality or if the tears are massive and longstanding.

Damage to the major artery and/or nerves

These pass in front of the shoulder. In the worst case scenario, damage, could lead to loss of the arm. The positioning of the operating portals and the operating position is such that the major artery and/or nerves are not placed at risk. In an

older age group who have known vascular disease the swelling as a result of the surgery can produce clotting in the artery but this does not damage the artery and in most cases this can be cleared either by catheter techniques and/or open surgery by a vascular surgeon. This is a very uncommon complication.

Sudden death from anaesthesia.

This is usually as a result of an allergic reaction to the anaesthetic agents. The incidence in our society for people undergoing elective shoulder surgery is estimated to be 1 in 80,000 to 100,000 people. To try and put this risk into context and compare them with other risks of modern living, recent statistics from the UK have shown that the risk for any individual in any one year of dying in a traffic accident is 1 in 5,000. The risk of dying in an accident in the home is 1 in 10,000 and the risk of being murdered is 1 in 80,000 to 100,000. It can be seen from these statistics that the risk of dying from anaesthesia is very low.

Awareness.

Many patients are rightfully concerned with waking up in the middle of their operation. With shoulder surgery drug paralysis is not used so that you are breathing spontaneously even though your airway is controlled. If the anaesthetic was to get light we would be aware of that by movement of yourself on the operating table.

Also with modern anaesthetic machines it enables us to directly monitor your brainwave function and be absolutely sure that you are fully anaesthetised. If you are still concerned by this you need to discuss this with your anaesthetist prior to surgery.

Heart attack and/or stroke

This is a potential risk for people who have known heart and/or vessel disease. Every effort will be made to ensure you are as fit and healthy as possible before any surgery is undertaken.

Pulmonary embolus.

Pulmonary embolus occurs when a blood clot forms in a vein. This vein is usually one of the deep veins in the pelvis. A part of this blood clot can then break off and float up to the heart and then be pumped out from the heart to the brain and/or lungs. This can result in varying levels of problems which if a worst case scenario could lead to sudden collapse and death. Pulmonary embolus can happen to anyone at any place at any time. There is an increased incidence at the time of surgery and this is more common with surgery in the pelvis and/or lower limb. The risk following shoulder surgery is less because there is no forced bed rest post surgery and you can walk around immediately

As mentioned, this list is not fully comprehensive but it does cover what I consider to be the major known risks of surgery or those which have the worst case outcome. If you would like to discuss these risks or any other concerns it is absolutely essential that you have these adequately explained to you before you embark upon surgery. You can contact Mr Campbell's rooms at any time if you have any concerns or wish to discuss these further.

On The Day Of Your Surgery

On the day of your surgery if you DO NOT have an appointment with Mr Campbell to sign a consent form **please report directly to Admissions (located opposite Western Orthopaedic Clinic.)** They will take care of your admission procedures.

Upon arriving on the ward the nurses will assist you in getting ready for theatre. This will involve admission questions and having your blood pressure, pulse and temperature taken. Your anaesthetist will visit you in the ward prior to surgery. We cannot give you an exact time that you will go to theatre. We will always admit you some hours early. This is in case of any unforeseen changes such as other patients' surgery being cancelled. Please bring a book or magazine with you.

When it is time for you to come to theatre you will be escorted to the operating suite and will have a short wait on your bed in a waiting room. A nurse

there will ask you some questions such as your name and what surgery you are having.

From there you will be wheeled on your bed to the operating room and met by the anaesthetist and an anaesthetic nurse. They will assist you onto the operating table and proceed to place ECG monitors on your chest, blood pressure cuff on your arm, and an oxygen probe on your finger. After this a drip will be placed into your hand or arm, and you will shortly fall asleep from an anaesthetic drug injected into the drip.

Once surgery is completed you will be taken to the recovery ward on your bed and the nurses will monitor you whilst you wake up. This usually takes around 1/2 hour. Once you are awake and comfortable you will be transferred back to your room in the ward. You will be away from your bed in the ward for about 2.5 to 3 hours, if you wish to inform relatives who are waiting for your return.



Intra and Post Operative Pain Management

Please discuss your pain management with your anaesthetist.

There are several inpatient phases following surgery. Our aim is for you to be as comfortable as possible within the safety limits of the drugs.

Surgery

During surgery your anaesthetist will give you pain relieving drugs with the aim of making you comfortable when you wake from surgery.

At the end of the surgical procedure local anaesthetic is injected into your shoulder joint and around the skin incisions.

In the recovery room if you still have pain the nurses will give you pain relieving medication into your intravenous drip. They will ensure that you are comfortable before you are transferred to the ward. In recovery or on the ward if you have pain inform the nurses.

After surgery

On the ward you will have been prescribed a combination of medications for pain control. These include:

Local anaesthetic infusion - "Pain control Infusion Pump" This infusion pump will automatically administer a constant flow of local anaesthetic into the operative area. More information on the infusion pump is on the following page. Whilst in hospital the nurses will give you injections of strong painkillers such as Morphine when you require them.

Discharge

Your anaesthetist will prescribe strong pain tablets for you to take home on discharge from hospital. You will have FOUR days supply of oral medication. **You will need to make an appointment to see your GP to review pain management and to get another prescription if needed. I WOULD STRONGLY RECOMMEND YOU PRE BOOK THIS APPOINTMENT WHEN YOU SET THE DATE FOR YOUR SURGERY.** Your take home medication instructions are as follows.

PATIENTS LESS THAN 60 YEARS OF AGE
Paracetamol. 1g Strictly four hourly for 4 days and then as required. Do not wake for night time dose

Oxycontin Slow release 20mg morning and night for 4 days then only as required.

Oxycodone 10mg capsules one to two 3 hourly if required for strong pain.

Coloxyl and Senna Two tablets morning and night to prevent constipation associated with strong analgesics. Cease after 3 days, but can continue use if it is required.

PATIENTS OLDER THAN 60 YEARS OF AGE
Paracetamol 1g Strictly six hourly for 4 days. Do not wake for night time dose

Oxycontin Slow release 10mgs morning and night for 2 days then only as required.

Oxycodone 5mg capsules one to two 3 hourly if required for strong pain.

Coloxyl and Senna Two tablets morning and night to prevent constipation associated with strong analgesics. Cease after 2 days, but can continue use if it is required.

It is very important that you write down the time and the name of each medication you take so as to ensure the infusion as to which medications you have taken.

Sleeping position

It is very difficult to get comfortable in the first few weeks after surgery. If you have access to a recliner or arm chair you will find it easier to get some sleep.

Ice Packs

I strongly recommend the use of ice packs especially after exercise.

The simplest ice pack is a bag of frozen peas wrapped in a tea towel.

It is normal for you to have pain in your shoulder after surgery, but we have endeavoured to reduce this as much as possible for you.

The Pain Control Infusion Pump

The Pain Control Infusion Pump (PCIP) is a portable pressure pump filled with local anaesthetic that will help to treat your pain after surgery.

The PCIP delivers local anaesthetic at a constant rate to the surgical site by a small catheter (small tube). The flow rate is pre set and cannot be changed. Whilst the pump is delivering local anaesthetic automatically, no care of the pump is required from you. The pump will deliver local anaesthetic for approximately 2 days. You will still require additional oral analgesia and you will be discharged from hospital with these.

Your health insurance fund will cover the cost of the pump.

Patient instructions

The PCIP Pain Control System

is a portable infusion pump designed to deliver medication directly to the surgical site for management of pain.

During Infusion

The Pain Control Infusion Pump is completely portable and can be worn in the carrying pouch provided. It is important that you do not attempt to tamper with it in any way.

Do not bathe or swim with the pump. You may shower however.

If Complications Arise

If any problems arise such as leakage, discomfort, excessive pain, or any part of the unit becomes disconnected, contact your doctor immediately. The



white clamp on the thicker tubing can be used to restrict the flow of fluid if necessary.

You will benefit from the use of the PCIP during your post-operative period. You will be more comfortable and on your way to a quicker recovery.



PCIP Removal Guide

When your pain pump is empty the ball will look deflated like this.



Step 1

- Wash your hands with soap and warm water.
- Have a paper or plastic bag available for waste disposal.
- Sit in a comfortable position.
- Take a few deep breaths and **relax**.
- Remove dressing which covers the catheter site and discard in plastic bag.



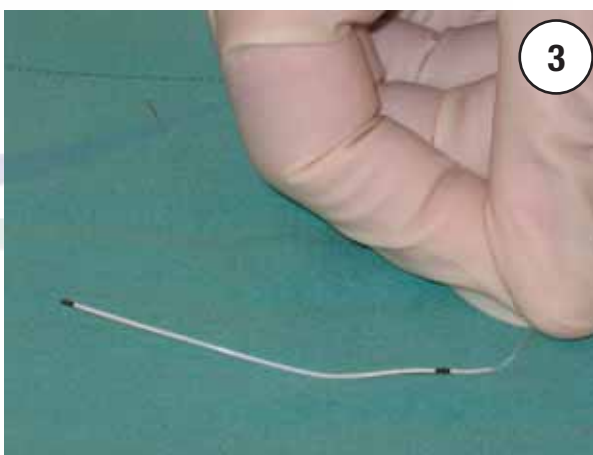
Step 2

- Grasp the tube firmly and pull outward from skin with a steady motion. The tube should come out easily. The tube is under the skin and will be approximately 15cm long when you pull it out.
- You will feel a pulling sensation, not pain.
- If tube begins to stretch excessively without releasing please STOP procedure and contact your



doctor. He/she may wish for you to return to the office for removal of the catheter.

Note: When the catheter is removed check the end. There are **2** black marks. Both of these need to be present. An example of this is in the photo. Please contact Mr Campbell's room if you have any concerns.



Step 3

With tube removed, place a bandaid over the area and apply pressure for at least 2 minutes

It is normal for there to be a leakage of clear or pinkish fluid for a few hours from the removal site. You may need to change the bandaid during this time. You may shower and get this area of your arm wet.

Report to your doctor's office for follow up visit as planned. If any problems or questions arise, please call your doctor's office at once.



Use Of Your Sling

I recommend the use of a sling following shoulder surgery. Initially following the surgery the arm will be painful and the sling does help support the shoulder itself. If you have had a repair of the rotator cuff or of the lining of the joint as in shoulder reconstruction the sling is an important part of the post operative rehabilitation course. It will be discussed with you in detail in the post operative visit how long you will need to wear the sling for. In general terms though a number of points can be made.

The times when you must wear a sling are –

In bed at night. Under the influence of pain killing medications your dreams tend to be more exotic than normal and you can fling your arms around and hurt yourself if you do not have the sling on.

The second time you must wear the sling when **in any form of transport**, that is plane, train or automobile. For this reason you cannot drive a motor vehicle in this period of time while you

are wearing a sling. If you were to drive and you had to react in an emergency situation you will either damage your surgery or you will not be able to react in time and you may have a collision or some form of accident. If this was the case you might find that your insurance company may not cover you and the police may consider that you are driving in a culpable manner.

Thirdly if you are out and about where there are a lot of people around you should wear the sling as it gives them a signal that you have had something done and they tend to give you a wider berth than they might otherwise do.

In this period of time though you will be referred to a physiotherapist and at the physiotherapist your arm will be out of the sling while you do specific exercises. There are many things you will be able to do around the house or in a controlled environment out of the sling as well and these will be discussed with you in your post operative visit.



The day after your surgery is day one post operative. The physiotherapists contracted to the hospital normally visit Mr Campbell patients in the morning after surgery. Their function is to advise you with respect to the use of your sling and to guide you through the exercises outlined in this booklet. I would advise that you have this reviewed by the physiotherapist but they will send you an account for their services which is not part of Mr Campbell's fees for his services. You may elect preoperatively not to have this physiotherapist visit if you so request it. Mr Campbell or a member of his team will also visit you in your room to see how you are feeling and ensure you are comfortable to be discharged that morning.

The nursing staff will assist you with showering and change your dressing on your shoulder. They will give you your discharge medications to take home with you. They will also give you some post operative information sheets on your

Post Operative Regimes

Your post operative information and management will be specific to what was found and treated at the time of surgery. Listed below is a brief overview of the postoperative management for the different types of shoulder surgery performed. You will be given detailed instructions specific to your surgery on the first post operative day.

Rotator Cuff Repair

- Sling for six weeks.
- No driving for six weeks.
- Return to work will be determined by job requirements and your recovery rate.

Acromioplasty +/- AC Joint Excision:

- Sling for comfort.
- Physiotherapy after two weeks.
- Driving when comfortable and confident.
- Return to work when comfortable.

Stabilisation:

- Sling for four weeks.
- No driving for four weeks.
- Physio after four weeks

WARNING

You cannot drive a motor vehicle when your arm is in a sling. Even though you physically can do this (especially automatic vehicles) if you are involved in an emergency, you would not be able to react appropriately. If you were involved in an accident your insurance company may not cover you and you could be charged with culpable driving.