Post Operative Care

POST OPERATIVE CARE

A sling is worn for four weeks, during which time simple passive range of motion is initiated. At four weeks a more active range of motion is initiated. Return to sport usually occurs at between 3 and 4 months.

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4. Tzannes A, Paxinos A, Callanan M, Murrell GAC. An assessment of the inter-examiner reliability of tests for shoulder instability. *J Shoulder Elbow Surg*. 2004;13(1):18-23.
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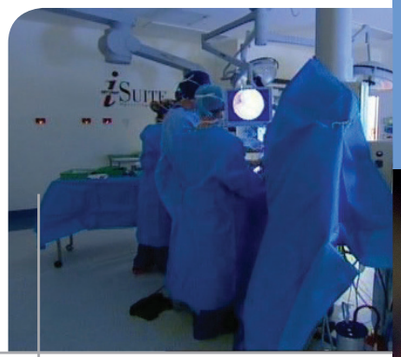
Shoulders



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PROF GEORGE MURRELL

SHOULDER INSTABILITY

George Murrell
Shoulders

SHOULDER INSTABILITY

The shoulder has the greatest range of motion of any joint in the body - but this comes at a price - it is the easiest to dislocate.

The most common form of dislocation is traumatic anterior dislocation - when the arm is abducted and externally rotated. The patient will almost always be able to describe the shoulder "coming out of joint". Sometimes this is associated with a feeling of a "dead arm".

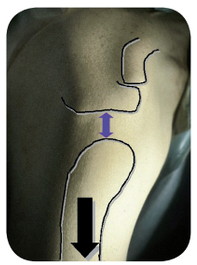
Diagnosis

DIAGNOSIS

The most useful clinical tests are: a large sulcus sign (for multidirectional instability), an O'Brien's sign[7] (for a superior labral tear) and an apprehension sign and it's variants (for traumatic anterior instability)[4].

O'Brien's sign[7]

Apprehension sign[4]



Sulcus Sign[5]

Imaging

IMAGING

Plain xrays, including an axial view, are useful for ruling out a fracture. Other imaging, including MRI, is not usually necessary.

Management

MANAGEMENT

Traumatic anterior dislocations

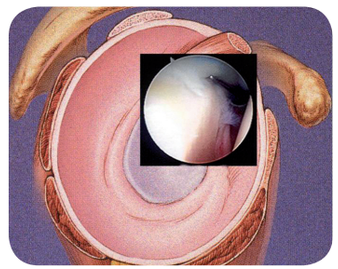
in young active individuals are likely to recur and we recommend surgical stabilisation.

In older induviduals (greater than 35 years old) the chances of recurrence diminish and surgery is not usually necessary unless there is an associated rotator cuff tear.

The shoulder should not be placed in traditional sling as this impairs the ability of the Bankart lesion to heal[2].

Superior labral (SLAP) tears

in individuals who have a good history of sudden load to their long head of biceps are best managed with arthroscopic repair of the torn labrum.



Multidirectional instability

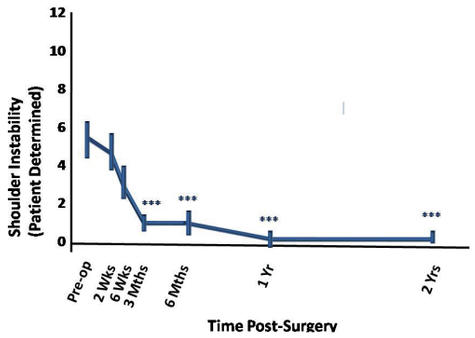
, particularly if there is not a traumatic inititiating event, is usually associated with capsular laxity and is best managed with a physiotherapy program focusing on scapular control in the first instance.

Arthroscopic Repair

ARTHROSCOPIC REPAIR

There have been a number of technological advances that allow unstable shoulders to be repaired as half day cases under regional anaesthesia.

The labral tear is repaired through keyholes using sutures and suture anchors.

We have found that arthroscopic repair[8]:

- Has less morbity than open repair
- Has a re-dislocation rate less than 10%
- Is effective, even after previous open stabilisation surgery[6]