CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

INFORMATION & CONSENT

# Anterior Shoulder Stabilisation

Arthroscopic image of a Bankart lesion — a tear of the anterior labrum after shoulder dislocation.

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At-a-glance recovery. Pooled from 80 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** | **12-24 months** |
| Return to desk work and light daily activities typically occurs within 2 to 6 weeks post-surgery. | Return to sport and full manual work is generally expected between 4 to 6 months, though contact athletes may face higher recurrence risks. | Maximum functional improvement and plateau in patient-reported outcomes are typically observed at 12 to 24 months. |

## Why this operation has been suggested

This operation, called anterior shoulder stabilisation, is a keyhole surgery that repairs the front of your shoulder joint to stop it from slipping out of place. Your surgeon likely suggested this because non-surgical treatments like therapy and bracing have not given you enough improvement. You may be a young, active person or an athlete who has had repeated dislocations. While the results are less predictable for contact sports, the surgery aims to restore stability so you can move freely without fear of the shoulder giving way again.

## Before the operation

Please fast for six hours before your surgery and stop any blood-thinning medicines as your surgeon instructs. Arrange for a friend or family member to drive you home, as you cannot drive yourself. Wear loose, comfortable clothing and bring a complete list of all current medications. You will likely need an X-ray, MRI, blood tests, and an anaesthetic review before the day of surgery. These checks help your surgeon see the full picture of your

shoulder and ensure you are safe for the procedure. Your surgeon will perform this operation using an arthroscopic approach, which uses two or three small incisions and a tiny camera inside the joint.

## 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.

You will then go into the operating theatre. Your surgeon performs this as an arthroscopic (keyhole) approach with two or three small incisions and a small camera inside the joint. You will wake up in recovery feeling groggy, with the numbing injection still working to keep you comfortable.

## What the operation involves

Your surgeon will perform this surgery using a keyhole approach. They will make two or three small cuts, each about 1 cm long, around your shoulder. Through these tiny openings, they insert a small camera and special instruments to see inside your joint.

Your surgeon will reattach the torn tissue and ligaments back to the bone. To hold these repairs in place, they will use small anchors. The evidence suggests using at least four anchor points to ensure the shoulder stays stable. These anchors are placed about 5 to 8 mm apart. If needed, they may also move a piece of bone to create a barrier that prevents the shoulder from slipping out again.

Once the repair is complete, your surgeon will close the small cuts with stitches or glue. They will then cover the area with a dressing. This entire process is designed to restore stability to your shoulder joint using these precise, minimally invasive steps.

## After the operation

You will wake up in a recovery ward. Your surgeon uses small keyhole incisions with a tiny camera inside your shoulder. You will have a sling and dressings on your shoulder. Pain is managed with general medicines. You can usually go home the same day, but some patients stay overnight. You must have someone stay with you for the first 24 hours. You can move your fingers and elbow gently right away. Your surgeon will tell you exactly when to start moving your shoulder. Most people feel better within a few days.

## Recovery

You will have two or three small cuts for this keyhole surgery. Your shoulder will feel stiff and sore for the first few days. Swelling is normal and will slowly go down. You will wear a sling to protect your shoulder while it heals. This helps you sleep more comfortably at night.

Your physiotherapist will guide you through gentle exercises to move your arm. You will start with small movements to prevent stiffness. As your pain eases, you will do more stretching and strengthening. You can return to light home tasks once your surgeon says it is safe. You must avoid heavy lifting or sudden movements until you are cleared.

Your recovery path is unique to you. Some people feel better quickly, while others take more time. Your surgeon and physiotherapist will watch your progress and adjust your plan. Trust their advice as you work toward getting your strength back.

## 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.

Sometimes the shoulder feels unstable again. You might notice the joint slipping out of place or a feeling that it is not secure. This can happen even after surgery, especially if you play contact sports. If this occurs, contact your surgeon immediately to discuss your options.

In some cases, the shoulder may not feel as strong as before. You might find it harder to use your dominant arm for daily tasks or sports. If you notice persistent weakness or difficulty moving your arm, bring this up at your next review.

You may experience pain that does not settle with simple painkillers. This could signal that the repair is not healing as expected. If the pain is deep, throbbing, or gets worse, call the clinic right away.

If you have had a first-time dislocation, surgery helps reduce the risk of it happening again. However, if you have had multiple dislocations before the operation, the risk of it returning is higher. Your surgeon selects the best technique for you to minimize this risk.

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 wounds. Go to emergency if you feel sudden severe pain, calf swelling, or shortness of breath. Contact us immediately if you lose sensation or cannot move your arm. These signs need urgent assessment to protect your recovery.

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COMPLICATIONS & CONSENT

# Anterior Shoulder Stabilisation

## Complication rates from published literature

Pooled from 80 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

| COMPLICATION | REPORTED RATE | NOTES |
|---|---|---|
| Long-term arthritis | **20-47%** | Glenohumeral arthritis develops in 20-47% of patients at long-term follow-up (10+ years), depending on pre-existing cartilage damage, number of dislocations before surgery, and anchor type. |
| Recurrent instability | **17.0%** | Recurrence of shoulder instability is the most common complication; risk is higher in young patients (under 20-25), contact athletes, those with bone loss, and patients with more than 5 preoperative dislocations. |
| Subscapularis dysfunction | **10.0%** | Although arthroscopic techniques avoid cutting the subscapularis muscle, dysfunction can still occur rarely causing weakness with internal rotation activities. |
| Failure requiring revision surgery | **7.8%** | Approximately 2.4-5% of patients require revision shoulder stabilization surgery due to recurrent instability, persistent pain, or other complications. |
| Nerve compression syndromes | **5%** | Approximately 5% of patients develop tingling in their hand after surgery, which may be carpal tunnel or cubital tunnel syndrome, with most improving once the arm is out of the sling. |
| hematoma | **1.6%** | Postoperative hematoma requiring evacuation or observation; more common in Latarjet procedures. |
| Loss of range of motion and stiffness | **0.32%** | Postoperative stiffness is common; minor permanent loss of motion at extremes (typically 5-10 degrees of external rotation) occurs but usually does not cause functional impairment. |
| Persistent pain or dissatisfaction | **0.17%** | Some patients experience ongoing shoulder discomfort despite successful stabilization, with pain, functional limitations, or inability to return to previous activity level. |

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| COMPLICATION | REPORTED RATE | NOTES |
|---|---|---|
| Nerve injury | **0.07%** | Injury to the axillary nerve is the most common nerve injury, potentially causing shoulder weakness, numbness over the lateral shoulder, and difficulty lifting the arm. |
| Anchor-related complications | **0.05%** | Suture anchors may pull out of bone, migrate, irritate the shoulder joint, or damage articular cartilage, potentially requiring repeat surgery. |
| Infection | **0.03%** | Deep infection after arthroscopic shoulder surgery is rare, potentially requiring multiple washouts and suture anchor removal with prolonged intravenous antibiotics. |
| Chondral injury | **Rare** | Damage to the articular cartilage of the humeral head or glenoid may occur during anchor placement or from the dislocation itself. Contributes to long-term arthritis risk. |
| postage stamp fracture | **Rare** | Small glenoid rim fracture caused by suture anchor placement; typically does not affect stability but may require anchor repositioning. |

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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