CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

INFORMATION & CONSENT

Latarjet Procedure

X-ray after a Latarjet procedure: two screws hold the transferred coracoid bone block against the front of the shoulder socket, restoring bone stock and stopping the ball from slipping out.

Kieran Hirpara 4.0

At-a-glance recovery. Pooled from 85 published studies — your own pace will vary.

LIGHT DUTIES desk work, driving, daily tasks	MOST EVERYDAY ACTIVITIES manual work, sport, gym	FINAL OUTCOME PLATEAU pain and strength
2-6 weeks	**5.5-7.4 months**	**30 months**
Return to desk work typically occurs within 2 to 6 months, with 98% of patients returning by 2.7 months.	Clinically significant outcomes are achieved at a median of 5.5 months and average of 7.4 months post-surgery.	Excellent clinical results are maintained at 30 years of follow-up, indicating long-term stability.

Why this operation has been suggested

Your surgeon has likely suggested this operation because your shoulder keeps slipping out of place (anterior instability) and other treatments have not provided enough relief. While most patients treated with this procedure have excellent outcomes, a minority may have poorer results based on their personal health factors rather than how severe the instability is. This surgery is often recommended when non-operative options like physical therapy have failed to stop the shoulder from dislocating.

The main goal of this operation is to provide greater stability than other repairs, significantly lowering the chance of the shoulder slipping again. Most patients return to work by 2.7 ± 3.0 months, and by 8 months, 73% have resumed their main sport. While the overall complication rate is 18.6%, serious events requiring further surgery occur in only 4.9% of cases. Your surgeon aims to restore your shoulder function and prevent future dislocations so you can return to your daily activities and sports.

Before the operation

You will need to fast before your surgery and stop certain medications as your surgeon advises. Please arrange a ride home and bring a list of your current medicines in comfortable clothing. You may need X-rays, MRI scans,

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blood tests, or an anaesthetic review to check your health and plan the procedure. Your surgeon performs this operation as an arthroscopic (keyhole) approach with two or three small incisions and a small camera inside the joint. This method helps restore stability while keeping the cuts small.

On the day

You will arrive at the hospital and check in with your surgeon's team. You will meet your anaesthetist before the operation to discuss your care plan. 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 performs this procedure using an arthroscopic approach with two or three small incisions and a small camera inside the joint. You will then be moved to the operating theatre where the team prepares you for surgery. After the procedure, you will wake up in the recovery area where nurses will monitor your comfort and vital signs. You will stay there until you are stable and ready to go home or to your hospital room.

What the operation involves

Your surgeon will perform this surgery using small keyhole cuts, known as an arthroscopic approach. They will make two or three small incisions, each about 1 centimeter long, on the front of your shoulder. Through these tiny openings, a small camera and special instruments are inserted to see inside the joint.

Inside your shoulder, your surgeon will repair the torn tissue and bone that are causing the instability. They will reattach the damaged structures to the bone to restore stability. Once the repair is complete, the small cuts are closed with sutures or glue, and a dressing is applied to protect the area. This procedure is designed to offer greater stability than other common repairs for recurrent shoulder instability.

After the operation

You will wake up in a recovery ward where your pain will be managed. Your shoulder will be wrapped in a dressing and placed in a sling or brace. You do not need to stay in the hospital overnight; most patients go home the same day. You must have someone stay with you for the first 24 hours. You can begin moving your arm gently soon after surgery. Your surgeon used an arthroscopic approach, meaning they made two or three small cuts and used a tiny camera inside your joint.

Recovery

You will likely feel some pain and swelling in your shoulder right after the surgery. This is normal as your body heals from the small keyhole incisions. Your surgeon will guide you on using ice and medication to keep the discomfort manageable.

For the first few weeks, you will wear a sling to protect your shoulder while it heals. You will do gentle physiotherapy exercises to keep your arm moving safely. Most people find it easier to sleep propped up on pillows rather than lying flat. Your surgeon will tell you when it is safe to stop using the sling and begin more active movement.

As the swelling settles and your strength returns, you will gradually resume daily tasks. You will start with simple activities like eating and dressing, then move to more complex movements. Your physiotherapist will help you rebuild your shoulder's range of motion step by step. Everyone heals at their own pace, so your timeline may differ from others. Your surgeon and physio team will guide you through every stage of your recovery.

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.

If you notice redness that spreads out from your small incisions or a fever that does not go away, call your surgeon right away. These signs could mean an infection is starting. You might feel a deep, throbbing pain that simple painkillers cannot ease.

Sometimes the bone graft used to fix your shoulder can cause issues. You might feel a new clicking or grinding sensation in your joint, or notice that the shoulder feels stiff and tight. If this happens, bring it up at your next review so your surgeon can check the graft position.

In rare cases, the shoulder might slip out of place again. You may feel a sudden pop or a sense that the joint is unstable when you move your arm. If this occurs, contact your clinic immediately to discuss your next steps.

Over time, wear-and-tear arthritis can develop or get worse in your shoulder. You might feel a dull ache that gets worse with activity or notice stiffness when you try to lift your arm. Most of the time, this arthritis remains mild, but you should mention any new pain to your surgeon.

Women may find they need to visit the emergency department more often than men after this surgery. If you experience sudden swelling, severe pain, or any other worrying symptom, do not wait. Go to the emergency department or call your surgeon immediately.

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 if you notice calf swelling, shortness of breath, loss of sensation, or cannot move your arm. While serious complications are rare, these signs need urgent assessment. Your surgeon wants to ensure your recovery stays on track.

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COMPLICATIONS & CONSENT

Latarjet Procedure

Complication rates from published literature

Pooled from 85 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
Postoperative arthritis	**23.5-38.2%**	Some patients may develop glenohumeral arthritis years after surgery, particularly with graft malposition, intra-articular placement, or pre-existing cartilage damage.
Persistent pain or dissatisfaction	**5-7%**	Daily or functionally limiting pain occurs in 5-7% of patients. Mild residual shoulder ache is more common (up to 25%) but typically does not limit activity.
Nerve compression syndromes	**5%**	Approximately 5% of patients develop tingling in their hand after surgery, which may be carpal tunnel or cubital tunnel syndrome.
Recurrent instability	**4.7-8.5%**	Despite the Latarjet procedure's excellent stability, recurrent dislocation or subluxation can occur due to graft malposition, nonunion, graft resorption, or unaddressed Hill-Sachs lesions.
Loss of range of motion and stiffness	**3.0%**	Postoperative stiffness is common; loss of external rotation is expected (average 10-15 degrees) due to the sling effect of the transferred conjoint tendon.
Reoperation rate	**2.6-5.1%**	Approximately 2.6-9.2% of patients require additional surgery within the first few years, most commonly for hardware removal, recurrent instability, or stiffness.
Subscapularis dysfunction	**2-10%**	Subscapularis insufficiency ranges from 2% (clinical failure) to 10% (positive lift-off test), depending on split vs peel technique.
Graft resorption	**1.6-30.0%**	Some degree of coracoid graft resorption occurs in over 90% of Latarjet procedures, with superior resorption common as the body remodels excess bone; extensive resorption may increase recurrence risk.

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COMPLICATION	REPORTED RATE	NOTES
Infection	**1.5-2.6%**	Surgical site infection is higher than arthroscopic procedures due to larger surgical dissection; deep infections may require graft removal and conversion to alternative procedures.
Nonunion or graft malposition	**1.3-16.7%**	The coracoid bone block may fail to heal to the glenoid in approximately 5-7% of cases, with risk factors including graft malposition, inadequate fixation, and smoking.
Symptomatic hardware	**1.0-6.5%**	Hardware prominence, irritation, or discomfort requiring screw removal, typically occurring after graft resorption makes the superior screw prominent.
Graft fracture	**1.0-6.0%**	The coracoid bone graft may fracture during harvesting, transfer, or fixation, potentially requiring alternate fixation techniques or bone grafting from iliac crest.
Vascular injury	**1%**	Vascular injuries reported at 1% in a systematic review of 2,532 cases; includes axillary artery injury.
Neurological complications	**0.6-2.4%**	The musculocutaneous nerve and axillary nerve are most at risk; most injuries are transient neurapraxias recovering within 3-6 months, though 8-17% of nerve injuries result in permanent deficits.
Hematoma	**0.4-4.4%**	Postoperative bleeding or hematoma formation requiring management.

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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