NHS
West Suffolk
NHS Foundation Trust

Patient information

Posterior Shoulder Stabilisation

You will be admitted for surgery to your shoulder because of an instability of your shoulder joint.

Dislocations to the shoulder joint are not infrequent. They mainly occur as a result of trauma but in some patients they may arise as a result of a deficiency of the ligaments. Normally the shoulder dislocates out in front (an anterior dislocation) but approximately 10% of shoulders dislocate out the back (posterior instability).

If non-operative management (physiotherapy) is unsuccessful at dealing with the shoulder instability, surgery is required. It should be noted that non-operative management is less successful when a shoulder is unstable as a result of trauma.

Surgery

Surgery is either performed under general anaesthetic or under sedation along with a nerve block of the area. Your anaesthetist will advise you about the most appropriate anaesthetic.

There are two main types of stabilisation:

- Anterior stabilisation which stabilises the shoulder at the front
- Posterior stabilisation which stabilises the shoulder from the back.

This leaflet concerns posterior stabilisations only. Your surgeon will have informed you which type of stabilisation you are having.

The shoulder joint is approached by releasing one of the major muscles running in front of the joint. The capsule is opened and either re-inserted if it has been found to be torn from its point of insertion or shortened if it is found to be lax. The shoulder muscle is then reinserted and the wound is closed.

Where the shoulder is unstable towards the back an approach to the shoulder from the back of the joint may be required. This is technically similar to the approach from the front (anterior stabilisation) but the post-operative regime is more restrictive.

Post-operative Care

Most patients are discharged on the day of surgery. If surgery has been performed using a nerve block, the operated area is usually numb for 12-18 hours after surgery.

After surgery a brace is worn holding the arm away from the body. This brace is called an abduction wedge. It should be worn for 4-6 weeks after the surgery and should not be removed at any time. Physiotherapy exercises are started once your Consultant has decided that the brace can be removed at a follow-up clinic appointment.

Rehabilitation

You will not need any physiotherapy until your brace is removed. You can move your elbow and wrist to prevent stiffness. You should not remove the brace, but you can clean under your arm with a damp flannel or cloth.

You should not return to driving for 6 weeks or until your surgeon has allowed you to.

Outcome of surgery

In general the results from stabilisation to the shoulder are good. Provided the arm is protected for the first three months and that heavy overhead lifts or contact sports are avoided for six months re-dislocations are rarely seen.

Complications

Wound seepage: Following surgery a certain amount of bloody seepage may be seen from the wound. This normally settles down within 24-48 hours. If bloody leakage should continue you should contact your General Practitioner or the surgical department.

Infection: Infections around the shoulder are rare. If the wound should become red, hot and tender or you should develop a temperature in association with shoulder pain you should contact your General Practitioner or the surgical department.

Pain: You will experience some pain and discomfort following surgery. The painkillers prescribed by your surgeon should be taken as prescribed. You may also place a bag of ice cubes or frozen peas over the shoulder to ease the swelling. You should furthermore rest the arm in a splint. Should this not settle your discomfort, you should contact your General Practitioner or the surgical department.

Nerve damage: Nerve damage is rarely seen following shoulder stabilisation. Temporary nerve irritation may be seen as the result of post-operative swelling. If the shoulder has previously been operated on the risk of nerve damage is greater but the likelihood of damage to one of the nerves to the shoulder muscles is still small. Should damage to the nerve which innervates the larger shoulder muscle (the deltoid) occur irreversible loss of shoulder function may be seen. This is as stated a very rare occurrence.

Recurrent instability: This is a rare occurrence following shoulder stabilisation. Further trauma to the shoulder may however result in instability recurring.

Stiffness : As a result of the tightening procedure to the shoulder a certain amount of stiffness is always seen for the first 3-6 months. This normally subsides with exercises but a lack of full external rotation may be seen following surgery.

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