What is Impingement Syndrome?

The subacromial area lies between the top of the arm bone (Humerus) and a bony prominence on the shoulder blade (acromion). A muscle and fluid filled cushion (bursa) lies between the arm bone and the acromion. With certain positions these structures can become pinched and inflamed. The pain that you have been experiencing is caused by this pinching and is typically felt on movements such as reaching and putting your arm into a jacket sleeve.

Arthroscopic Subacromial Decompression (ASD) Excision of the acromioclavicular joint.

What does the Operation entail?

The operation is done by ‘key hole surgery’; usually through two or three 5mm puncture wounds. It involves cutting the ligament and shaving away part of the acromion bone. This increases the size of the subacromial area and reduces the pressure on the muscle and bursa allowing them to heal.

What happens after the operation?

You will usually be in hospital either for a day or overnight. A doctor/physiotherapist will see you prior to discharge and you will be taught exercises to do and given further advice to guide you through your recovery. You will be given a sling. This is provided purely to keep your arm comfortable. It may be taken off as much as you wish and discarded as soon as possible. You will be encouraged to use your arm. You should be back at work between one and four weeks depending on your job. Your symptoms should be approximately 80% better after three months but may take a year to totally settle.
What are the complications

As with all surgery there is a risk of some complications. These are rare, but you should be aware of them before your operation. They include:

Complications relating to the anaesthetic.

Infection.

A need to redo the surgery.

Prolonged stiffness and or pain.

If you require further information please discuss with the doctors either in clinic or on admission.
Guidelines for patients following Arthroscopic Subacromial Decompression / excision of the acromioclavicular joint

Introduction

The subacromial area lies between the top of the arm bone (humerus) and a bony prominence on the shoulder blade (acromion). The coracoacromial ligament completes the arch.

A muscle and fluid filled cushion (bursa) lie between the arm bone and acromion. With certain movements and positions these structures can become pinched and inflamed. The pain that you have been experiencing is caused by this pinching and is typically felt on movements such as reaching and putting your arm into a jacket sleeve.

The operation aims to increase the size of the subacromial area and reduce the pressure on the muscle. It involves cutting the ligament and shaving away part of the acromion bone. This allows the muscle to heal.

General guidelines

Pain:

A nerve block is used during the operation which means that immediately after
the operation the shoulder and arm may feel numb. This may last a few hours. After this the shoulder may well be sore and you will be given painkillers to help this whilst in hospital. These can be continued after you are discharged home. Ice packs may also help reduce pain. Wrap frozen peas or crushed ice in a damp, cold cloth and place on the shoulder for up to 15 minutes.

Wearing a Sling:

You will return from theatre wearing a sling. This is for comfort only and should be discarded as soon as possible (usually within the first 3 to 4 days). Some people find it helpful to continue to wear the sling at night for a little longer if the shoulder feels tender.

The Wound:

This is a keyhole operation usually done through two or three 5mm puncture wounds. There will be no stitches only small sticking plaster strips over the wounds. These should be kept dry until healed. This usually takes 5 to 7 days.

Driving:

You may begin driving one - three weeks after your operation or when you feel comfortable.

Returning to work:

This will depend on your occupation. If you are in a sedentary job you may return as soon as you feel able usually after one week. If your job involves heavy lifting or using your arm above shoulder height you may require a longer period of absence.

Leisure activities:

You should avoid sustained, repetitive overhead activities for three months. With regard to swimming you may begin breaststroke as soon as you are comfortable but you should wait three months before resuming front crawl. Golf can begin at six weeks. For guidance on DIY and racquet sports you should speak with your physiotherapist

Follow up Appointment:

You will be made a follow up appointment at the Shoulder Unit for around three
weeks after your surgery. At this stage you will be reviewed by the specialist physiotherapist or Consultant who will check your progress, make sure you are moving your arm, and give you further exercises as appropriate.

Progression:

This is variable. However experience shows us that by 3 weeks movement below shoulder height becomes more comfortable. By this stage you should have almost full range of movement although there will probably be discomfort when moving the arm above the head. At three months after your surgery your symptoms should be approximately 80% better and you will continue to improve for up to a year following the procedure.

Exercises:

After leaving hospital you should exercise the arm frequently throughout the day. The arm may feel sore whilst you are doing the exercises but there should be no intense or lasting pain. Aim for four exercise sessions per day.

Exercises for Patients following shoulder arthroscopy

1) Stand. Lean forwards. Let your arm hang down. Swing your arm forwards and backwards. Repeat 10 times. (Shown for the right shoulder).
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<table>
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<tr>
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<tbody>
<tr>
<td><strong>2) Stand.</strong></td>
<td>Lean forwards. Let your arm hang down. Circle your arm clockwise &amp; anti-clockwise. Repeat 10 times. (Shown for right shoulder).</td>
</tr>
<tr>
<td><img src="image" alt="Standing" /></td>
<td><img src="image" alt="Standing" /></td>
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<tr>
<td><strong>3) Lying or sitting.</strong></td>
<td>Put your hands behind your head, and gently stretch the elbows towards the floor/ backwards to feel a gentle stretch on the front of your shoulders. Repeat 5 times.</td>
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<tr>
<td><img src="image" alt="LyingSitting" /></td>
<td><img src="image" alt="LyingSitting" /></td>
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<tr>
<td><strong>4) Lying on your back.</strong></td>
<td>Support your operated arm with the other arm and lift it up overhead. Repeat 10 times. (Shown for right shoulder).</td>
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<tr>
<td><img src="image" alt="LyingBack" /></td>
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<tr>
<td>5) Lying on your back. Grasp a stick in both your hands. Lift the stick up and gently take overhead until you feel a gentle stretch in your shoulder. Repeat 10 times.</td>
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<tr>
<td>6) Take your affected arm across your body to rest the hand on the opposite shoulder. Grasp the elbow with your good hand and gently stretch the arm across your body. Repeat 5 times.</td>
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<tr>
<td>7) Lying on your back, keeping the elbow to your side. Hold a stick in your hands. Move the stick sideways, gently pushing the hand on your operated arm outwards. Repeat 5 times.</td>
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</tbody>
</table>
8) Standing with your arms behind your back. Grasp the wrist of your operated arm and gently stretch the hand on your affected arm towards the opposite buttock. Then slide your hands up your back. Repeat 5 times.

9) Standing with your arms behind your back and grasp a stick between them. Gently lift the stick up away from your body. Repeat 5 times.
10) Lying on side, with operated arm upwards. Keep the elbow bent and close to your side. Lift the hand up away from your body. Repeat 10 times.

11) Stand sideways with operated arm against a wall. Keep the arm close to your side, and push the hand against the wall, hold for 5 seconds. Repeat 10 times.
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<tr>
<td>12) Standing, with elbow flexed to 90 degrees, and held close to body, grasp the wrist of the affected arm with the good hand. Attempt to move the hand of the affected arm inward resisting the motion with the good hand. Keep the affected arm still. Hold for 5 seconds. Repeat 10 times.</td>
<td><img src="image1.png" alt="Diagram" /></td>
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<tr>
<td>13) Standing, with elbow flexed to 90 degrees, and held close to body, grasp the wrist of the affected arm with the good hand. Attempt to move the hand of the affected arm outward resisting the motion with the good hand. Keep the affected arm still. Hold 5 seconds. Repeat 10 times.</td>
<td><img src="image2.png" alt="Diagram" /></td>
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What is frozen shoulder?

A shoulder becomes frozen when the soft tissues around the joint become tight and short. This prevents the shoulder from moving and leads to the pain and stiffness with which you are familiar.

The problem may resolve over time but it can take up to few years or sometimes even 10 years.

**Manipulation under Anaesthetic (MUA) OR arthroscopic release**

What does MUA mean?

This technique is used in the treatment of frozen shoulders. The aim of the manipulation is to reduce the recovery time by stretching the joint to gain full range of movement and injecting local anaesthetic and steroid to reduce inflammation and pain.

Occasionally if the shoulder is very stiff even after a MUA an arthroscopic release of the tight capsule may be necessary.

What happens after?

You will usually only be in hospital for a day. A doctor/physiotherapist will see you before you go home. You will be given exercises to do immediately after the procedure. These exercises are an essential part of your recovery.

Outpatient physiotherapy should be arranged for the day after your procedure. This should be organised before you are admitted to hospital.

You can return to work as soon as you feel able and driving is usually possible after one week but may take up to 3-6 weeks.

It is essential that you attend regular physiotherapy in the first few weeks following your procedure. Please ensure that your employers are aware of this commitment.
What are the complications?

As with all surgery there is a risk of some complications. These are rare, but you should be aware of them before your operation. They include:

Complications relating to the anaesthetic.

Injury to the nerves around the shoulder.

Failure of the operation in improving pain or movement in your shoulder. There should be about 75% improvement in symptoms in the first four to six weeks.

The upper arm bone (humerus) breaking. This is extremely rare.

If you require further information please discuss with the doctors either in clinic or on admission.

Guidelines for patients following manipulation under anaesthetic.

Introduction

This technique is used in the treatment of frozen shoulders. A shoulder becomes frozen when the soft tissues around the joint become tight and short. This prevents the shoulder from moving and leads to the pain and stiffness with which you are familiar.

General guidelines

Pain:

A nerve block is used during the procedure, which means that immediately after the operation the shoulder and arm may feel numb. This may last a few hours. The shoulder will be sore when this wears off and this may last for the first few
weeks. It is important that you continue to take the painkillers prescribed in hospital. Ice packs may also help reduce pain. Wrap frozen peas/crushed ice in a damp, cold towel and place on the shoulder for up to 15 minutes.

**Movement:**

It is of the utmost importance that you begin moving and exercising the arm on the day of the procedure. Adequate pain relief will enable you to perform the exercises demonstrated by the physiotherapist. Try to use the arm for normal daytime activities where possible.

**Driving:**

You may drive after one week (3-6 weeks).

**Returning to work:**

If you have a desk job you will probably be able to return after one week. You may need slightly longer if your job involves lifting or manual work.

**Leisure activities:**

These will depend on the range of movement and strength in your shoulder. It is possible to do most things as long as your shoulder feels comfortable. Please discuss specific activities with your physiotherapist.

**Follow up appointments:**

You will have a follow up appointment at The Shoulder Unit about three weeks following your procedure. You will be reviewed by the surgeon/specialist physiotherapist who will check your progress.

**Progress:**

This is variable. In the first few weeks your shoulder will be sore although your movements will have improved. Do not be surprised if the soreness affects your daily activities. You should continue to move and use your arm normally. Over the weeks following your surgery you will notice a gradual improvement in movement and pain.
Exercises:

It is essential that you carry out the exercises regularly following your procedure, ideally four to five times per day increasing as able. It is quite normal for you to experience aching, discomfort and stretching when doing the exercises but decrease the exercises if you experience intense or lasting pain.

Exercises for Patients after MUA

1) Stand. Lean forwards. Let your arm hang down. Swing your arm forwards and backwards. Repeat 10 times. (Shown for the right shoulder).
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<thead>
<tr>
<th></th>
<th>2) Stand. Lean forwards. Let your arm hang down. Circle your arm clockwise &amp; anti-clockwise. Repeat 10 times. (Shown for right shoulder).</th>
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<td></td>
<td>3) Lying on your back. Support your operated arm with the other arm and lift it up overhead. Repeat 10 times. (Shown for right shoulder).</td>
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<td>4) Lying or sitting. Put your hands behind your head, and gently stretch the elbows towards the floor/ backwards to feel</td>
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<td>Step</td>
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<tr>
<td>1.</td>
<td>a gentle stretch on the front of your shoulders. Repeat 5 times.</td>
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<td>5.</td>
<td>5) Take your affected arm across your body to rest the hand on the opposite shoulder. Grasp the elbow with your good hand and gently stretch the arm across your body. Repeat 5 times.</td>
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<tr>
<td>6.</td>
<td>6) Standing with elbow flexed to 90 degrees. Hold the elbow close to your body, gently push the hand against a door frame, hold for 5 seconds. Repeat 10 times.</td>
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<td>your operated arm outwards. Repeat 5 times.</td>
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<td>![Image](90x326 to 278x605)</td>
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<tr>
<td>Standing with your arms behind your back and grasp a stick between them. Gently lift the stick up away from your body. Repeat 5 times.</td>
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</table>
What is Rotator Cuff Tear?

The rotator cuff consists of four muscles and their tendons. These surround the ball of the shoulder joint.

The muscles fine tune the movements of the shoulder joint and assist other large muscles in moving the arm.

The tendons run under the acromion (part of the shoulder blade) where they are very vulnerable to being damaged. This can lead to a tear resulting in a painful, weak shoulder.

A tear may result suddenly from a single traumatic event or develop gradually. When the tendons or muscles of the rotator cuff tear, the patient is no longer able to lift or rotate his or her arm with the same range of motion as before the injury and/or has significant pain associated with shoulder motion.

Rotator cuff repair

The Operation

A repair involves stitching the torn tendon back onto its attachment to the arm bone (Humerus). May be performed either through keyhole surgery or open surgery.

General Advice
You will be admitted to hospital for between 0 (if it’s a daycase) to 3 days.

Your arm will remain in a special sling for at least 3 weeks. This means that you will be unable to use the arm throughout this time and you will be unable to return to work.

The length of time that you will be off work will depend on your job but expect a minimum of 3 weeks.

Out patient physiotherapy will be organised for when you leave hospital and may well continue for some considerable time.

You will be guided through the rehabilitation programme by your physiotherapist. It is of the utmost importance that you stick strictly to this programme.

Complications

As with all surgery there is a risk of some complications. These are rare, but you should be aware of them before your operation. They include:

Complications relating to the anaesthetic

A stiff shoulder

Shoulder infection

A further tear of the tendon. The larger the tear the more chance there is of this occurring

Failure to regain strength (dependant upon the size of the tear)

If you require further information please discuss with the doctors either in clinic or on admission
Guidelines for patients following rotator cuff repair.

Introduction

The rotator cuff consists of four muscles and their tendons which surround the ball (humeral head) of the shoulder joint. The muscles fine tune the movements of the shoulder and help keep the ball of the shoulder joint in its socket.

The tendon of the rotator cuff passes through a narrow space between the top of the arm bone and a prominent bone on the shoulder blade (the acromion). The tendon is very vulnerable to being pinched here when the arm is moved especially above the head. Over time this pinching can lead to tears of the tendon, the chances of this increases as we get older.

When repeated tearing occurs, the fabric of the tendon becomes weakened and finally, like the cloth at the knees of old trousers, splits. This leads to pain, which can be severe. Weakness of the shoulder can occur and often clicking and crunching on movement.

Other forms of treatment such as injection and physiotherapy are available but sometimes it is necessary to repair the tendon. How well this does will depend upon the size of the tear. If we think about the trousers again, the bigger the split in the cloth, the more difficult is the repair and the more likely the repair is to tear. Your consultant will have discussed this with you.
The Operation

This is carried out under a general anaesthetic. Either an incision is made over the top of the shoulder, or if suitable the operation is performed through the keyhole. The tendon is repaired by stitching it to the bone. The arm is then placed in a sling.

General guidelines

Pain:

A nerve block may be used during the surgery. This means that immediately after the operation the shoulder and arm often feel completely numb. This may last for a few hours. After this the shoulder may well be sore and you will be given painkillers to help this whilst in hospital. These can be continued after you are discharged home. Ice packs may also help reduce pain. Wrap crushed ice or frozen peas in a damp, cold cloth and place on the shoulder for up to 15 minutes.

Wearing a Sling:

You will return from theatre wearing a sling. The surgeon/physiotherapist will advise you on how long you are to continue wearing the sling. This is usually for between 3 and 6 weeks depending upon the size of the tear. You will be expected to remove the sling for exercises/hygiene only. Your physiotherapist will advise you of these.

The Wound:

**Open repair:** there is an incision at the top of the shoulder. The stitch is dissolvable but is usually removed at 3 weeks. Keep the wound dry until it is well healed.

**Arthroscopic (keyhole) repair:** This keyhole operation usually done through two or three 5mm puncture wounds. There will be no stitches only small sticking plaster strips over the wounds. These should be kept dry until healed. This usually takes 7 days.

Driving:

You will not be able to drive for a minimum of 8 weeks. Your surgeon will confirm when you may begin.
Returning to work:

This will depend upon the size of your tear and your occupation. You will need to discuss this with your surgeon.

Leisure activities:

This will depend upon the size of the tear. Your physiotherapist and surgeon will advise you when it is safe to resume your leisure activities.

Follow up appointments:

An appointment will be made for you to see a physiotherapist after your discharge and you will be seen at The Shoulder Unit at 3 weeks. You will be monitored by a physiotherapist throughout your rehabilitation.

Exercises:

You may well be expected to perform the following exercises. Your physiotherapist will teach you the following exercises before you leave hospital, if appropriate:

1) With your arm in the sling move your hand up and down at the wrist.

2) With your arm out of the sling bend and straighten the elbow.

3) With your arm in the sling and the elbow bent at your side, turn the hand to face the ceiling and then the ground.

Repeat these exercises four times per day. The number you should perform at each session will be recorded for you by your physiotherapist.

Continue these exercises until otherwise advised by your physiotherapist.

If your wound changes in appearance, weeps fluid or pus or you feel unwell with a high temperature, contact your GP.

If you have a query concerning your exercises contact the physiotherapy department where you are receiving treatment.
Shoulder Replacement

Why do I need a shoulder replacement

The shoulder is a ball and socket joint with a large range of movement. The joint sometimes needs replacing. This is usually when severe arthritis affects the joint surfaces and the shoulder becomes painful and difficult to move.

The main reason for this operation is to reduce the pain in your shoulder. The operation replaces the damaged surface of the ball of the joint (see pictures) This shoulder replacement called "the Copeland Shoulder". Occasionally a different type of replacement may be used (Stemmed implant or Reverse Shoulder prosthesis). The doctors will discuss your individual surgery.
What happens after the operation?

You will usually be in hospital for about 3-7 days after your operation. Following your surgery you will be in a sling. This is for comfort only and you may take it off as you wish.

A physiotherapist will see you in hospital to give you advice about using your arm and exercises. Outpatient physiotherapy will be arranged when you are discharged.

Your arm will be painful at first and in the first three to four weeks you will be quite one handed which will significantly affect your daily activities. As your pain improves so will the amount you can use your arm.

Driving and most light activities are usually possible four to six weeks after the surgery. However the strength in your arm will take longer to improve, and will be dependent on the amount of pain and stiffness you had prior to the surgery. A doctor or physiotherapist will discuss this with you.

What are the complications

As with all surgery there is a risk of some complications. These are rare, but you should be aware of them before your operation. They include:

Complications relating to the anaesthetic.

Infection, Unwanted prolonged pain and/or stiffness

Damage to the nerves or blood vessels around the shoulder and rarely a need to redo the surgery.

If you require further information please discuss with the doctors either in clinic or on admission.
Guidelines for patients following Total Shoulder Replacement

Introduction

Following your operation you will have a scar approximately 3 inches long on the front of your shoulder.

Your arm will be supported in a sling and a physiotherapist will teach you how to take it on and off to do your exercises. You will be in hospital for about one week.

General guidelines

Pain:

A nerve block may be used during the operation which means that immediately after the operation the shoulder and arm may feel numb. This may last a few hours. After this your shoulder will be painful and this may last a few weeks. You will be given painkillers to help this whilst in hospital. These should be continued after you are discharged home.
Wearing a Sling:

You will return from theatre wearing a sling. This is used for the first 3 weeks following your operation. It is important that you remove the sling to exercise. You can stop wearing the sling as soon as you feel comfortable.

The Wound:

Keep the wound dry until it is healed. This normally takes 10 to 14 days. Your stitch is dissolvable and needs only to be trimmed at your clinic visit.

Driving:

This is usually possible after about three weeks, but will be dependant on your recovery.

Returning to work:

This is dependent upon your occupation. Light activities which involve using your arm in front of your body may be resumed after about three weeks, but if your job involves heavy lifting you will be off work for up to three months.

Leisure activities:

Gentle swimming and exercises in water can begin at 4 to 6 weeks Golf Ð 6 weeks.

Follow up appointments:

You will have an appointment to see the doctor/specialist physiotherapist three weeks after your operation.

Progress:

This is variable and dependant on the amount of movement and the strength of your muscles prior to surgery. Following discharge your pain will slowly decrease and you will become more confident. You will be able to use your arm in front of you for light activities. After six weeks your strength will start to improve.
Exercises:
You will start exercises on the first day after your operation. A physiotherapist will see you to teach you these and progress them. Out patient physiotherapy will be arranged for when you are discharged.

1) Stand. Lean forwards. Let your arm hang down. Swing your arm forwards and backwards. Repeat 10 times. (Shown for the right shoulder).

1) Lying on your back. Support your operated arm with the other arm and lift it up overhead. Repeat 10 times. (Shown for right shoulder).
<table>
<thead>
<tr>
<th><strong>3)</strong> Stand sideways with operated arm against a wall. Keep the arm close to your side, and push the hand against the wall, hold for 5 seconds. Repeat 10 times.</th>
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<tr>
<td><strong>4)</strong> Standing, with elbow flexed to 90 degrees, and held close to body, grasp the wrist of the affected arm with the good hand. Attempt to move the hand of the affected arm outward resisting the motion with the good hand. Keep the affected arm still. Hold 5 seconds. Repeat 10 times.</td>
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</tbody>
</table>
5) Standing with your back against a wall. Keep the arm close to side, elbow bent. Push the elbow back into the wall. Hold for 5 seconds. Repeat 10 times
Shoulder Arthroscopy

The Operation

The operation is done by key hole surgery; usually through two or three 5mm puncture wounds. It involves examination of the shoulder joint using a tiny telescope with television camera introduced through a key hole.

General Advice

You will usually be in hospital either for a day or overnight. A doctor/physiotherapist will see you prior to discharge and you will be taught exercises to do and given further advice to guide you through your recovery.

You will be given a sling. This is provided purely to keep your arm comfortable. It may be taken off as much as you wish and discarded as soon as possible. You will be encouraged to use your arm.

You should be back at work between one and four weeks depending on your job.

Complications

As with all surgery there is a risk of some complications. These are rare, but you should be aware of them before your operation. They include:

Complications relating to the anaesthetic.

Infection.

A need to redo the surgery.

Prolonged stiffness and or pain.

If you require further information please discuss with the doctors either in clinic or on admission.
Guidelines for patients following shoulder arthroscopy

Introduction

This is a keyhole operation performed under a general anaesthetic, sometimes combined with nerve block, which allows the surgeon to investigate the shoulder joint from inside.

General guidelines

Pain:

Following the procedure the shoulder may be sore for a few days. You will be given painkillers to help this whilst in hospital and should continue to take these at home if necessary.

Wearing a Sling:

You will return from theatre with your arm in a sling. The arm should be rested in the sling only until the soreness has settled. This should be a day at the most. It is important that you begin to move the shoulder and arm immediately after the procedure.

The Wound:

There will be two or three small 5-mm puncture wounds in your shoulder. There will be no stitches, only small sticking plaster strips over the wounds. These should be kept dry until healed. This usually takes four to seven days.

Driving:

You may drive as soon as you feel able and can manage all the controls safely.

Returning to work:

You may return to work as soon as you feel able.
Leisure activities:
These can be resumed as soon as you feel able. There are no restrictions but use soreness as your guide and stop if the shoulder feels uncomfortable.

Exercises:
After leaving hospital you should exercise your arm frequently throughout the day. The arm may feel sore whilst you are doing the exercises but there should be no intense or lasting pain. Aim for four exercise sessions per day.
Open / Arthroscopic stabilisation of the shoulder

INTRODUCTION

The shoulder joint is designed to give a large amount of movement. Therefore support from the ligaments and muscles is essential.

When the shoulder dislocates the ligaments can be torn or stretched and in some cases need to be repaired.

THE OPERATION

The operation involves repairing the over-stretched or torn ligaments deep around the shoulder joint. If suitable, the surgeon may perform Arthroscopic (Keyhole) Stabilisation.

General Guidelines

PAIN

A nerve block may be used during the surgery. This means that immediately after the operation the shoulder and arm often feel completely numb. This may last for a few hours. After this the shoulder may well be sore and you will be given painkillers to help this whilst in hospital. These can be continued after you are discharged home. Ice packs may also help reduce pain. Wrap crushed ice or frozen peas in a damp, cold cloth and place on the shoulder for up to 15 minutes.
WEARING A SLING

You will return from theatre wearing a sling. The surgeon/physiotherapist will advise you on how long you are to continue wearing the sling. This is usually for 6 weeks. You will be expected to remove the sling for exercises only. Your physiotherapist will advise you of these.

THE WOUND

Open stabilisation:

There is an incision at the front of the armpit within the natural skin crease. The stitch is dissolvable but is usually removed at 3 weeks. Keep the wound dry until it is well healed.

Arthroscopic (keyhole) stabilisation:

This keyhole operation is usually done through two or three 5mm puncture wounds. There will be no stitches only small sticking plaster strips over the wounds. These should be kept dry until healed. This usually takes 5 to 7 days.

DRIVING

You will not be able to drive for a minimum of 8 weeks. Your surgeon will confirm when you may begin.

RETURNING TO WORK

This will depend upon the size of your tear and your occupation. You will need to discuss this with your surgeon.

LEISURE ACTIVITIES

Again this will depend upon the size of the tear. Your physiotherapist and surgeon will advise you when it is safe to resume your leisure activities.

FOLLOW UP APPOINTMENTS

An appointment will be made for you to be reviewed at The Shoulder Unit at 3 weeks. You will be monitored by a physiotherapist throughout your rehabilitation with formal physiotherapy normally beginning 6 weeks after surgery.
Exercises

The shoulder must remain immobilised with a sling and a body belt (underneath the clothes) for 3 weeks. This may only be removed with care for hygiene and exercises. At your follow-up appointment the body belt will be removed and you will be allowed to wear the sling on top of your clothes.

You will perform first only elbow, wrist and hand exercises.

You may well be expected to perform the following exercises when you leave hospital. Please check with your physiotherapist before commencing.

1. Keep your arm in the sling and move your hand up and down at the wrist.

2. With your arm out of the sling bend and straighten the elbow

3. With your arm in the sling and the elbow bent at your side, turn the hand to face the ceiling and then the ground.

4. With arm in the sling regularly shrug shoulders up and down and circle forwards and backwards

Repeat these exercises four times per day. The number you should perform at each session will be recorded for you by your physiotherapist.

Continue these exercises until otherwise advised by your physiotherapist.

If you require further information please discuss this with the doctors either in clinic or on admission
Radiofrequency/ Arthroscopic placation Stabilisation of the Shoulder

The Operation

When a shoulder dislocates (comes out of joint) or subluxates (partly comes out of joint) the capsule (lining of the joint) stretches.

The radiofrequency heat probe may be used in this procedure shrinks the capsule so that it tightens and stabilises the joint.

General Advice

You will usually only be in hospital for a day or overnight.

A doctor/physiotherapist will see you before you go home. You will be given exercises to do after the procedure.

An outpatient physiotherapy appointment will be arranged before you are admitted to hospital. The post operative physiotherapy programme plays an essential part in your recovery.

You will be able to drive and return to work as soon as you feel able but you should avoid overstretching your shoulder for six weeks.

Complications

As with all surgery there is a risk of some complications. These are rare, but you should be aware of them before your operation. They include:

Complications relating to the anaesthetic.

Infection.

Restretching of the capsule. This may mean that the procedure needs to be repeated. And Nerve damage. This is very rare.

If you require further information please discuss with the doctors either in clinic or on admission.
Guidelines for patients following Radiofrequency stabilisation of the shoulder.

Introduction

When the shoulder dislocates (Comes out of joint) or subluxates (partly comes out of joint), the lining (capsule) of the joint can become stretched. Using a radiofrequency heat probe, the capsule of the joint can be shrunk so that the joint can be restabilised. This mechanically tightens the joint and makes the sensor mechanism within the joint more sensitive so that the muscles respond earlier to stabilise the joint.

General guidelines

Pain:

A nerve block may be used during the surgery, which means that immediately after the operation the shoulder and arm often feel completely numb. This may last a few hours. After this the shoulder may well be sore and you will be given painkillers to help whilst in hospital, which you should continue to take at home if necessary. Ice packs may also help reduce pain. Wrap frozen peas/crushed ice in a damp, cold towel and place on the shoulder for up to 15 minutes.

Wearing a Sling:

You will return from theatre with your arm in a sling. The arm should be rested in the sling until the majority of the soreness has settled. This should only take a couple of days. However it is important that you start moving the arm and using it for daily activities as soon as possible. You should avoid forcing the shoulder and stretching it for the first six weeks.

The Wound:

This is a keyhole operation usually done through two or three small 5mm puncture wounds. There will be no stitches only small sticking plaster strips over the wounds. These should be kept dry until healed. This usually takes four to seven days.
Driving:

You may drive as soon as you feel able and can manage all the controls safely.

Returning to work:

You may return to work as soon as you feel able.

Leisure activities:

These can be resumed when you feel able but you should avoid activities, which may stretch your shoulder for at least six weeks.

Follow up appointments:

You will have an appointment with the physiotherapist and a follow up appointment will be made at The Reading Shoulder Unit at three weeks. Here you will be seen by either the doctor or specialist physiotherapist, to assess your progress.

Exercises:

These are an important part of the procedure, re-educating the muscles around the shoulder and stabilising the joint. Your physiotherapist will guide you through the exercise programme. It is essential that this be carried out regularly.
<table>
<thead>
<tr>
<th>Exercises for Patients following shoulder arthroscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> Stand. Lean forwards. Let your arm hang down. Swing your arm forwards and backwards. Repeat 10 times. (Shown for the right shoulder).</td>
</tr>
<tr>
<td><strong>4)</strong> Take your affected arm across your body to rest the hand on the opposite shoulder. Grasp the elbow with your good hand and gently stretch the arm across your body. Repeat 5 times.</td>
</tr>
</tbody>
</table>
5) Standing with your elbow bent. Keep your elbow into your side. Grasp cliniband and pull across your body. Repeat 10 times.

6) Standing with your elbow bent. Keep your elbow to your side. Grasp cliniband and pull outwards away from your body. Repeat 10 times.
OPEN/ARTHROSCOPIC ANTERIOR STABILISATION

Physiotherapy MYSS
The operative procedure is performed to correct recurrent dislocations and will involve soft tissue, and/or bony reconstruction. Details regarding the pathology can be obtained from the Mid Yorkshire Shoulder Surgery Service (MYSS), which may include Bankart, SLAP or Hill-Sachs lesions.

Day 1 Post-op
• Mastersling with body belt attached for 3 weeks.
• Finger, wrist and radio-ulnar and scapular movements.
• Assisted elbow flexion and extension in standing (in sitting with SLAP lesion)
• Teach axillary hygiene
• Teach postural awareness
• To go home when comfortable

3 Weeks
Patient attends for review and removal of stitches and body belt
• Gentle pendular exercises, flexion/extension and circumduction only

6 Weeks
The sling is removed and the patient begins formal physiotherapy, including hydro.

Aims of Physiotherapy
• Regain scapular and gleno-humeral stability working for shoulder joint control.
• Gradually increase range of movement – do not push external rotation.
• Strengthen the rotator cuff muscles.
• Increase proprioception, using open and closed chain exercise.
• Core stability work as appropriate

No abduction coupled with external rotation until 3 months.

Return to Functional Activities
• Driving 8 weeks
• Return to work Light duties as tolerated after 6 weeks
Heavy duties at 3 months
• Swimming Breaststroke at 8 weeks
Freestyle at 3 months
• Golf 3 months
• Contact sports 6 months - sport including horse riding, football, martial arts, racquet sports and rock climbing.
PHYSIOTHERAPISTS’ INFORMATION

The Mid Yorkshire Hospitals NHS Trust

ARTHROSCOPIC SUBACROMIAL DECOMPRESSION -
This operative procedure aims to increase the size of the subacromial space. Evidence of inflammation or scuffing on the under surface of the acromion, coraco-acromial ligament and on the bursal side of the rotator cuff (“kissing lesion”) indicates the presence of an impingement. The condition of the acromial surface (A) and the bursal surface (B) are scored on a scale of 1-3.

The operation involves the removal of the anterior 1/3 of the acromion and partial resection of the coraco-acromial ligament. The acromio-clavicular joint (ACJ), remains intact unless excision is indicated. The superior AC ligament remains intact so that the joint remains stable.

Protocol
The patient is seen post-operatively and given exercises and advice. Information regarding the pathology seen during the operation can be obtained from the Shoulder Unit, and should be taken into consideration when guiding the patient through their rehabilitation. The Mastersling should have been discarded within the first 1-2 days, pain permitting (1 -10 days).

Day 0-7
Pendular exercises.
Assisted elevation to shoulder height.

1-3 Weeks
Progress to pulley exercises,
Scapular stabilizer
Postural correction

In the first 3 weeks following surgery the patient should be encouraged to move the shoulder into range as pain allows.

Isometric strengthening begins and as soon as possible is progressed using pain and range of movement as limiting factors.

It must be remembered however that over zealous physiotherapy and repetitive or sustained overhead activities could lead to delayed recovery.

The patient is seen for follow-up at the Shoulder Unit at 3 weeks.
At this stage passive flexion is usually full. Active flexion and abduction are both comfortable to 90 degrees. It is normal for there to be some discomfort with movement above 90 degrees. The progress of patients with ACJ excision may be slower.
80% of improvement will occur by 3 months, but improvement will continue to occur for several months after that.

**Aims of Physiotherapy**
- Achieve full range of movement
- Improve postural awareness and initiate scapula stability.
- Strengthen the rotator cuff
- Restore proprioception using open and closed chain activities.
- If the rotator cuff is deficient, strengthen anterior deltoid in supine.

**Return to Functional Activities**
- Driving 1 week
- Swimming Breaststroke at 2-3 weeks
- Freestyle at 3 months
- Return to Work Dependant on the patient’s occupation
- Golf 6 weeks, (but not driving range)
- Racquet Sports Sport specific training when comfortable
- Competitive play after 3 months
- Lifting As able

It is important to avoid repetitive or sustained overhead activity at or above the shoulder height for 3 months.
RADIOFREQUENCY STABILISATION (OR CAPSULAR Plication) OF THE SHOULDER

THERAPIST INFORMATION

It is used specifically for shoulders where capsular stretching appears to be the major source of the problem. We tend not to use it in shoulders that have a large Bankart defect or a fractured glenoid lip.

It may be used in not just the dislocating shoulder but also those in which the shoulder painfully subluxates, i.e. the throwing shoulder and dead arm syndrome, which are unresponsive to rest and physiotherapy. It is thought that the capsular shrinkage acts in several ways to stabilise the shoulder:

1. Mechanical shortening of the capsule in the area that is stretched.
2. Tightening the proprioceptive sensor feedback mechanism. In the same way that you would use strapping around the shoulder to increase skin sensory input we can improve the shoulder proprioception by tightening the capsule.

As this procedure is done arthroscopically there is no need to wait to start post-operative physiotherapy. However there is some concern about temporary weakness of the capsule round about 3-6 weeks and hence stretching to regain motion has no part in the early post-operative phase.

The procedure is done under general anaesthesia with a temporary brachial plexus block. The block wears off after about 10 hours and the arm is treated in a sling purely for pain relief during the first few days. As soon as pain allows proprioceptive physiotherapy is started.

The early results are encouraging but approximately one third can stretch out with time. It may be necessary to repeat the procedure at a later date if this were to happen. This particular group of patients are difficult to treat even by open surgery and the results of heat shrinkage stabilisation, appears to be comparable.

The presenting symptoms may be those of impingement but the causation may be instability. With experience, very minor degrees of subtle instability may be recognised more easily which may be useful to confirm or refute the clinical findings.

EUA is just part of the investigation of the unstable shoulder. Combined with the history and clinical examination, then in all but the minority of cases, adequate diagnosis can be made and the surgery tailored more exactly to the patient’s instability.

Protocol

Post operatively patients are in a master sling for pain relief but the aim is to remove this between 1 and 5 days.

The patient is encouraged to use the arm functionally, and active assisted and active ranges of movement exercises are given.

The patient should be instructed not to push the shoulder or stretch to end of range as the capsule remains weak for the first 6 weeks following the procedure.
Out patient physiotherapy is arranged prior to discharge.  
An appointment is made at the shoulder service for 3 weeks post-op.

**Aims of Physiotherapy**
- Improve scapula and glenohumeral stability
- Restore normal scapula humeral rhythm
- Improve shoulder proprioception
- Retain functional mobility of the shoulder with avoidance of stretching into end of range.

**Return to Functional Activities**
Patients should avoid contact sports for 3 months, but precision sports e.g. racquet sports can be useful for improving proprioception. Any overhead activities should be avoided until the patient has adequate scapula control and cuff strength below shoulder height.
COPELAND SURFACE REPLACEMENT ARTHROPLASTY

Introduction
This operative procedure is performed in cases of severe Osteo or Rheumatoid arthritis where pain is the predominant feature.
The hemi arthropalsty is the usual method of choice.
Early mobilisation is encouraged.
As subscapularis is released and reattached to the anatomical neck of humerus at the end of the procedure, there should be no resisted internal rotation for the first three weeks and care should be taken with the range of external rotation.

Pre op
• Patient assessment
• Patient’s Constant score recorded
• Information given

Post op
Day 1 (Discharge)
• Mastersling with body belt fitted in theatre
• Finger, wrist and radio ulnar movements
• Active elbow flexion and extension
• Shoulder girdle exercises and postural awareness

Day 2 – Day 3-5 (Discharge)
• Body belt removed
• Axillary hygiene taught
• Exercises continue as above
• Hand gripping exercise
• Pendular exercises
• Passive flexion/extension in scapular plane in supine
• Continue with shoulder girdle exercises, postural awareness and include scapular setting.

Day (3-5) to 3 Weeks
Remove sling when comfortable
• Pendular exercises continued
• Isometric strengthening exercises of all muscle groups (except IR)
• Begin passive abduction (maintain shoulder in IR)
• Begin passive external rotation to neutral only.
• Begin active assisted flexion in supine and progress to sitting position as soon as the patient is able. Progress to active when possible.
• Encourage relaxation and breathing control
• Hydrotherapy may begin if available

3 Weeks – 6 Weeks
• Encourage the patient to actively move into all ranges. Gentle assisted stretching exercise to increase range – gentle in ER
• Add isometric IR – sub maximally and only if painfree
• Commence isometric theraband exercises - resistance dependant on individual

N.B. Take care with IR
• Progress to isotonic strengthening
• Encourage proprioceptive exercises-weight and non weight bearing

6 Weeks
• Progress strengthening and include anterior deltoid exercises
• Continue to regularly stretch the joint to end of its available range
• Can begin breaststroke if pain and range of movement allows

How well the patient progresses and the outcome will depend on the condition of the joint and soft tissues preoperatively. A better outcome is expected with patients whose joint is replaced for primary OA. Improvement continues for 18 months to 2 years and where possible the patient should not be discharged or should continue exercising until their maximum potential has been reached. The protocol outlined applies to patients with an intact rotator cuff. If a rotator cuff repair has been carried out in addition to the above procedure, the therapist should adhere to the strengthening protocol for the repair.

Return to Functional Activities
These are approximate and may differ depending upon each patient’s individual achievements. However, they should be seen as the earliest that these activities may commence.

• Driving After 4 weeks
• Swimming Breaststroke 6 weeks, Freestyle 3 months
• Golf 3 months
• Lifting Light lifting can begin at 3 weeks. Avoid lifting heavy items for 6 months.
• Return to work Dependant upon the patient’s occupation: -
  - Those with sedentary jobs may return at 6 weeks.
  - Manual workers or those whose occupations demand excessive shoulder use should be guided by the surgeon.
STEMMED HEMIARTHROPLASTY FOR FRACTURE
THERAPIST INFORMATION

Post op
Day 1
• sling with body belt fitted in theatre
• Finger, wrist and radio ulnar movements
• Active assisted elbow flexion and extension
• Teach axillary hygiene
• Hand gripping exercises
• Shoulder girdle exercises and postural awareness
  • Gentle pendular can be started from 1 week if patient can tolerate it
Continue the exercises above for 3 weeks at which time the patient will be reviewed at MYSS

3 Weeks
Body belt removed
• pendular exercises
• Continue with shoulder girdle exercises, postural awareness and include scapular setting

6 Weeks
• Gradually discard sling
• As pain allows progress to full passive range of movement
• Add active assisted progressing to active exercises
• Introduce anterior deltoid strengthening exercises as appropriate
• Isometric strengthening of all groups and progress to isotonic, as the patient is able
• Can begin hydrotherapy where available
• Can encourage the patient to move through all ranges with attention to selfstretching at end of range
• Proprioceptive exercises and core stability work as required

Return to Functional Activities : (earliest recommendations)
• Driving 8 weeks (dependent on ease of movement and safety)
• Swimming 8 weeks for breaststroke, freestyle will take longer
• Golf 3 months
• Lifting Light lifting can begin at 8 weeks. Avoid lifting heavy items for 6 months
• Return to work The patient should be guided by the surgeon.

N.B. The protocol for a shoulder replacement following a fracture is less aggressive than that of the Copeland Shoulder Replacement due to the bony injury. Active movement is delayed to allow for bony union. Progression will be slower. Use pain and the patient’s ability as your guide.
ROTATOR CUFF REPAIR
PHYSIOTHERAPIST INFORMATION

• Most repairs are now performed arthroscopically so there is less tissue trauma and reduced risk of adhesions. Post-op stiff shoulder is now rarely a problem, so the priority is to protect the repair from breaking down.
• Always be guided by the patient’s pain. Do not force, stretch or stress the repair before 8 weeks (6 weeks for MINORS)
• Protocol selection will be determined not just by the size of tear, but also the shape of the tear, strength of repair and general tissue & joint condition. Always check with the Consultant.
• Educate patients about basic rotator cuff function and lever principles to reduce the risk of stressing the repair prematurely.
• Patients are in a sling for 6 weeks (except MINORS) and should not drive for 6 to 8 weeks.

ROTATOR CUFF REPAIR
PHYSIOTHERAPIST INFORMATION
[1]
MINOR (small): Less than 1 cm

Day 1 – 2 Weeks
• sling with/without body belt
• Wrist exercises
• Elbow exercises
• Shoulder girdle
• Initiate scapula setting
• Begin pendular exercises

3 Weeks
• DO NOT FORCE OR STRETCH
• Wean off sling (may be delayed till 6 weeks)
• Continue pendular exercises
• Progress passive flexion in scapular plane and external rotation to neutral
• Progress to assisted flexion, extension, abduction as is comfortable – internal and external rotation to neutral only.
• Initiate gentle cuff isometric exercises as pain allows
• Encourage normal function around waist level
• May begin active exercises if appropriate - ONLY IF GUIDED BY THE CONSULTANT
• Can start driving (guided by Consultant)

6 Weeks
• Continue active exercises progressing into range
• Commence anterior deltoid exercises as range allows
• Commence rotator cuff strengthening and closed chain exercises
• Start stretching limited movements
• Encourage functional movement within pain limits
• Begin gentle hydrotherapy if available
• Proprioceptive exercises and core stability work as appropriate

[2]
MEDIUM: 1 cm – 3 cms

Day 1 to 3 Weeks
• Sling with body belt plus abduction pad
• Wrist, hand and finger exercises
• Elbow exercises
• Shoulder girdle
• Initiate scapular setting/ may begin gentle pendular

3 Weeks – Review by Consultant
• Abduction pad removed, unless otherwise stated by Consultant
• Sling retained
• Pendular exercises

4 to 5 Weeks
• Start physiotherapy. DO NOT FORCE OR STRETCH
• Passive flexion in scapular plane + external rotation
• Initiate gentle cuff isometrics as pain allows
• Progress when comfortable to assisted exercises
• Begin hydrotherapy if available

6 Weeks
• Wean out of sling
• Begin active exercises. Encourage functional movements at waist level
• Anterior deltoid strengthening exercises as range of movement allows
• Progress range adding resistance as appropriate
• Start rotator cuff strengthening progressively, dependent on pain
• Add closed chain exercises
• Begin proprioceptive skills

8 Weeks
• Start driving

[3]
MAJOR (large): 3 cms – 5 cms
MASSIVE: greater than 5 cms

Day 1 to 3 Weeks
• Mastersling with body belt plus abduction pad
• Wrist and finger exercises
• Elbow exercises
• Shoulder girdle
• Initiate scapula setting

3 Weeks – Review by Consultant
• Abduction pad retained/ removed, as stated by Consultant
• Sling retained
• Begin pendular exercises as instructed

6 Weeks
• Remove abduction pad if not already done so
• Commence physiotherapy. DO NOT FORCE OR STRETCH
• Wean out of sling
• Passive flexion
• Gentle rotator cuff isometrics, pain limiting
• Begin assisted exercises
• Gradually progress to active exercises
• Begin hydrotherapy
• Encourage normal function around waist level

8 Weeks
• Start stretching if appropriate
• Add resisted exercises within pain limits
• Start rotator cuff strengthening
• Anterior deltoid strengthening as range of movement allows
• Add closed chain exercises
• Begin proprioceptive skills
• Encourage functional movement within pain limits
• Start driving if comfortable

Consideration should always be given to the individual patients’ ability.
The protocol is based on maintaining range of movement in the first phase and then gradually building strength in the middle to last phase. Progression should be tailored to the individual patient but the times quoted should be the earliest for active movement and when strengthening (resisted exercises) begins.

Return to Functional Activities
These are approximate and will differ depending upon the individual. However, they should be seen as the earliest that these activities may commence.

• Driving 6-8 weeks
• Swimming Breaststroke – MINOR/MEDIUM 6 weeks, MAJOR 12 weeks Freestyle – MINOR/MEDIUM 3 months, MAJOR unlikely to progress
• Golf 3 months
• Lifting No heavy lifting for 3 months. After this be guided by the strength of patient
• Return to work Dependant upon the patient’s occupation. With minor and medium tears, patients in sedentary jobs may return at 6 weeks. Major tears may take at least 8 weeks. Manual workers should be guided by the surgeon.

Note: These are guideline protocols only.
MODIFIED WEAVER-DUNN THERAPIST INFORMATION

This operative procedure aims to stabilize the acromio-clavicular joint.

**Day 1 Post-op**
- sling and body belt attached for 6 weeks
- Finger, wrist and Radio-ulnar movements
- Supported elbow flexion and extension in standing
- Teach axillary hygiene
- Teach postural awareness
- Home when comfortable

**3 Weeks**
The patient is reviewed at the MYSS. The arm remains in the sling until week 6, but the bodybelt is removed.
- Start gentle pendular exercises

**6 Weeks**
The sling is removed and the patient begins formal physiotherapy
- Avoid all range of movement above shoulder height until 12 weeks.

**Aims of Physiotherapy**
- Regain scapular and gleno-humeral stability working for shoulder joint control rather than range
- Gradually increase range of movement
- Strengthen the rotator cuff muscles
- Progress proprioception through open and closed chain exercises.

**Return to Functional Activities**
- Driving 6 weeks
- Return to Work Light duties as tolerate
- Heavy duties at 4 months
- Swimming breaststroke, 8 weeks; freestyle, 3 months
- Golf 3 months
- Contact sport 6 months - including horse riding, football, martial arts, racquet sports, and rock climbing
- Heavy Lifting 4 months
MANIPULATION UNDER ANAESTHETIC (MUA) OF THE SHOULDER

PHYSIOTHERAPIST INFORMATION

An MUA/arthroscopic release is performed for primary frozen shoulder (adhesive capsulitis).
The operation is performed under general anaesthetic with injection of local anaesthetic and steroid into the joint. Full range of motion is achieved operatively unless otherwise stated.
The procedure is done as a day case except where the patient has diabetes or other systemic problems where overnight stay may be indicated.

Protocol
The patient is seen prior to discharge by the physiotherapist when passive and active range of motion is begun. It is important that the joint is taken through all planes of movement.
The patient is discharged with exercise and advice on pain control.

A physiotherapy appointment must be pre-arranged for the following day.

Aims of Physiotherapy
• Restore FULL range of movement as quickly as possible through passive and active assisted exercise, maintain this range
• Encourage resumption of ADL immediately.
• Exercising in water is particularly beneficial
• Strengthen rotator cuff as appropriate

3 Weeks
Patient attends for review at the MYSS
General Instructions on ADL for patients – MYSS

Precautions following your shoulder

Washing: For the first 3 weeks you will need assistance to wash and dress.

TO WASH AND DRESS YOUR OPERATED ARM, REMOVE YOUR SLING AND HAVE YOUR ARM BY YOUR SIDE. YOU WILL FIND IT EASIER TO EITHER SIT ON THE EDGE OF A CHAIR OR STAND UP, WITH YOUR ARM ‘HANGING’ BY YOUR SIDE. YOU SHOULD BE ABLE TO WASH YOUR OPERATED ARM WITH YOUR UN-OPERATED ARM IN THIS POSITION. FOR THE FIRST 3 WEEKS YOU WILL NEED ASSISTANCE TO WASH YOUR UN-OPERATED ARM, AS YOU WILL NOT BE ABLE TO USE YOUR OPERATED ARM FOR THIS. IT MAY BE POSSIBLE TO USE EITHER A CUBICLE SHOWER, OR AN OVERBATH SHOWER AFTER 5 DAYS, YOUR OCCUPATIONAL THERAPIST WILL ASSESS YOU WITH THIS PRIOR TO DISCHARGE. THIS WILL MAKE WASHING EASIER. TO DRY YOURSELF, IT MAY BE EASIER TO PUT A TOWELLING BATHROBE ON, WHICH WILL HELP TO DRY YOUR UN-OPERATED ARM.

GETTING DRESSED: YOU WILL FIND IT EASIER TO WEAR FRONT OPENING CLOTHES. ALWAYS DRESS YOUR OPERATED ARM FIRST. SIT ON THE EDGE OF A CHAIR OR STAND WITH YOUR ARM ‘HANGING’ BY YOUR SIDE. SLIDE YOUR OPERATED ARM INTO THE GARMENT FIRST USING YOUR UN-OPERATED ARM. DO NOT ASSIST WITH YOUR
OPERATED ARM, JUST LET IT HANG LOOSE. ONCE THIS ARM IS FULLY IN THE SLEEVE BRING THE GARMENT AROUND YOUR BACK AND PUT THE OTHER ARM IN. ANY FASTENERS MUST BE FASTENED ONLY WITH YOUR UN-OPERATED ARM. YOUR OCCUPATIONAL THERAPIST WILL SHOW YOU HOW TO DO THIS. ONCE YOU HAVE DRESSED YOUR UPPER BODY, PLACE YOUR ARM BACK IN THE SLING.

THREE WEEKS AFTER YOUR OPERATION, YOU CAN RETURN TO DRESSING ‘NORMALLY’.

FEEDING: FOR THE FIRST 3 WEEKS AFTER YOUR OPERATION, YOU MUST FEED YOURSELF WITH YOUR UN-OPERATED HAND ONLY. AFTER THIS TIME YOU MAY RETURN TO FEEDING YOURSELF ‘NORMALLY’ USING BOTH HANDS. YOUR OCCUPATIONAL THERAPIST WILL ASSESS YOU WITH THIS.

TRANSFERING: THIS MEANS GETTING IN AND OUT OF YOUR CHAIR, BED AND BATH AND GETTING ON AND OFF YOUR TOILET. FOR THE FIRST 3 WEEKS YOU MUST ONLY PUSH UP FROM THE BED, CHAIR, TOILET AND BATH USING YOUR UN-OPERATED ARM. AFTER THREE WEEKS YOU MAY RETURN TO USING BOTH ARMS AS PAIN ALLOWS.

SLEEPING: FOR THE FIRST 6 WEEKS YOUR SLING SHOULD BE KEPT ON WHILE YOU ARE IN BED. YOU MAY FIND IT MORE COMFORTABLE TO SLEEP ON YOUR BACK INITIALLY, WITH A PILLOW UNDER YOUR OPERATED ARM FOR SUPPORT.
KITCHEN ACTIVITIES: THIS INCLUDES MAKING MEALS, SNACKS AND DRINKS FOR YOURSELF. FOR THE FIRST 3 WEEKS YOU MUST ONLY USE YOUR UN-OPERATED ARM FOR KITCHEN ACTIVITIES. AFTER THIS TIME YOU MAY RETURN TO USING BOTH ARMS. AVOID LIFTING ANYTHING HEAVY FOR 6 MONTHS. AT 3 WEEKS AFTER SURGERY YOU MAY LIFT LIGHT ITEMS, THIS MEANS THINGS THAT YOU CAN LIFT EASILY WITH ONE HAND.

HOUSEWORK: LIGHT HOUSEWORK MAY RESUME AFTER 3 WEEKS. MORE STENUOS HOUSEWORK SHOULD BE AVOIDED UNTIL 6 MONTHS AFTER YOUR OPERATION. IF YOU ARE IN ANY DOUBT ABOUT THIS PLEASE CONTACT YOUR CONSULTANT.

STAIRS: WHEN CLIMBING/DESCENDING THE STAIRS, HOLD THE BANNISTER WITH YOU UN-OPERATED ARM. THIS MAY MEAN THAT A SECOND BANNISTER IS REQUIRED. YOUR OCCUPATIONAL THERAPIST CAN REFER FOR THIS. AFTER THREE WEEKS YOU MAY HOLD THE BANNISTER WITH EITHER ARM.

NB ALL THE ABOVE ARE GUIDELINES ONLY. IF YOU HAVE ANY CONCERNS OR ADDITIONAL QUERIES PLEASE CONTACT YOUR CONSULTANT.

For further information:
Consultants
Mr B Venkateswaran
Mr B Ketzer
Mr C Tuson

Physiotherapists
Ms Anouska Doodsan
Mr Neil Callenger