

SHOULDER STABILIZATION FOR MDI

INDICATIONS (Who Needs Surgery, When, Why & Goals)

Surgery for shoulder instability is reserved for people who have recurrent shoulder dislocations or subluxation that affects activities of daily living and/or sports activities. It is usually reserved to those patients that have tried an appropriate rehabilitation program for at least 6 months with symptomatic recurrent shoulder dislocation and/or subluxation. This type of instability is rarely due to trauma. More often, there is no history of trauma or repetitive trauma, such as with repetitive throwing or swimming. The likelihood of success of a rehabilitation program is 80%. Surgery may also be performed in a patient who has had a prior failed operation for shoulder instability. The goal of surgery is to stabilize the shoulder to prevent further subluxations or dislocations. One of the reasons the shoulder is the most commonly dislocated major joint is the fact it has more motion than any other major joint. Thus, tightening the shoulder joint may reduce some shoulder motion. Stabilizing the shoulder is done by tightening the capsule. The directions of instability are anterior (front), posterior (back) or inferior (below the glenoid). Less often other structures may be moved or used to replace or give additional support to the capsule of the shoulder. Recurrent dislocations or subluxations without fracture is rarely associated with arthritis. Thus, the timing of surgery in relation to the injury is not critical. The results of shoulder stabilization for multidirectional instability are not as good as for anterior stabilization.

CONTRAINDICATIONS (Reasons Not To Operate)

- Infection of the shoulder
- Inability or unwillingness to complete the post-operative program of keeping the shoulder in a sling and/or immobilizer or to perform the rehabilitation necessary.
- Patients who have emotional or psychological problems that contribute to their shoulder condition
- Patients who have voluntary instability (dislocate their shoulder at will, particularly for secondary gain)
- Nerve injury about the shoulder causing weak rotator cuff muscles is a relative contraindication
- Shoulder arthritis is a relative contraindication

RISKS AND COMPLICATIONS OF SURGERY

- Infection
- Bleeding
- Injury to nerves (numbness, weakness, paralysis) of the shoulder and arm
- Recurrence of instability (dislocation and/or subluxation)
- Over-tightening in one direction resulting in subluxation or dislocation in the opposite direction
- Continued pain
- Stiffness or loss of motion of the shoulder
- Inability to return to same level of competition
- Moving or breaking of surgical anchors
- Arthritis

TECHNIQUE (What is Done)

Different techniques are in use at this time. There are arthroscopic techniques and open techniques. The overall goal is to tighten the capsule and ligaments. Though the looseness is in more than one direction, there is usually one direction of instability or looseness that predominates. The surgical approach is dependent on the direction of greatest looseness and on the degree of ligament laxity. The surgical approach may be from the front of the shoulder, the back of the shoulder or both.

One of the most popular open techniques involves getting to the shoulder capsule by splitting or moving muscles and tightening the stretched capsule and ligaments by folding the excess capsule underneath itself and stitching it together with sutures (threads) with or without surgical anchors which are inserted into the glenoid rim. This can be done in the front of the shoulder or from the back of the shoulder. Usually, some looseness of the back of the shoulder and bottom of the shoulder can be performed while tightening from the front of the shoulder.

Arthroscopic techniques involve using small incisions (arthroscopy portals) to tighten the stretched capsule either by folding the excess capsule underneath itself and sewing it together with sutures (threads) with or without surgical anchors which are inserted into the glenoid rim.

Other techniques involve techniques that do not try to replicate the normal anatomy of the shoulder capsule and ligaments. These include techniques that involve moving muscle to reduce shoulder motion or moving bone from another area and using the bone to block shoulder dislocations.

POST-OPERATIVE COURSE

- Management after surgery varies based on technique used and surgeon preference as well as arm dominance and the sport you participate in.
- Keep wound clean and dry for the first 10 - 14 days after surgery
- Keep the shoulder in a sling, brace or immobilizer for as long as your surgeon tells you, usually 3 - 12 weeks
- You will be given pain medications by your physician
- Post-operative rehabilitation and exercises are very important to regain motion and then strength

RETURN TO SPORTS

- Depends on the type of sport and position as well as the quality of ligaments at the time of repair.
- A usually 6 - 12 months is necessary after surgery before return to sports.
- Full shoulder motion and strength are necessary before returning to sports

NOTIFY OUR OFFICE IF:

- You experience pain, numbness, or coldness in the hand
- Blue, gray or dusky color appears in the fingernails
- Any of the following occur after surgery:
 - Increased pain, swelling, redness, drainage or bleeding in the surgical area.
 - Signs of infection (headache, muscle aches, dizziness, or a general ill feeling with fever)
- New, unexplained symptoms develop. Drugs used in treatment may produce side effects.

Do not eat or drink anything before surgery. Solid food makes general anesthesia more hazardous.