

SHOULDER DISLOCATIONS, CHRONIC INSTABILITY, ARTHROSCOPIC CAPSULOLABRAL REPAIR, EDEN-HYBINNETTE AND THE LATARJET PROCEDURE

This information aims to help you understand your condition and gain maximum benefit from your treatment. It covers the most commonly asked questions. However, every individual is different, and you should ask as many questions as you like.

SHOULDER ANATOMY

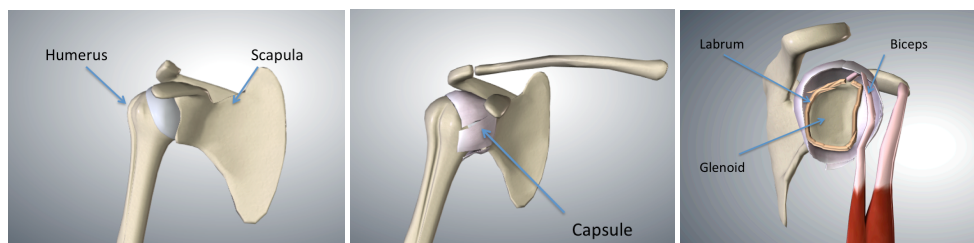
The shoulder joint is a ball and socket joint. Most shoulder movements occur where the ball at the top of your arm bone (the humerus) fits into the shallow socket (the glenoid) which is part of the shoulder blade (the scapula).

There are various structures which help to keep the joint in position. The most important ones are:

Capsule and Ligaments – a soft tissue ‘bag’ which holds the bones together

A rim of cartilage (labrum); which deepens the socket

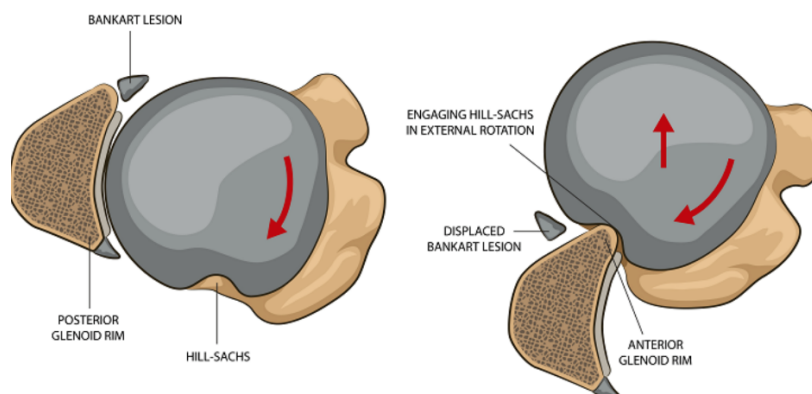
Muscles: which keep the shoulder joint in the correct position when using or moving the arm



SHOULDER DISLOCATION

When the shoulder joint is viewed from underneath the ball sitting on the socket looks a lot like a golf ball sitting on a golf tee. The shoulder usually dislocates forwards and downwards so that the top of the arm bone is in front of the socket. When the shoulder first dislocates the ligaments and cartilage at the front of the shoulder are usually damaged (this is usually called a labral tear or Bankart lesion)

There is also usually an impression fracture of the soft bone of the back of the humeral head called a ‘Hill-Sachs’ lesion’ where it sits on the rim of the socket. Sometimes the bone at the front of the socket is also damaged (this is called a ‘bony Bankart lesion’). The ligaments and cartilage generally do not heal themselves and because of this there is a risk of further dislocation.



Further occurrences of dislocation cause further damage to the ligaments and cartilage and lead to further loss of bone from the front of the socket or the back of ball of the humeral head. This damages the ‘golf ball’ or makes the ‘golf tee’ smaller making it more likely that the ball falls off the tee (dislocates).

TYPES OF SURGERY

ARTHROSCOPIC CAPSULOLABRAL REPAIR / ARTHROSCOPIC BANKART REPAIR

The aim of surgery is to reattach the labrum and to tighten the stretched ligaments. After the repair your body's natural healing process can occur.

This can be done through arthroscopic (keyhole) surgery involving 2-4 small cuts.

This is the most common type of surgery performed.

After this type of surgery, the chance of dislocation falls to around 10% after 10 years.

But certain patients have a higher risk on dislocation after arthroscopic capsulolabral repair surgery:

- Males who participate in contact sports

- Those with glenoid bone loss

- Those with large Hill-Sachs's lesions

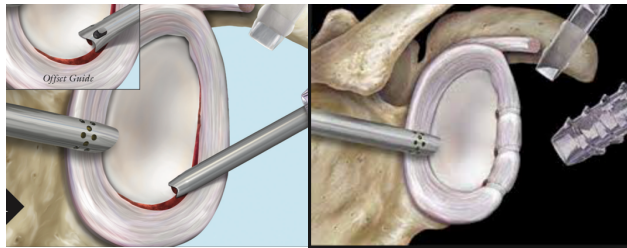
A video of this type of surgery is available on the website www.drgeoffreysmith.com.au

ARTHROSCOPIC BONY BANKART REPAIR

The aim of this surgery is to re-attach the bony Bankart fragment to the socket. This can be done in a similar way to a capsulolabral repair (if the bone fragment is small) or by using small screws or 'buttons' (if the bone fragment is bigger). The repair is then completed with a capsulolabral repair.

'REMPLISSAGE'

The aim of this surgery is to 'fill' (Remplissage means fill in French) the Hill-Sachs lesion to prevent it contributing to the risk of recurrent dislocation. The overlying infraspinatus tendon is sewn down into the Hill-Sachs's lesion. This is combined with capsulolabral repair. It may be chosen as a technique if there is no glenoid bone loss but a large Hill-Sachs lesion is present.



LEFT and CENTRE:
Arthroscopic
capsulolabral repair
RIGHT: Remplissage

GLENOID BONE GRAFT SURGERY

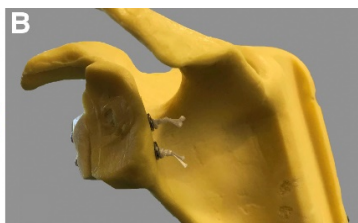
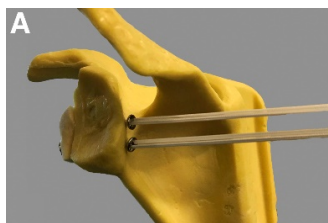
In this surgery the aim is to attach extra bone to the front of the socket (make the 'golf tee' bigger). This technique is chosen if there is bone loss from the socket. Shoulder arthroscopy is performed prior to deciding which of the following techniques is most appropriate.

Eden-Hybinette:

Autologous (your own) bone is taken from either the outer part of the clavicle or the iliac crest (the bone at the top of the pelvis). This is performed arthroscopically and is combined with capsulolabral repair. This technique is chosen if there is bone loss from the socket and the residual soft tissues are of good quality.

'Latarjet' procedure.

Here the coracoid process (a finger like piece of bone attached to the upper part of the scapula) is cut and moved to the front of the socket and held with screws or buttons. The coracoid process has a tendon attached to it which reinforces the repair. This surgery can be performed arthroscopically (keyhole) or through a larger incision 5-7 cm long on the front of the shoulder. This technique is chosen if there is bone loss from the socket and the residual soft tissues are not of good quality.



L and C: Eden-Hybinette
R: Latarjet

THE OPERATION

You will come to hospital on the day of surgery. You will have a general anaesthetic. A nerve block may also be used. The surgery usually takes 1-2 hrs.

AFTER SURGERY

You may go home either on the same day or the day after surgery

You will see a physiotherapist before you leave hospital.

You will use a sling for 4-6 weeks.

The speed of recovery is variable. It can be rapid or seem slow. Most improvement occurs in the first 6 months. The end of recovery is around 12-24 months after surgery.

Further general information is available in the 'Information for patients undergoing surgery' leaflet

APPOINTMENTS AFTER SURGERY

10-14 days; 6 weeks, 3 months, 6 months, 12 months.

REHABILITATION EXERCISES

Specific rehabilitation exercise sheets will be given to you in hospital and during your follow-up visits. Only do the exercises shown to you in hospital and demonstrated to you in clinic. Do not remove the sling until you are told to do so. Your therapist will suggest whether you can do the exercises yourself at home or would be better with regular supervised physiotherapy sessions. You will need to get into the habit of doing the exercises several times a day for around 6 months.

MILESTONES

0-4 weeks

Sling full time

4-6 weeks

Wean out of sling when at home

6-12 weeks:

Sling is removed Normal day to day use of the arm is allowed.

Strengthening work can start

3-6 months:

Normal day to day use of the arm is allowed

Physiotherapy for range of motion and strengthening continues

6 months +:

Full activity

RETURN TO WORK/SPORTS

Work (light duties / office) 1-2 weeks

Swimming (breaststroke) 6-8 weeks

Driving 6-8 weeks

Work (manual) 3-6months

Light lifting 3-4months

Heavy lifting 4-6months

Swimming (freestyle) 3-4months

Golf 3-4months

Light sports (non-contact) 3-6months

Contact sports 6 months

DRIVING

You cannot drive while you are using a sling.

Once you have been told that you can remove the sling you can drive when you feel that you have full control of the vehicle. It is your responsibility to make this decision.

LIKELY OUTCOMES

The main aim of surgery is to prevent recurrent dislocations.

A recurrent dislocation rate after surgery of <10% is expected

