Patient and Carer Information

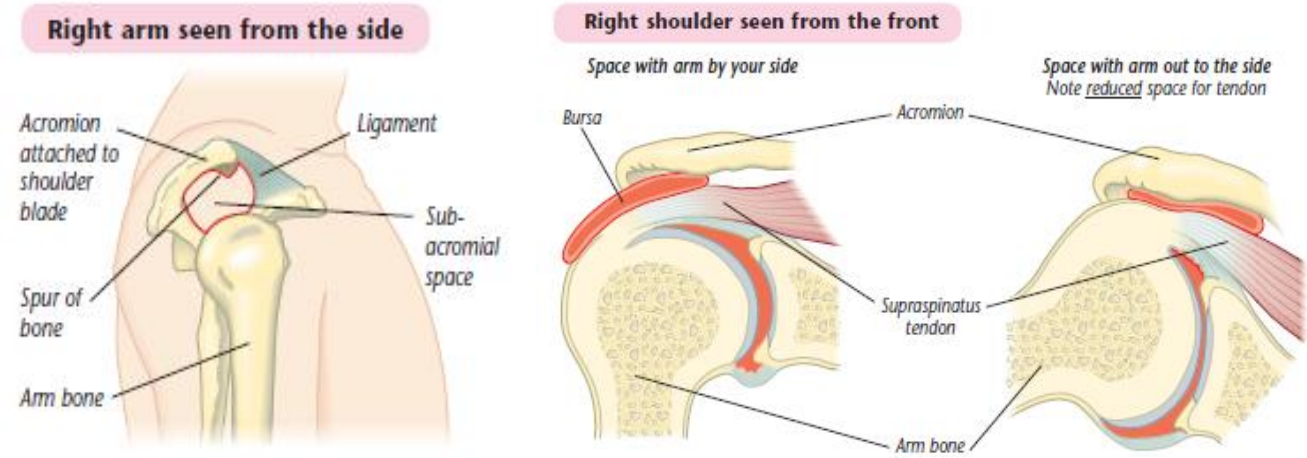
ROTATOR CUFF RELATED SHOULDER PAIN AND ARTHROSCOPIC SUB ACROMIAL DECOMPRESSION

The aim of this leaflet is to give you some advice and understanding on why your shoulder may be painful and what you may be able to do to help it.

About your shoulder

The shoulder joint is a complex joint. It consists of a large ball at the top of the arm bone (the 'humerus') which is joined to a small shallow socket which is part of the shoulder blade. Sitting above the ball is a roof, formed by a bony part of the shoulder blade at the back (the 'acromion') and a ligament at the front. The space in between the ball and the roof is called the **sub acromial space,** see picture.

The rotator cuff muscles, which help to move the arm and keep the ball sitting in the correct position on the socket, pass through the sub acromial space. A fluid filled sac (the 'bursa') sits on top of these tendons to cushion them from the bony roof. When the arm is lifted to shoulder height, the sub acromial space narrows, in positions above and below this the sub acromial space is much larger.



What is rotator cuff related shoulder pain?

Rotator cuff related shoulder pain (RCRSP) is the medical name for pain arising from the sub acromial space; it is often commonly referred to as 'impingement'. It is very common and affects one in five people at some point in their life, most commonly in middle age, and often in people who do heavy manual work.

RCRSP is often due to inflammation of the rotator cuff tendons and bursa, though there are many possible causes. Once enlarged and inflamed the tendons cause pain, commonly when elevating the arm at shoulder height, which corresponds with narrowing of the sub acromial space.

Why does it happen?

The tendons of the rotator cuff are susceptible to wear and tear. This, in conjunction with a period of increased demand (e.g. painting the ceiling, washing the windows or pruning the hedge) can be enough to trigger off a process of inflammation, swelling and pain. Sometimes arthritis in the joint between the collar bone and shoulder blade – the acromioclavicular joint or ACJ – can contribute to shoulder pain.

What is arthroscopic sub acromial decompression?

Arthroscopic subacromial decompression is performed for patients who have painful shoulder impingement that has not resolved with non-surgical treatments. The operation helps to prevent the bones and tendons in the shoulder rubbing against each other when the arm is raised. The procedure involves removing the inflamed bursa, cutting the ligament and shaving some bone (from the acromion) to create more space for the tendons to move freely. People with ACJ pain may also be listed for an ACJ resection – a procedure to shave some bone from the end of the collar bone. This is performed by keyhole (arthroscopic) surgery, as a day case procedure.

What are the reasons for doing this?

Pain is relieved by removing the inflamed and painful bursa and by creating more space for the tendons to move freely in the subacromial space.

Are there any alternatives?

- Steroid injections into the shoulder
- Taking regular pain killers and/or anti-inflammatory tablets
- Seeking advice from a shoulder physiotherapist

Surgery should only be performed when these have been tried and failed.

What are the risks?

Risks of the operation are:

- Wound infection - rare and usually involves the skin. Occasionally a deep infection can occur, the risk is less than 1%.
- Stiffness – shoulders can become stiff after shoulder surgery. Around 5% of patients develop stiffness that normally resolves with physiotherapy.
- Nerve injury – there is a very small risk to nerves around the shoulder. The risk is less than 1%.
- On-going pain – 5-20% of patients will have some on-going discomfort / pain after surgery.

Risks of the anaesthetic:

Your anaesthetist will talk to you about this. There is some information about anaesthetics below and there is additional patient information from the Royal College of Anaesthetists available.

What anaesthetic will be used?

You will meet the anaesthetist before your operation and will have a chance to ask any questions you might have about your anaesthetic. Most patients will have a general anaesthetic and possibly a supplementary nerve “block” (regional anaesthetic) that provides pain relief in the immediate post-operative period. The block numbs your arm and you will not be able to move the arm until the block wears off (usually 12-18 hours). Your arm will be in a sling. It is important to take some painkillers before the block wears off, generally before you go to bed the day you have had surgery, to reduce the risk of developing pain.

Jewellery

All jewellery needs to be removed from the arm that is to be operated on before surgery.

Blood clot prevention

Risk of blood clot in the arm (deep vein thrombosis or DVT) is rare following shoulder surgery. Prevention is by physical means of stockings and pumps in theatre and early mobilisation after surgery (walking). Keeping well hydrated after surgery is also advised (drinking water).

Consent

You will be asked to give your consent to this treatment following further discussion with medical or nursing staff. It is important that you understand what is involved and you will have an opportunity then to ask any questions that you might have.

Plan ahead for discharge home

If you think you may have any difficulties, please discuss these at your pre-operative assessment appointment. The procedure is performed as a day case and you will be in a collar and cuff sling for a few days (as comfort allows). The only restriction to movement after surgery is discomfort.

You will need someone at home for at least the first night after surgery.

Normally there are no stiches, your wounds should be covered until dry, but you can shower with waterproof dressings within a few days of surgery.

Contact your GP if

- You have severe pain
- You develop a fever

- Your wound appears red and lumpy or starts to leak fluid
- You develop arm/leg pain and swelling, or if your arm/leg becomes warmer than usual, or reddish / purplish in colour.
- You develop unexplained shortness of breath, chest pain and / or coughing up blood

Physiotherapy

Total recovery time can be up to twelve months. You will attend an education group before your operation. At this appointment you will be taught exercises to do after your operation. You will then start physiotherapy within a week of surgery (when you see the therapist). Your physiotherapist will explain what you can and can't do with your arm and shoulder and will show you how to do the exercises you need. Your exercise plan may be different to other patients who have had similar operations. This is because each operation is slightly different and so the exercises needed are also different. Your physiotherapist will have instructions for your exercises.

Milestones (as able):

Return to work

Sedentary job:	2-4 weeks as tolerated
Manual job:	Up to 6-8 weeks; may need to modify activities for 2-3 months
Driving:	Normally 2 weeks *the law states that the patient should be in complete control of the car, it is their responsibility to ensure this and to inform their insurance company about their surgery*

Swimming

Breaststroke:	As able
Freestyle:	12 weeks

Golf:	As able
Lifting:	As able
Racquet sports:	Avoid repetitive overhead shots for 3 months

Further Information

If you require further information or advice please contact the ward you have been on

Exercises

You can begin to exercise the arm with the following exercises as soon as the anaesthetic block has worn off.

1. Neck Rolling

- Stand/Sit with arms relaxed
- Make Backward Circles with your shoulders
- Relax and Repeat
- Repetition: 10 Frequency: 4 times a day

2. Table Slide Flexion


- Start sitting or standing with hands supported on table top
- Slowly slide arms in front in a comfortable range
- DO NOT push into resistance
- Use a towel under hands to reduce friction
- Repetition: 10 Frequency: 4 times a day

3. Assisted Movement - Shoulder Rotation


- Resting Elbow at 20 degrees abduction away from side. Hold a stick in your hands and push operated hand outwards.
- Only move as far as post-operative restrictions allow
- DO NOT push into resistance
- Repetition: 10 Frequency: 4 times a day

4. Assisted Movement - Shoulder Flexion


- Lye on your back with knees bent and hold stick firmly
- Using good arm to help operated arm, lift arms towards vertical as in picture
- DO NOT push into resistance
- Maintain the position and relax for 5 seconds
- Repetition: 10 Frequency: 4 times a day

5. Assisted Movement - Shoulder Abduction


- Start sitting or standing with operated arm supported on table
- Slowly Slide arm out to the side in a comfortable range
- DO NOT push into resistance
- Slowly return to the start position and repeat
- Repetition: 10 Frequency: 4 times a day

6. Elbow Movement - Flexion


- Sit on a chair with your arm straight along the side
- Bend your elbow keeping the palm of your hand facing upwards
- Use your other hand to support your elbow.
- Repetition: 4 Frequency: 4 times a day

7. Neck Movement - Rotation

- Stand or sit tall
- Slowly turn your head to bring chin over your shoulder and look over your shoulder
- Return to start position and repeat on other side
- Repetition: 4 Frequency: 4 times a day

8. Neck Movement – Flexion

- Stand or sit tall
- Slowly bend chin to chest to look down at floor
- Return to start position and repeat
- Repetition: 4 Frequency: 4 times a day

9. Finger Flexion

- Clench a tight fist then straighten fingers
- Repetition: 20 Frequency: 4 times a day

These exercises are intended as a guide; if you have any difficulties please contact your physiotherapist. Regular exercise is the best way to optimise the outcome of your operation, however, only perform exercises that you have been instructed to do.

If you require this information in an alternative language or format (such as Braille, audiotape or large print), please ask the staff who are looking after you.