Patient information surgery - Shoulder Replacement

DIARMUID MOLONY
ORTHOPAEDICS

Your operation replaces the main ball and socket joint in the shoulder. Metal and plastic implants are used to replace the ball at the top of your arm bone (humerus) and the socket (glenoid) which is part of the shoulder blade (scapula). This procedure is typically done with a general anaesthetic. The joint is exposed through a 10-15cm skin incision over a gap in the muscles in your shoulder. This gap is then utilised to access the joint. Using specialised tools the original joint is removed and is replaced with the implants.

The main reason for surgery is to reduce the pain in your shoulder you may also gain movement in your shoulder but this is less predictable. This depends on how stiff the joint was before the operation and whether the muscles around the shoulder are able to work normally. In order to maximise your function, engagement with rehabilitation is key. It may take several months and sometimes over a year to reach your potential.

Following your consultation and post operatively I will explain the findings and advise you of the likely post operative recovery. In general however the following applies:

Potential complications:

All operations involve an element of risk. We do everything to minimise these risks but they do persist in a small percentage of patients. The decision to proceed with surgery is really about weighing up the risks of surgery versus the potential benefits of the operation. In general 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 early lack of function are completely normal for the post operative period. . 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 total shoulder replacement the risks include but are not limited to:

1. Complications relating to the anaesthetic. These include nausea or rarely heart or lung problems including chest infections and heart attack. There is also a very small risk of stroke. Where a nerve block is used, there is the potential for nerve injury or infection around the nerve.

2. Infection: Occasionally deep infection may occur after the operation. This is not common and is in the order of 3%. In severe cases explantation of the replacement may be necessary to clear the infection. Surface or wound infections are a little more frequent but can usually be managed with antibiotics

3. Persistent pain and stiffness. Some patients are not fully satisfied with their implant and while most see an improvement in both pain and movement about 20% of patients will have some pain and stiffness although there is usually an improvement by comparison to their pre op state.

4. Damage to the nerves and blood vessels around the shoulder. (less than 1%)

5. De-functioning or wear of the replacement requiring a revision of the surgery. (about 10% at 10 years)

6. Clots: While clots in upper limb surgery are very rare, they do sometimes occur. Even more rarely these clots can migrate to the lung which is a serious and sometimes fatal event. Anticoagulants (medication to prevent clots) are rarely required in upper limb surgery. This will be assessed based on any other risk factors you might have.

7. Dislocation: Instability of your implant in the early period has been reported as high as 10%. In our experience it is about 3%. When this happens early on it is not always a major issue as the joint requires muscle tension to keep it stable. This muscle tension may take a few weeks to develop. Persistent instability is rare but may require revision surgery to stabilise the joint.

8. Fracture: It is possible that in the process of inserting the implant we inadvertently fracture either the humerus or the glenoid. Usually this means “on table” adjustments to fix the problem. Very rarely the fracture can mean that we are unable to complete a joint replacement as planned and we have to move to a fallback option

Will it be painful?

Although the operation is to relieve pain, it may be several weeks until you begin to feel the benefit. Our anaesthetic team may offer you a pre operative nerve block. This does help with post op pain control and your anaesthetists 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. You will be given pain-killers (either as tablets or injections) to help reduce the discomfort while you are in hospital. A prescription for continued pain medication will be given to you on discharge. Please visit your General Practitioner if you require further medication after that.

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

Remember that physiotherapy may cause some pain and so taking some 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. Be careful to protect your skin with a towel or similar as direct application of cold packs may damage your skin. Use the pack to 10–15 minutes and you can repeat this several times a day.

Wound and Follow up:

Keep the wound dry until it is healed. This is normally for 10–14 days. You can shower or wash and use ice packs but protect the wound with cling film or a plastic bag. Avoid using deodorant, talcum powder or perfumes near or on the scar. If your dressing becomes wet you should change it. At a minimum try to avoid this until after day 5. Bruising and swelling around the shoulder/upper arm is normal. Bruising tends to pool at the elbow. The bruised area itself may be tender. This will gradually disappear over a period of a few weeks.

Normally you should arrange with your GP practice to have your stitches or clips removed 10 -14 days following your operation. Please arrange this with your family doctor preoperatively so as to avoid late removal of sutures which can be uncomfortable. Where there are concerns regarding your wounds please contact my office and we will arrange an early review if necessary. Usual follow up in the clinic is at week 6. You will require an up to date x-ray at your first and some subsequent reviews.

Sling:

The sling is for comfort and to protect the shoulder after the operation. When in a safe environment you can take it on and off as you wish and you do not need to have your arm strapped to your body all the time. Nonetheless there are some limitations on your range which the phsyios will go through with you prior to discharge. In most cases patients find the sling more comfortable for 6 weeks In general for the first month I prefer if you wear the sling in bed at night and when out and about. Using a pillow behind your elbow at night is also useful to minimise the risk of damaging muscle repairs and dislocation. The therapists and nurses will show you how to take the sling on and off. You will gradually wear the sling less over the 4–8 week post op period.

Driving:

In general it will be possible to drive an automatic at 6 weeks using your non operated arm to control the steering wheel. A manual will be at least 6 weeks but is frequently longer. You must trial driving in a safe environment before getting out on the road. Check you can manage all the controls and can stop suddenly without difficulty. It is advisable to start with short journeys. The seat belt may be uncomfortable initially, but your shoulder will not be harmed by it. In addition, check your insurance policy. You will need to inform the insurance company of your operation as they may have specific rules in the policy.

DO NOT DRIVE, USE POWER TOOLS OR WORK MACHINERY IF TAKING NARCOTIC PAIN MEDICATION

Physiotherapy:

Physiotherapy is an essential part of shoulder surgery. 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 but you should seek to see a physio comfortable with managing shoulder problems in a unit convenient to you within the first week or two post operatively. We would advise you make such arrangements prior to your operation. There is guidance for physiotherapists on our website.

The exercises aim to stop your shoulder getting stiff and strengthen muscles. They will be changed as you progress and made specific to your shoulder and your lifestyle. A progressive rehab plan is key to maximising the benefit of your shoulder replacement. You will need to get into the habit of doing regular daily exercises at home for several months. Initially short, frequent sessions (eg. 5–10 minutes, 2-3 times a day) rather than one long session are usually better tolerated. Over time the number of repetitions and the length of time exercising can be increased.

It is normal for you to feel aching, discomfort or stretching sensations when doing these exercises. However, if you experience intense and lasting pain (e.g. more than 30 minutes), it is an indication to change the exercise by doing it less forcefully, or less often. If this does not help, discuss the problem with your physiotherapist.

How I am likely to progress?

This can be divided into 3 phases:

Phase 1. After you have been discharged and for up to 6 weeks after the operation

The pain in your shoulder will gradually begin to reduce and you will become more confident. Wean yourself out of the sling slowly over this time, using it only when you feel necessary. Do not be frightened to try and use your arm at waist level for light tasks. You will be seeing a physiotherapist and doing regular exercises at home to get the joint moving and to start regaining muscle control. Lifting your arm in front of you will require support from your other arm or an assistant.

Phase 2. Between 6 and 12 weeks

The pain should be lessening. The exercises are now designed to improve the movement available and get the muscles to work, taking your arm up in the air or away from your body when you are sitting or standing with less assistance. Overall, you will have an increasing ability to use your arm for daily tasks including driving, non-manual work and some leisure activities.

Phase 3. After 12 weeks

You can progress to stretching your range and using the arm for loading without restriction. It is important to remember that the muscles are still weak at this point. This is because of the long period of disuse preoperatively and the "injury" of surgery stopped you being able to use them. You should find that you will regain the strength in them with regular exercise however. Aim for range first. Strength and function can continue to improve for many months, even up to a year or more. Expecting "normal" shoulder function is unrealistic but strength and movement can continue to improve for 18 months to 2 years so don't give up on your rehab!

Return to work:

If wearing a sling precludes you from doing your job then obviously the above time frames related to the sling requirement will dictate your return to work. Likewise inability to drive may dictate this also. For most desk jobs 2 weeks should suffice to allow for pain control and early mobility. After joint replacement heavy manual work is not recommended because of the potential to wear the joint replacement out early. Return to light pulling and pushing will take at least 12 weeks. Overhead function will take much longer. Please be conscious of this and make plans for help to be available for the postoperative period. No matter how well the surgery goes, if you challenge the shoulder severely in the post operative period you may disrupt the repair or loosen your implant prior to healing having been completed. Adhering to the post operative physio plan and doing enough but not too much rehab is key to a successful outcome in the end.

Return to Sport:

Generally at least 3 months. After this much is determined by your progress with physiotherapy. General examples are :

Swimming: Low intensity 8 weeks

Gardening (light tasks e.g. weeding) – after 8-10 weeks

Golf. - after 5-6 months

Make sure you have the necessary range of motion and strength for your chosen sport prior to returning to play.
Your physio will guide you on this.

Are there things that I should avoid?

For the first 6 weeks avoid taking your arm out to the side and twisting it backwards. For example when putting on a shirt or coat it is best to put your operated arm in its sleeve first. Try not to reach up and behind you (e.g. putting a seat belt on in your car). Do not force these movements for 3 months. Also allowing your elbow to drop behind your chest in bed at night is best avoided. Use a pillow behind the elbow to prevent this. Likewise you should avoid leaning with all your body weight on your arm with your hand behind you. For example leaning heavily on your arm to get out of a chair. Finally, do not load the arm with anything heavy.

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 shoulder condition and in addition to our own website www.dmorthopaedics.ie (Services/shoulder/shoulder arthritis) we recommend the website www.shoulderdoc.co.uk or the BESS website for this purpose.

You can 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 orthopaedics 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 please contact your GP or local A/E.