



Shoulder Instability

Physiotherapy can improve problems arising from instability by training the muscles in the shoulder to control the joint correctly. Anti-inflammatory and painkillers can be used to tackle pain from instability.

Chronic instability can be treated with a number of surgical procedures. Arthroscopic (keyhole) Stabilisation is a procedure in which the torn labrum and capsule are repaired. Stabilisation can be performed arthroscopically or as an open procedure although arthroscopy is less invasive.

The aim of this surgery is to stabilise the ball of the humerus in the shallow glenoid socket without compromising the range of motion in the joint. Shoulder instability is a challenging problem to treat surgically. Surgery may fail if all contributing factors to instability have not been identified and addressed.

The argument of early versus late shoulder stabilisation procedures remain unresolved. The patient, once informed of all the pros and cons, best decides these.

Instability is investigated with MR arthrogram. This gives information on the Bankart lesion (tissue detachment from the socket), the Hill Sachs lesion (dent in the humeral head) and rarely a HAGL lesion (tissue detachment from the base of the humeral head).

Arthroscopic stabilisation involves Bankart repair and capsular shift. The labrum needs to be mobilised initially. The anterior glenoid is prepared and 2 or 3 anchors are required. Again various techniques are described and several instruments have been specially designed for this particular purpose.

After shoulder stabilisation, a sling will be required for 4-6 weeks and some simple exercises will help with rehabilitation. Physiotherapy will help with regaining motion and strengthening the muscles. Often, the shoulder will have recovered enough to return to everyday activities within 6 weeks.

Arthroscopic/Open Anterior Stabilisation

The operative procedure is performed to correct recurrent dislocations and will involve soft tissue, and/or bony reconstruction.

Day 1 Post-op

Mastersling with body belt attached for 3 weeks. Finger, wrist and radio-ulnar and scapular movements. Assisted elbow flexion and extension in standing (in sitting with SLAP lesion). Teach axillary hygiene. Postural awareness is encouraged. To go home when comfortable.

3 Weeks

Patient attends review and removal of stitches and body belt. Gentle pendular exercises, flexion/extension and circumduction only

6 Weeks

The sling is removed and the patient begins formal physiotherapy, including hydrotherapy

Aims of Physiotherapy

Regain scapular and gleno-humeral stability working for shoulder joint control. Range of movement is gradually increased. Strengthen the rotator cuff muscles. Increase proprioception, using open and closed chain exercise. Core stability work as appropriate. No abduction coupled with external rotation until 3 months.

Return to Functional Activities

Driving: 8 weeks, Return to work: light duties as tolerated after 6 weeks, heavy duties at 3 months, Swimming: breaststroke at 8 weeks, Golf: 3 months. No Contact sports for 6 months – including horse riding, rugby, football, martial arts, racquet sports, wind surfing, hand gliding and rock climbing.

Bristow- Latarjet Procedures

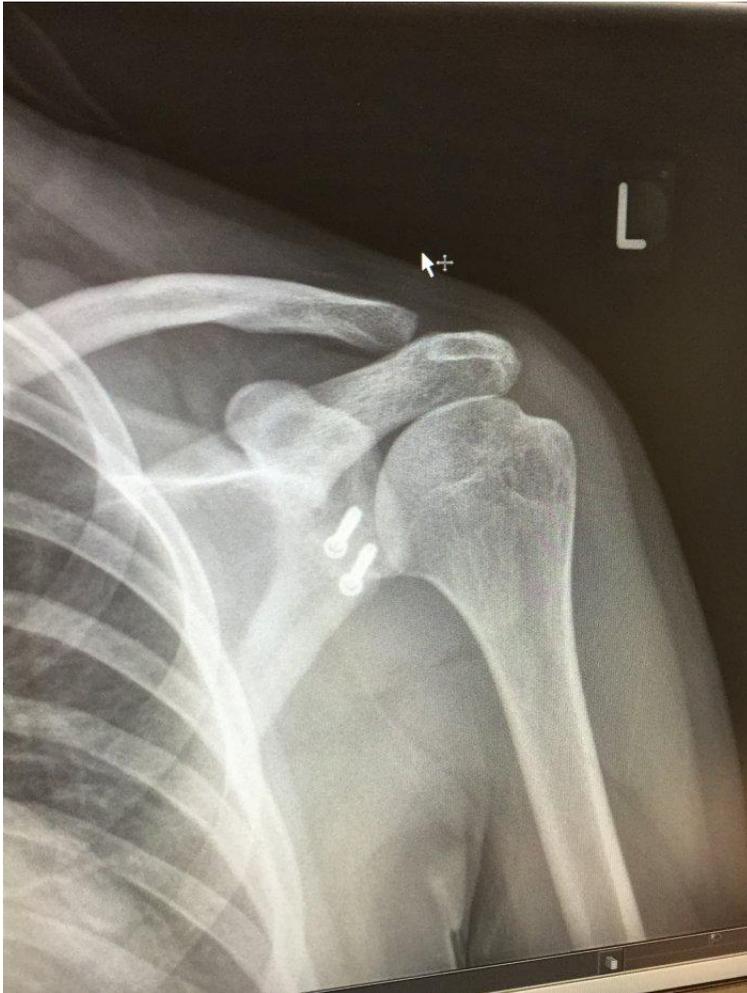
This is a procedure performed when there is some bone loss from the front of the glenoid after dislocations (bony bankart lesion), or large dent in the back of the humeral head (hillsack lesion).

The procedure involves transfer of the coracoid with its attached muscles to the deficient area over the front of the glenoid. The bone is usually fixed with two screws. This replaces the missing bone and the transferred tendon and muscle also acts as an additional muscular strut preventing further dislocations. I have performed over 30 of these with no complications to date, and no recurrence of dislocations.

Post-op Recovery

A sling is worn for 2-4 weeks, with gentle passive range of movement (ROM) allowed. Thereafter active ROM is encouraged until 8 weeks post-op and then strengthening exercises begin.

Patients cannot drive until 6 weeks post-op and no contact sport until 3-6 months post-op.



Post op: Day 1

Mastersling with body belt fitted in theatre Cryocuff to reduce inflammation. Finger, wrist and radio ulnar movements. Active elbow flexion and extension. Shoulder girdle exercises and postural awareness.

Day 2 – Day 3-5 (Discharge)

Body belt removed. Axillary hygiene taught. Continue using cryocuff. Exercises continue as above. Hand gripping exercise. Pendular exercises. Passive flexion/extension in scapular plane in supine. Continue with shoulder girdle exercises, postural awareness and include scapular setting.

Discharge (Day 3-5) to 3 Weeks

Remove sling when comfortable. Pendular exercises continued. Isometric strengthening exercises of all muscle groups (except IR). Begin passive abduction (maintain shoulder in IR). Begin passive external rotation to neutral only. Begin active assisted flexion in supine and progress to sitting position as soon as the patient is able. Progress to active when possible. Relaxation and breathing control are encouraged.

4 Weeks – 6 Weeks

The patient is encouraged to actively move into all ranges. Gentle assisted stretching exercise to increase range - do not force. Commence isometric theraband exercises - resistance dependent on individual N.B. Take care with IR Progress to isotonic strengthening. Proprioceptive exercises are encouraged -weight and non-weight bearing

6 Weeks

Progress strengthening and include anterior deltoid exercises. Continue to regularly stretch the joint to end of its available range. Swimmers can begin breaststroke if pain and range of movement allow.

Patient progress and the outcome will depend on the condition of the joint and soft tissues preoperatively. A better outcome is expected with patients whose joint is replaced for primary OA. Improvement continues for 18 months to 2 years and where possible the patient should not be discharged or should continue exercising until their maximum potential has been reached.

Return to Functional Activities

These are approximate and may differ depending upon each patient's individual achievements. However, they should be seen as the earliest that these activities might commence. Driving: after 6 weeks, Swimming: breaststroke 6 weeks, freestyle 3 months, Golf: 3 months, Lifting: light lifting can begin at 6 weeks but avoid lifting heavy items for 6 months. Return to work - Dependent upon the patient's occupation: Those with sedentary jobs may return at 6 weeks; manual workers or those whose occupations demand excessive shoulder use should be guided by the surgeon.