Patient Advice Sheet Distal Biceps Repair

DIARMUID MOLONY ORTHOPAEDICS

The distal biceps is a commonly injured tendon in the front of the elbow. The biceps is responsible for turning the forearm palm up (supination) and also is a key elbow flexion motor. Repair of the tendon is necessary in cases where a full rupture has occurred or if there is persistent pain related to partial tears which do not settle with non operative management. The surgery is performed through an incision in the front of the elbow. The tendon is retrieved and damaged tissue is removed. The tendon is then reattached to the radius where it belongs using an anchor called an endobutton and sometimes augmented with a screw. In cases where there has been a large time lapse between the injury and surgery, the tendon is very degenerate and retracted occasionally a graft from the bone bank to augment the tendon is required. In this event the rehab is somewhat slower but the same rules as below apply.

If you have any specific concerns, please ask either in the clinic or at the time of consent pre- operatively. It may be helpful to write any questions you may have down prior to your consultation or when we review you on the morning of surgery. You may wish to educate yourself regarding your condition. There are several online platforms including our own website www.dmorthopaedics.ie and the BESS website for this purpose. Post operatively I will explain the findings and advise you of the likely post-operative recovery. In general however the following applies:

Dressings and Sling:

In general, a sling is only required for comfort. We will be encouraging you to move your elbow as early as possible in the post op phase but limitations in range will be set, Initially this is in either a half cast or brace and later a hinged brace. If a brace is used from the beginning (usual), you will have a bulky dressing on initially which acts to soak up any fluid coming out of the elbow in the initial phase. This can be removed at 48 hrs. The inner dressings should remain for 5 days and can be exchanged for new ones then. The range of your elbow will be progressed in a stepwise fashion over a 6 week period.

Wounds:

We usually use dissolving stiches to seal off your wound. There will be a small tail of the suture at each end . This should be pulled and the remaining suture cut between the knot and the skin at day14. The deep part of the suture will then dissolve. You can do this yourself with a small scissors or see your GP for removal of the suture ends. It is advisable to arrange this consultation with your GP in advance of surgery if that is your plan. Occasionally if the repair is tight the skin will be closed with clips and attending your GP or therapist will be required for clip removal. Where there are concerns regarding your wounds please contact my office and we will arrange an early review if necessary

Post Op Therapy:

Occupational therapy and Physiotherapy is an essential part of the treatment. It is important you engage fully with a physio program post operatively. In general you will be seen by a physiotherapist before discharge from hospital. You should seek to see a therapist comfortable with managing elbow problems in a unit convenient to you within the first week or two post operatively. Range is initially protected in a brace. Motion tolerance and strengthening can begin according to our protocol. There is guidance on our website for your therapist.

Pain Control:

You will require pain relief post operatively and a prescription will be provided for you on discharge. This will include a range of medication depending on the usual requirements for your operation.

PLEASE LET US KNOW OF ANY ALLERGIES OR MEDICATION INTOLERANCES IN ADVANCE OF SURGERY

In general taking pain medication regularly for the first 5 days is recommended. After this your requirements are likely to reduce. Remember that physiotherapy may cause some pain and so taking pain medication in advance of sessions is wise. In addition do not underestimate the ability of simple measures to impact significantly on pain relief.

A good example of this is cryotherapy (ice packs). There are several on the market and your local pharmacy will be able to guide you. In general, the more simple the better. If a cryotherapy device is complex for you to put on, you are less likely to use it. Often a simple bag of frozen peas is as good as any other. It is important to protect your skin with a towel or similar when applying a cold pack to your joint as prolonged cold can damage your skin.

Our anaesthetic team may offer you a pre-operative nerve block. This does help with post op pain control and your anaesthetist will discuss the risk/benefit of it with you. Where a block is administered, post-operative pain control is usually good but the duration will be limited so it important that you take your pain medication before the block wears off. Pre loading your systemic pain control in this way will prevent you from getting sudden onset of severe post -operative pain when the block wears off.

Return to work:

For desk-based work in general you will need 2 weeks to allow wounds to heal and for your pain relief requirement to fall. With more manual activity it will take longer . We do not recommend loading the repair until at least week 12. Work hardening of the arm may take several months.

Driving:

You should be able to drive an automatic after 2 weeks. If you have a manual, return to driving may take 6 weeks.. It is important you advise your insurer of your surgery and that you are sensible about returning to driving. We would advise that you try driving in a safe environment first before returning to the road, for example a quiet car park or other open space.

DO NOT DRIVE OR OPERATE MACHINERY WHEN TAKING NARCOTIC PAIN MEDICATIONS

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Risks of surgery:

These will be discussed with you at the time of your consultation and on the day of your procedure during the consent process. These typically include infection, bleeding, nerve and vessel injury , instrument failure, damage to joint surfaces, fracture and the risk of post operative pain and stiffness. In addition, there are the risks of anaesthesia which include chest infections, stroke, heart attacks and clots either in the leg or lungs. While rare, these complications can be serious and in some cases fatal. Specific risks associated with distal biceps repair are forearm bone fracture, damage to the motor nerve that serves your finger extension (less than 1%) and damage to the nerve that serves the sensation on the outer aspect of your forearm (10-15%).

It is important to remember that while controlled, surgery is in and of itself an injury. Inflammation, pain and swelling are natural reactions to injury and while we will attempt to minimise the effects of these, post-operative pain and frustrating lack of function are completely normal for the post-operative period. This may be for a period of several weeks. Typically the discomfort gets better over time. If you are not seeing an improvement or indeed your pain is worsening, or if swelling and redness are developing, then you should let us know early so that post-operative complications such as infection or bleeding can be dealt with as soon as possible.

For further information please consult our website. You can also call us during office hours on 089-4004995 or email us on info@dmorthopaedics.ie. In case of emergency there will always be a member of the orthopaedic team on call in Tallaght hospital so you may attend the A/E there and look to be seen by the orthopaedic team on call. In addition, there are A/E facilities in the Blackrock clinic which may be able to help you and who will liaise with us as necessary. If you are based outside Dublin and require urgent review you should contact your GP or attend your local A/E.