Shoulder instability

What is it?

Some patients are born with loose (hypermobile) shoulders.

Most patients with an unstable shoulder have experienced a single or repeated injury (dislocation). The joint capsule may have stretched or torn away from the bony socket (Bankart lesion).

After an acute dislocation, the shoulder needs to be put back into place urgently – usually in hospital.

In long standing cases, the shoulder may be painful, click, catch and feel unstable.

How is it diagnosed?

An unstable shoulder is diagnosed on the basis of a detailed clinical history and examination.

Often an MRI scan and/or shoulder arthroscopy may be required to confirm the diagnosis and plan treatment.

What is my approach to treatment?

It is important to prevent repeat episodes of shoulder dislocation, or the joint can wear out (osteoarthritis).

Physiotherapy is usually attempted in the first instance. If this fails or there are other associated problems such as rotator cuff tear, unstable biceps tendon or SLAP lesion, then surgery is usually recommended.

What does an operation involve?

Surgery is carried out under general or regional anaesthetic as a day case or with an overnight stay.

Essentially, the loose shoulder capsule is tightened up and/or reattached to the edge of the bony socket. This can be carried out either open or by keyhole (arthroscopically). The type of shoulder instability and the individual requirements of the patient dictate the best treatment option. You can discuss this fully during your consultation.

At the end of the procedure, incisions are closed using non-absorbable sutures. A long acting local anaesthetic injection may then be administered to provide additional pain relief. Finally, a dressing, bandaging and sling are applied.

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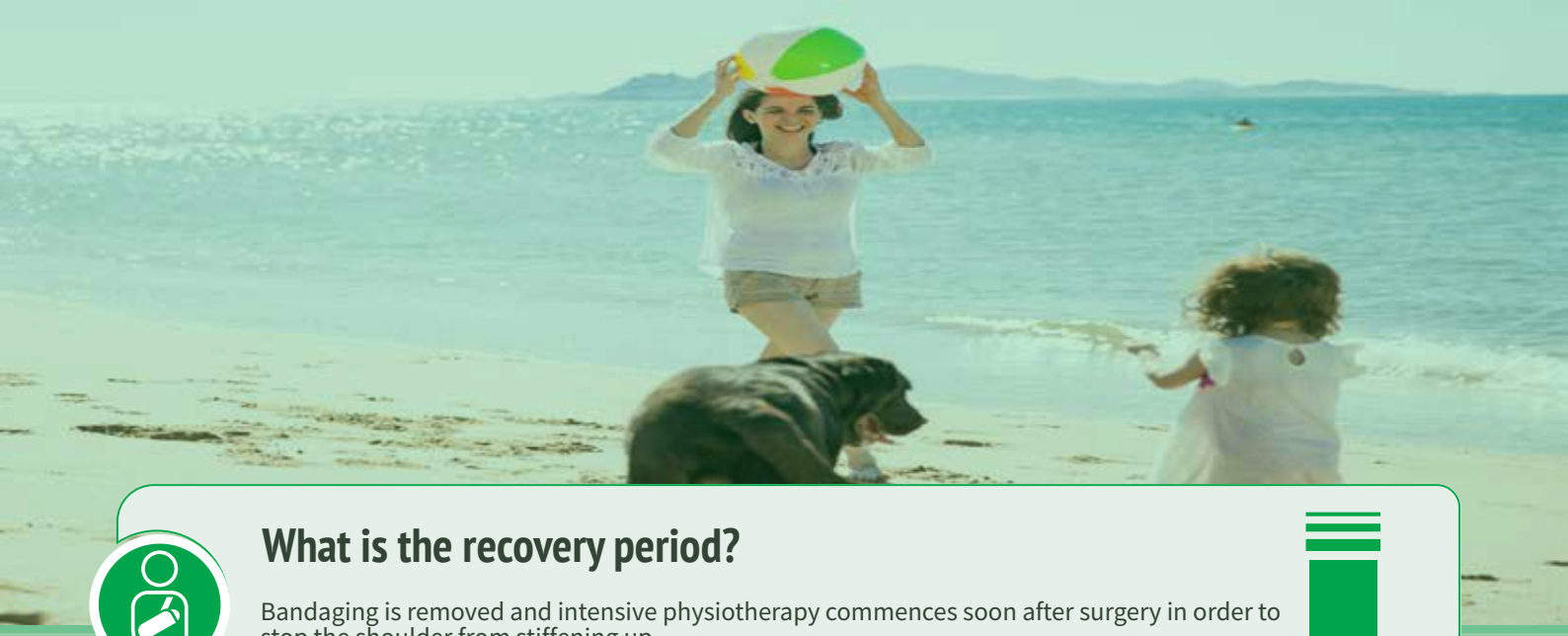

What is the recovery period?

Bandaging is removed and intensive physiotherapy commences soon after surgery in order to stop the shoulder from stiffening up.

The patient has to be prepared for some discomfort, although strong pain killing medicines can be given via tablet or injection once the local anaesthetic has worn off – normally 6 to 8 hours. Sutures and dressings are removed in the clinic after two weeks.

The arm is kept in a sling and controlled shoulder movements continue under supervision of the physiotherapists for up to six months. The exact regimen may vary as it will depend on numerous factors.

Driving may be possible after 6 to 8 weeks.

When a patient is ready to return to work depends on their specific job role and may also vary from individual to individual. It may be possible to resume light keyboard work after 3 to 4 weeks. Heavy manual work should be avoided for a minimum of three months.

Patients should not attempt to return to contact sports for six months.

Are there any possible complications?

Over 90% of patients are satisfied with the results of surgery.
However, as with any treatment, there are always risks involved: Infection: 2%,
Frozen shoulder: 2-3%,Nerve injury: 2%

Recurrent dislocation varies from 3-20% as it depends on numerous factors.
You can ask for more details at your first consultation.

Insurance fee assured:

AXA Bupa HCAHealthcare UK

Member of:

General Medical Council BMA BESS BSSH The British Society for Surgery of the Hand British Orthopaedic Association RCS Ed

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