CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

INFORMATION & CONSENT

Rotator Cuff Repair

A torn supraspinatus tendon — the most common rotator cuff tear pattern. The repair operation re-attaches the torn tendon back onto the upper arm bone using small anchors.

Kieran Hirpara 4.0

At-a-glance recovery. Pooled from 80 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	**6-8 months**	**12 months**
Driving fitness is not negatively impacted as early as 2 weeks; return to desk work typically occurs within 2 to 6 weeks.	Return to previous work occurs at approximately 8 months for injured workers, with 88.5% returning to activities by a mean of 6.59 months.	The plateau of maximum recovery occurs at 1 year, with patient-reported outcomes degrading after this point.

Why this operation has been suggested

This operation repairs a torn shoulder tendon using a small camera and keyhole incisions. Your surgeon likely recommended it because non-surgical treatments like physical therapy did not give you enough relief from pain or weakness. While many people can manage with therapy alone, surgery is often suggested when the tear is large, the tendon has failed to heal, or your symptoms are severe and limit your daily life.

The main goal is to restore your shoulder function and reduce pain. Evidence shows that most patients achieve significant improvement in how they use their arm within 12 months. Even for older patients or those with large tears, this repair can provide lasting relief and better movement compared to not having surgery.

Before the operation

Your surgeon will likely order X-rays, an MRI, blood tests, and an anaesthetic review to check your shoulder and overall health. Please bring a list of all current medications and wear comfortable clothing to your visit. You must fast before the surgery and stop certain medicines as your surgeon instructs. Arrange for someone to drive you home, as you cannot drive yourself. Your surgeon performs this repair using an arthroscopic (keyhole)

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approach with two or three small incisions and a small camera inside the joint. This method allows the surgeon to see and treat the tear through tiny openings.

On the day

You will arrive at the hospital and meet your anaesthetist before the operation. They will explain how your pain will be managed and answer any questions you have. 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 then perform the repair using an arthroscopic approach. This means they use two or three small incisions and a tiny camera inside your joint to see and fix the tear. You will wake up in the recovery area once the procedure is finished. You will be monitored closely until you are ready to go home or to your room.

What the operation involves

Your surgeon will perform this surgery using an arthroscopic, or keyhole, approach. This means they will make two or three small cuts, each about 1 cm long, over your shoulder. Through these tiny openings, they insert a small camera and special instruments to see inside your joint. This method allows them to view the tear from multiple angles without needing a large cut.

First, your surgeon will clean away any scar tissue or inflamed fluid that limits movement. They will then gently release tight tissue to bring the torn tendon back to its normal position. If the tear is large, they may need to remove a small piece of bone at the front of the shoulder to create more space. The surgeon will then reattach your torn tendon to the bone using small anchors and strong sutures. They place these anchors in a trough on the bone surface to ensure a strong hold.

Once the tendon is secured, your surgeon will close the small cuts with dissolving stitches or glue and cover them with a dressing. This procedure is designed to restore the natural shape of your shoulder while minimizing damage to the surrounding muscles.

After the operation

You will wake up in the recovery ward. Your surgeon uses a keyhole approach with two or three small incisions and a small camera inside the joint. You will have a dressing and a sling to support your arm. Pain will be managed with general methods. Most patients go home the same day, but some stay overnight. You must have someone stay with you for the first 24 hours. You can begin gentle movement as advised. Your arm will be protected while it heals.

Recovery

You will likely feel soreness and swelling in your shoulder for the first few days. This is normal. Your surgeon may recommend pain relief to help you rest comfortably. Most people find that pain and swelling begin to settle as you start gentle movement.

You will wear a sling to protect your shoulder while it heals. Your physiotherapist will guide you through specific exercises to keep your arm moving safely. You can perform light daily tasks at home, but avoid lifting anything heavy. Sleep may be difficult at first; propping yourself up with pillows often helps.

As your strength returns, you will gradually do more activities. You can drive once your surgeon clears you to do so. Many patients return to work and sports as their shoulder feels stronger. Your journey is unique, so follow the specific plan your surgeon and physiotherapist create for you.

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 tendon does not heal back to the bone. You might notice that your shoulder still feels weak or painful after several months. This can happen even if the surgery looked successful at first. The highest risk for this happens between 6 weeks and 3 months after surgery. If your pain does not improve or returns, tell your surgeon at your next review.

Infection is a possible risk, though rare. You might see redness spreading out from your small cuts, or feel a deep, throbbing pain that does not ease with simple painkillers. You may also notice swelling or warmth. If you see these signs, call the clinic right away.

Blood clots in the leg are a possible risk with routine surgery. You might feel sudden swelling and tenderness in your calf. If this happens, go to the emergency department immediately.

Your shoulder might not feel as good as you hoped, even if the repair holds. Some patients find their function does not improve much after one year. If you feel your shoulder is not getting better, bring it up at your next appointment.

Smoking can affect healing. If you have quit smoking more than 6 months before surgery, your risk is similar to someone who never smoked. If you are still smoking, talk to your surgeon about how this might affect your recovery.

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

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COMPLICATIONS & CONSENT

Rotator Cuff Repair

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
Perianchor cyst	**35-43%**	Radiographic finding in 35-43% of cases; usually asymptomatic and does not require intervention.
Retear or failure of healing	**15-30%**	The rotator cuff repair may fail partially or completely, with most retears (94.7%) occurring 6-26 weeks post-surgery; risk increases with larger tears, age over 65, smoking, diabetes, and fatty infiltration.
Postoperative stiffness	**13-44%**	Stiffness is the second most common complication, with most cases responding to physical therapy; approximately 5% develop severe frozen shoulder requiring manipulation or capsular release.
Persistent pain or incomplete relief	**5-10%**	Incomplete pain relief despite intact repair; may relate to pre-existing arthritis, fatty infiltration, or concurrent pathology.
Reoperation rate	**2-7%**	Most common reasons for reoperation are symptomatic retear (88%), persistent stiffness (5%), and infection (4%).
Adhesive capsulitis	**1.4-5.0%**	Adhesive capsulitis occurs in a small percentage of patients; patient-reported allergies are associated with increased rates.
Nerve compression syndromes	**<1%**	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.
Deep venous thrombosis	**<1%**	Blood clots are rare complications that may require anticoagulation therapy.
Infection	**0.2-0.5%**	Deep infections may require multiple washouts, suture/anchor removal, and prolonged IV antibiotics; the most common organisms are Cutibacterium acnes and Staphylococcus.

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COMPLICATION	REPORTED RATE	NOTES
Anchor-related complications	**Rare**	Anchor pullout, migration, or cartilage damage from prominent anchors; may require removal.

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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