Reading Shoulder Unit

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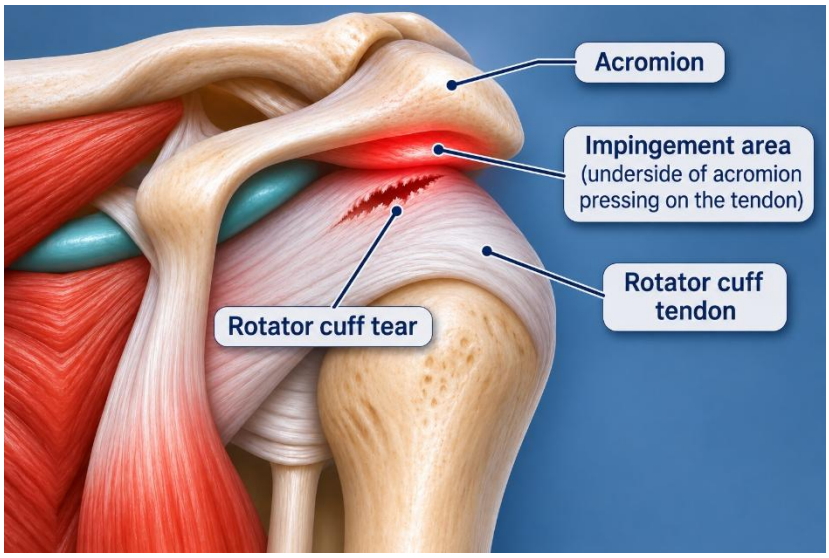
Rotator cuff tears – Arthroscopic Rotator Cuff Repair

Introduction

The rotator cuff consists of four muscles and their tendons which surround the ball (humeral head) of the shoulder joint. The muscles fine tune the movements of the shoulder and help keep the ball of the shoulder joint in its socket.

The tendon of the rotator cuff passes through a narrow space between the top of the arm bone and a prominent bone on the shoulder blade (the acromion). The tendon is very vulnerable to being pinched here when the arm is moved, especially above the head. Over time this pinching can lead to tears of the tendon; the chance of this increases as we get older.

When repeated tearing occurs, the fabric of the tendon becomes weakened and finally, like the cloth at the knees of old trousers, splits. This leads to pain, which can be severe. Weakness of the shoulder can occur, often with clicking and crunching on movement.





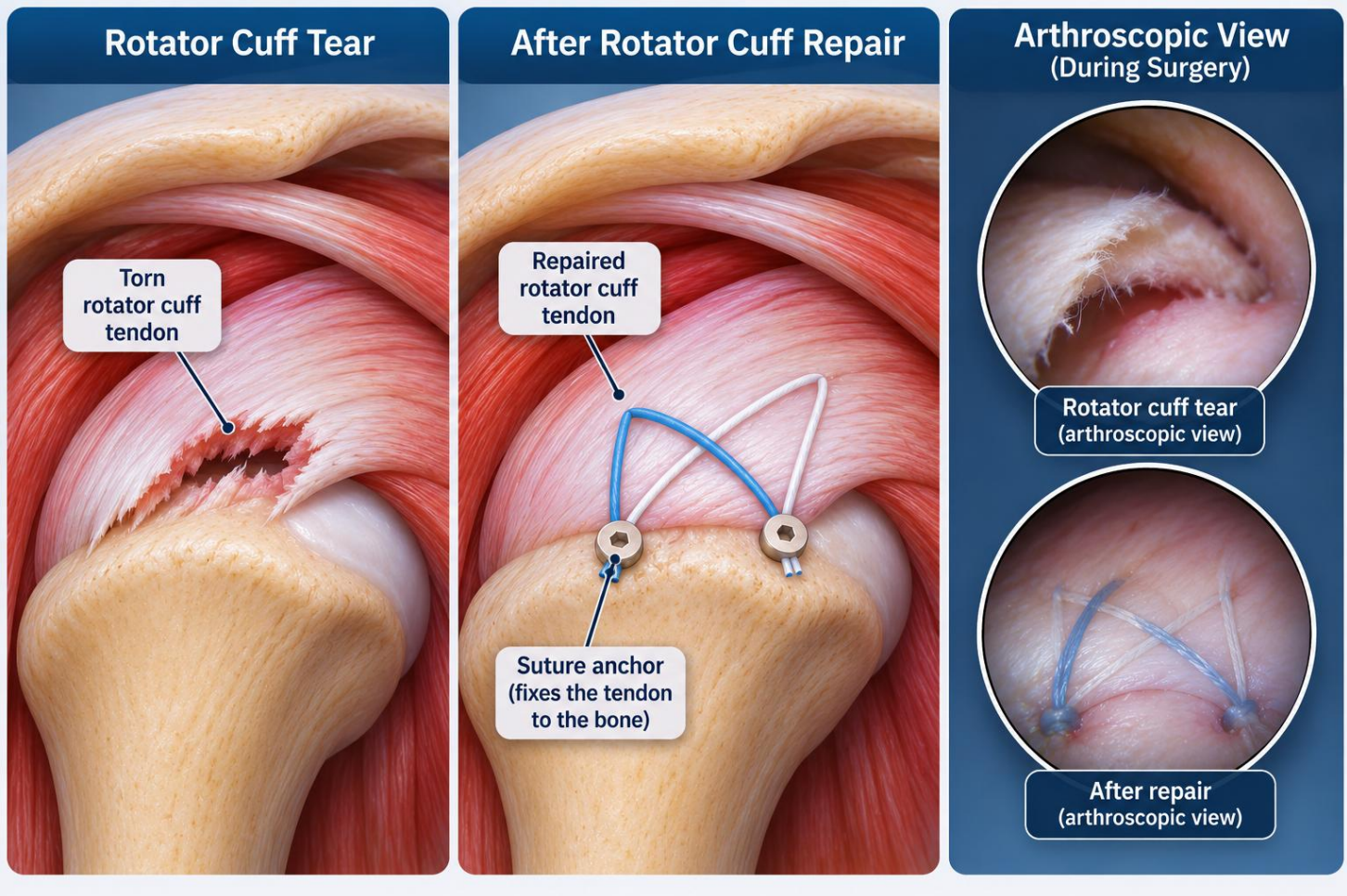
Other forms of treatment such as injections and physiotherapy are available, but sometimes it is necessary to repair the tendon. How well this does will depend upon the size of the tear. If we think about the trousers again, the bigger the split in the cloth, the more difficult is to repair and the more likely the repair is to re- tear. Your consultant will have discussed this with you.

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The Operation

This is carried out under a general anaesthetic. It is performed as a day surgical procedure in most patients. The operation is usually performed as keyhole surgery. However,occasionally it is necessary to make a larger cut over the shoulder. The tendon is repaired by stitching it to the bone

using a tiny suture anchor. The suture anchors can be absorbable or nonabsorbable (metallic/peek). The arm is then placed in a sling to allow for healing. Sometimes, the tear is too large to repair; in such cases, either partial repair of the tear is performed or arthroscopic debridement is performed to relieve the pain.



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Additional procedures

In some patients, additional sources of pain or associated pathology may be identified, such as arthritis of the acromioclavicular (AC) joint, subacromial pain syndrome (impingement), or pathology of the long head of the biceps tendon.

In these cases, it may be necessary to perform additional procedures at the time of surgery. These may include excision of the acromioclavicular joint (distal clavicle excision), subacromial decompression to create more space for the rotator cuff tendons, and treatment of the biceps tendon by either tenotomy or tenodesis.

In selected cases, where the tendon tissue is of poor quality or the tear is more complex, augmentation of the repair using a synthetic patch may also be considered to support healing.

These procedures are commonly performed alongside rotator cuff repair when indicated and are aimed at improving pain, function, and overall outcomes.

Complications

As with all surgery there is a risk of some complications. These are rare, but you should be aware of them before your operation.

They include:

- Complications relating to the anaesthetic.
- Infection.
- Failure to achieve a successful result.
- A need to redo the surgery.
- Injury to the nerves or blood vessels around the shoulder.
- Fracture
- Prolonged stiffness and or pain.
- Implant failure
- Re-tear of the tendon.

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If you require further information please discuss with the doctors either in clinic or on admission.

You will usually be in hospital either for a day or overnight. A doctor/physiotherapist will see you prior to discharge and you will be taught exercises to do and given further advice to guide you through your recovery.

General guidelines

Pain:

A nerve block is usually used during the surgery. This means that immediately after the operation the shoulder and arm often feel completely numb and weak. This may last for a few hours. After this, the shoulder may well be sore and you will be given painkillers to help with this whilst in hospital. These can be continued after you are discharged home. Ice packs may also help reduce pain. Wrap crushed ice or frozen peas in a damp, cold cloth and place on the shoulder for up to 15 minutes.

Wearing a Sling:

You will return from theatre wearing a sling. The surgeon/physiotherapist will advise you on how long you are to continue wearing the sling. This is usually for 6 weeks. Depending upon the size of the tear you will commence physiotherapy immediately, at 3 weeks or only after 6 weeks. You will be expected to remove the sling for exercises only. Your physiotherapist will advise you of these.

The Wound:

Open repair: there is an incision at the top of the shoulder. The stitch is dissolvable but is usually removed at 3 weeks. Keep the wound dry until it is well healed.

Arthroscopic (keyhole) repair: This keyhole operation is usually done through three to five 4mm puncture wounds. There will be no stitches; only small sticking plaster strips over the wounds. These should be kept dry until healed. This usually takes 5 to 7 days.

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Driving:

You will not be able to drive for a minimum of 8 weeks. Your surgeon will confirm when you may begin.

Returning to work:

This will depend upon the size of your tear and your occupation. You will need to discuss this with your surgeon.

Leisure activities:

This will depend upon the size of the tear. Your physiotherapist and surgeon will advise you when it is safe to resume your leisure activities.

Follow up appointments:

An appointment will be made for you to see a physiotherapist after your discharge and you will be seen in clinic at 3 weeks. You will be monitored by a physiotherapist throughout your rehabilitation

Further follow up appointments will be at 3 months, 6 months and 12 months post-op.

Exercises:

You may well be expected to perform the following exercises. Your physiotherapist will teach you the following exercises before you leave hospital, if appropriate:

1) With your arm in the sling, move your hand up and down at the wrist.
2) With your arm out of the sling bend and straighten the elbow
3) With your arm in the sling and the elbow bent at your side, turn the hand to face the ceiling and then the ground.

Repeat these exercises four times per day. The number you should perform at each session will be recorded for you by your physiotherapist.

Continue these exercises until otherwise advised by your physiotherapist.

If your wound changes in appearance, weeps fluid or pus or you feel unwell with a high temperature, contact your GP.

If you have a query concerning your exercises contact the physiotherapy department where you are receiving treatment.

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Appointments:

Private:

Professor Ofer Levy, MD MCh(Orth) FRCS

Practice Manager: Cherie Emmitt
Telephone: 07367 582777

e-mail: bm@readingshoulderunit.com

NHS:

Reading Shoulder Unit
NHS Choose & Book -

The Berkshire Independent Hospital
Swallows Croft, Wensley Road,
Reading, RG1 6UZ

Secretary: Helen Henly
Telephone: 0118 902 8109

e-mail: Helen.Henly@ramsayhealth.co.uk

Reading Shoulder Unit
NHS Choose & Book -

Spire Dunedin Hospital
16 Bath Road,
Reading, RG1 6UZ

Secretary: Karen Dawson
Telephone: 0118 955 3496

email: karen.dawson2@spirehealthcare.com

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He and his team believe that the treatment offered is the best for your specific medical needs, but you are completely free to ask for an alternative or a second opinion

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