CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

INFORMATION & CONSENT

# AC Joint Stabilisation

Anatomy of the shoulder. The acromioclavicular joint is the small joint at the top of the shoulder, where the outer end of the collarbone meets a bony shelf on the shoulder blade — the part that gets disrupted in an AC joint injury.



At-a-glance recovery. Pooled from 45 published studies — your own pace will vary.

| LIGHT DUTIES<br>desk work, driving, daily tasks | MOST EVERYDAY ACTIVITIES<br>manual work, sport, gym | FINAL OUTCOME PLATEAU<br>pain and strength |
|---|---|---|
| **2-6 weeks** | **4-6 months** | **12-20 months** |
| Return to desk work and light activities typically occurs within 2 to 6 weeks for nonoperative management or early postoperative phase. | Full shoulder function and return to non-contact activities is typically achieved within 4 to 6 weeks for Type I and II injuries, though surgical patients may require longer. | Maximum clinical improvement and return to full contact sports or heavy labor may take 12 to 20 months, with some residual symptoms persisting long-term. |

## Why this operation has been suggested

This operation repairs the ligaments that hold your collarbone to your shoulder blade after a severe separation. Your surgeon likely suggested it because you have a high-grade injury where the bones are significantly displaced and the joint is unstable. While mild separations usually heal with a sling, surgery is recommended for severe cases to prevent lasting pain and limited movement.

The main goal of this procedure is to restore stability to your shoulder so you can return to daily activities and work without pain. It is typically offered when non-surgical options have failed or when the injury is too severe to heal on its own. By fixing the joint, the operation aims to relieve pain and help you regain full function.

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## Before the operation

You will need to fast for several hours before your surgery and stop certain medications as your surgeon advises. Please arrange for someone to drive you home and bring a list of all current medicines. You may need X-rays, an MRI, blood tests, or an anaesthetic review to check your health and plan the procedure. Your surgeon will use a single open incision over the shoulder to stabilize the joint. This approach allows direct access to repair the ligaments. Wear comfortable clothing to your appointment. Most patients with this injury have a bump on the top of the shoulder that may need fixing.

## On the day

You will arrive at the hospital and meet your surgeon and the anaesthetist. This operation is done under general anaesthetic combined with a regional nerve block. You will be fully asleep for the operation, and the block – an injection that numbs the nerves supplying the arm before you wake up – provides pain relief for the first 12 to 24 hours after surgery. The anaesthetist will meet you before the operation and talk you through both parts.

Your surgeon will perform the procedure through a single conventional incision over the operative site. You will then be moved to the recovery area to wake up. You may feel sleepy or groggy as the anaesthetic wears off, but your team will monitor you closely until you are stable.

## What the operation involves

Your surgeon will make a single cut over the front of your shoulder, extending from the collarbone toward the breastbone. This approach, often called a 'bra-strap' incision, gives your surgeon a clear view of the joint while protecting the surrounding soft tissues.

Inside, your surgeon will repair the torn ligaments that hold your collarbone in place. For high-grade injuries, this involves fixing both the top joint and the deeper ligaments connecting the collarbone to the shoulder blade. If you are having surgery for arthritis, your surgeon will remove a small piece of bone from the end of the collarbone. This piece is usually between 5 to 10 mm long to stop the bones from rubbing together.

Once the repair is complete, your surgeon will close the cut with stitches. The skin is then covered with a dressing to protect the area while it heals.

## After the operation

You will wake up in the recovery ward. Your surgeon will manage your pain using standard methods. You will have a dressing over your incision and wear an arm sling. The sling is usually used for about 1 week for type I injuries or 2 to 3 weeks for type II injuries. You can usually go home the same day or after one night. You must have someone stay with you for the first 24 hours. You will begin moving your arm gently soon after surgery, but avoid heavy lifting or contact sports for about 2 to 3 months.

## Recovery

In the first few days, you will feel soreness and swelling around your shoulder. This is normal as your body heals. Your surgeon may recommend a sling to support your arm and limit movement. You will likely sleep with your upper body slightly elevated to reduce discomfort.

As the swelling settles, your physiotherapist will guide you through gentle exercises. These movements help restore your shoulder's range of motion without straining the repair. You will gradually learn to use your arm for daily tasks like eating or dressing. Heavy lifting and contact sports are not allowed until your surgeon confirms your shoulder is stable.

Your recovery journey is unique. While most people regain full function, the pace depends on your body and how well you follow your plan. Your surgeon and physiotherapist will monitor your progress and adjust your exercises as needed. You will know you are ready for the next step when you can move your arm without pain.

## What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

You might notice a deep, throbbing pain in your shoulder that does not ease with simple painkillers. This can happen months or even years after your injury or surgery. If this pain persists, call your surgeon's clinic to discuss your next steps.

Some patients feel a clicking or grinding sensation in the joint. You might also notice the bump on top of your shoulder looks different or feels unstable. This could mean the joint has slipped back out of place. Contact your surgeon immediately if you see this change.

You may experience redness, warmth, or swelling around the incision site. If these signs spread or you develop a fever, go to the emergency department right away.

If you have persistent symptoms that do not improve with rest, your surgeon might discuss further treatment. This could involve another procedure to fix the joint.

The complications table on this page lists typical rates if you want the specifics.

## When to call us

Call us if you have a fever, increasing redness or discharge from your wound, or sudden severe pain. Go to emergency immediately if you notice swelling in your calf, shortness of breath, loss of sensation, or if you cannot move your arm. These signs may indicate infection, a blood clot, or nerve issues that need urgent care.

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COMPLICATIONS & CONSENT

# AC Joint Stabilisation

## Complication rates from published literature

Pooled from 45 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

| COMPLICATION | REPORTED RATE | NOTES |
|---|---|---|
| loss of reduction | **56.0%** | Observed in nonoperative management of Type V dislocations, resulting in a Rockwood type 3 state. |
| reconstruction failure | **19.1%** | Overall failure rate following primary coracoclavicular reconstruction, ranging from 8% to 52.6% across studies. |
| posttraumatic osteoarthritis | **17%** | Higher incidence in operative groups compared to nonoperative for Type III injuries, with some studies reporting up to 66.7% in specific cohorts. |
| heterotopic ossification | **17%** | Observed in operative groups for Type III injuries. |
| implant irritation | **16.0%** | Tenderness on pressure above the implant, often requiring unplanned removal. |
| revision surgery | **14.3%** | Rate of revision ACJ stabilization at minimum 10-year follow-up after arthroscopically-assisted anatomic coracoclavicular reconstruction. |
| persistent pain | **5-8%** | Persistent pain or discomfort after surgical stabilisation occurs in 5-8% of patients. The higher figure of 50% applies to non-operatively managed Type I/II injuries. |
| coracoid fracture | **2-3%** | Risk associated with coracoid drilling; 2.3% in the largest clinical series (n=43). Higher rates reported in early small studies and cadaveric biomechanical models. |
| infection | **1.9%** | Superficial or deep infection rates reported in surgical cohorts. |
| nerve injury | **1%** | Rare, including suprascapular nerve or brachial plexus injury. |
| clavicle fracture | **Rare** | Reported at 20% in one tunnel-free reconstruction study (n=22); rare with standard tunnel or drill-free techniques. |

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I have read this information and have had the opportunity to ask Dr Hirpara questions about the procedure, its expected recovery, and the complications listed above.

| PATIENT — PRINT NAME | SIGNATURE | DATE |
| --- | --- | --- |

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