Lisa Tourret
Consultant Hand & Upper Limb Surgeon

PO Box 5388 Hove East Sussex BN52 9XU
t: 07791 801 232 (Cath Amos: Private Practice Manager)
e: shoulder2hand@gmail.com. e: lisa.tourret@springgroup.org. w: www.shoulder2hand.com

spring orthopaedic centre

Shoulder Stabilisation

Description:

The shoulder joint is an inherently unstable joint as it is a ball and socket joint, which allows such a wide range of movements. The socket, or Glenoid, is very shallow and relies on its rim, or Labrum, to help keep the ball of the shoulder in place. If the dislocation has damaged the joint during a dislocation, it may be at an increased risk of repeated episodes of dislocation or instability; this is usually because the rim of the socket or Labrum, has been torn from the edge of the bone of the socket itself, the Glenoid. If this is the case it may require surgery to restore stability.

Surgery:

Surgery for shoulder dislocation is usually carried out as a day case procedure and can be done arthrosopically or “key-hole”.

While under a general anaesthetic, a camera is used to look inside the joint while special bone anchors are used to sew the torn Labrum back onto the edge of the Glenoid. These are put in place through 2 or 3 small cuts at the front of the shoulder, while the camera is inserted through a small cut at the back of the shoulder.

Pain relief such as Paracetamol may be required but local anaesthetic is administered in theatre and the shoulder is not usually very sore. Discharge home on the day of surgery is usual.

Rehabilitation:

After the surgery a sling is usually worn for a week or two while gentle movements under guidance are carried out. In the first 2 weeks mainly wrist and elbow exercises are undertaken with pendulum shoulder exercises, followed by a gradual increase in movements, before finally strengthening exercises are introduced over subsequent weeks.

A return to full movement is expected by 3 months and all activities, including contact sport is expected by 6 months