



Dr. Stephen Thon

Surgery Guide: Shoulder Instability Surgery

Your guide to Surgery and Recovery

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SHOULDER STABILIZATION SURGERIES: WHAT ARE THE OPTIONS?

We understand the importance of providing comprehensive information to patients. Here's a detailed overview of various shoulder stabilization surgeries, including their pros and cons and the ideal patient for each. The choice of shoulder stabilization surgery depends on various factors, including the extent of the injury, bone loss, patient activity level/sport, and individual patient considerations. Please consult with Dr. Thon to determine the most suitable option for your specific case.

(Note: This information is for informational purposes only and should not replace professional medical advice. Please consult with a qualified orthopedic surgeon for personalized recommendations.)

Arthroscopic Bankart Repair: A minimally invasive procedure that repairs torn labrum and capsule, suitable for patients with small to moderate labral tears and **minimal bone loss** (<10%).

Pros:

- Minimally invasive procedure through an arthroscope, Generally shorter recovery time compared to open surgeries, Allows for repair of torn labrum and capsule, Can be performed as a standalone procedure or in combination with other techniques (see below)

Cons:

- Limited effectiveness for large bone defects or bone loss (>10-15%), Higher risk of recurrent instability compared to some other procedures in contact athletes or when bone-loss is present

Ideal Candidate:

- Individuals with small to moderate-sized Bankart lesions (tears in the labrum and capsule), **Minimal bone loss or defect**

Arthroscopic Remplissage: Addresses Bankart tears and engaging Hill-Sachs lesions to reduce the risk of recurrent instability, ideal for patients with both these conditions and minimal bone loss (up to 15%).

Pros:

- Addresses Hill-Sachs lesions (bone defects on the humeral head) in addition to Bankart tears, Reduces the risk of recurrent instability caused by engaging Hill-Sachs lesions, Can be combined with Bankart repair for comprehensive stabilization

Cons:

- Limited effectiveness for large bone defects or bone loss (>20%), May result in a slightly longer recovery time compared to Bankart repair alone

Ideal Patient:

- Individuals with Bankart tears and engaging Hill-Sachs lesions, **Minimal bone loss or defect (<10-15%)**

Distal Clavicle Bone Transfer: Utilizes the distal end of the clavicle to augment glenoid bone stock, suitable for patients with small to moderate glenoid bone defects or loss (>15%). Combination of arthroscopic repair of the labrum and a small open incision for the clavicle harvest.

Pros:

- Utilizes the distal end of the clavicle to augment glenoid bone stock, Suitable for certain types of shoulder instability caused by bone loss, Combination of minimally invasive repair of the labrum and open clavicle harvest

Cons:

- Limited effectiveness for significant bone defects or loss (>20%), May not be appropriate for all patients due to anatomical considerations

Ideal Patient:

- Individuals with **small to moderate-sized glenoid bone defects or loss**, Appropriate anatomy for clavicle bone transfer

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Latarjet Coracoid Transfer: Involves transferring a bone graft from your coracoid process to the front of the glenoid socket, effective for people who have had multiple dislocations and moderate to large bone defects (>15%).

Pros:

- Provides stability by transferring a bone block from the coracoid process to the glenoid socket, Effective for recurrent instability and large bone defects, Offers a high success rate in preventing future dislocations

Cons:

- Involves an open surgical approach, Potential risk of complications associated with graft placement

Ideal Patient:

- Individuals with **recurrent instability (multiple dislocations), prior failed surgery**, Moderate to large bone loss or defects (>15%), Contact Athletes (hockey, football, rugby, etc...)

Distal Tibial Allograft: Utilizes a cadaveric graft to reconstruct the glenoid bone, effective for severe glenoid bone loss or large bone defects, particularly in cases where previous stabilization procedures have failed.

Pros:

- Utilizes a cadaveric graft to reconstruct the glenoid bone, Effective for severe bone loss or large bone defects (>30%), Offers stability and potential for improved long-term outcomes with large bone-loss

Cons:

- Requires a fresh allograft from a donor, Potential risk of complications associated with graft placement, high cost associated with graft

Ideal Patient:

- Individuals with **severe glenoid bone loss (>25-30+%)** or large bone defects, Failed previous stabilization procedures

WHAT IS BONE LOSS AND WHY IS IT IMPORTANT?

When your shoulder dislocates, the bone from the ball and the socket make contact with each other which can cause the bone to chip away and cause "Bone Loss". Bone loss in the glenoid socket or humeral head can compromise the joint's ability to hold the shoulder in place, increasing the risk of recurrent instability and dislocation. Addressing bone loss during surgery is crucial to restore stability and prevent further complications, as it often requires additional procedures or specialized techniques such as bone grafts to reconstruct or augment the bone structure. With each dislocation the damage to the bone can increase the amount of bone loss. When the bone loss reaches a certain level, standard arthroscopic procedures have a higher chance of failure. If your bone loss reaches this threshold you may be better served by an additional or different procedure.

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MEDICATIONS

You will take multiple medications as part of our opioid sparing protocol. This protocol is designed to have fewer side effects, better, pain relief, and reduced opioid use/addiction rates. There are multiple medicines we provide but none are addictive or habit forming. You will be given a small prescription of oxycodone to take **ONLY AS NEEDED**. Start taking your medications the day of your surgery. It is important to have started the pain medications before your block wears off and the pain returns. You should also set an alarm for the middle of the night to take your medications.

Sample Medication Schedule below starting first medicines at 8am

<u>Three Times per Day</u>		
8am:	Acetaminophen 1000mg* Meloxicam 7.5mg* Methocarbamol 750mg Omeprazole 20mg Aspirin 81mg	2pm: Acetaminophen 1000mg* Methocarbamol 750mg
		~8pm: (or before bed) Acetaminophen 1000mg* Meloxicam 7.5mg* Methocarbamol 750mg

Can also alternate every 4 hours

SLING WEAR

Your sling must be worn at all times **including while you sleep**. There are only four situations in which you may remove your sling: 1) during physical therapy, 2) to shower, 3) to change clothing, and 4) while awake and at complete rest (I.e. sitting on couch watching TV, etc...). If up and walking about the sling must be worn, this is to protect your newly repaired shoulder from re-injury. Click the link to the right for instructions on how to apply your sling.



Length of time in sling is generally 6 weeks after a shoulder stabilization procedure.

DRESSINGS

Your outer dressings may be removed after 48 hours (or the morning of the second day). Leave the steri-strips (little band-aids) over each incision until they fall off naturally. It is normal for your incisions to drain water like fluid that may be tinged red some time after your surgery. If you have some drainage, reapply some clean gauze with tape until the drainage stops. Do **NOT** apply any lotions, ointments, or other liquids (besides running water) to your incisions until they have completely closed and there are no scabs over the incisions. This usually takes at least 3-4 weeks.

SHOWERING/HYGIENE

You may shower once your dressings are removed on the second day after your surgery. Running water is ok over the incisions, but you may not soak or submerge your incisions in water for a minimum of 3 weeks after your surgery. Soaking/Submerging your incisions too soon can increase your risk of getting an infection.

MOVEMENT/ACTIVITY/SPORTS

You are encouraged and allowed to move your arm from the elbow down including your forearm, wrist, hand, and fingers as much as you can tolerate once your nerve block wears off. Any movement in the box from the top of your shoulders to your hip bones is safe to do as much as you'd like. It is OK to use your arm/hand for simple and light activities such as reading, writing, texting, typing, and working on the computer. Do not lift anything heavier than a "coffee cup" with your surgical arm. The motions you **absolutely want to avoid without proper supervision are:** reaching behind you, reaching out to the side away from your body, and reaching above your head. Going for light walks multiple times per day is encouraged to keep your blood flow up. Also when at rest make sure to perform ankle pumps multiple times per day to help reduce the risk of blood clots.

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SLEEP

Sleeping is difficult after most shoulder surgery. It is often very difficult to sleep in the first few weeks after surgery. The surgery/anesthesia itself may interfere with your sleep-wake cycle. In addition, many patients have increased shoulder pain lying flat on their back. We recommend that you try sleeping in a recliner or in a reclined position in bed. This is often much more comfortable. You may place a pillow between your body and your arm and also behind your elbow in order to move your arm away from your body slightly. This often helps with the pain. You need to wear your sling when you sleep.

DRIVING

Returning back to driving is different for everyone but for most is sometime between 2-6 weeks after surgery. Some requirements to resume driving are: you **MUST** no longer be taking opioid pain medications, you must be able control the steering wheel on your own while adhering to your restrictions with your shoulder, and your reaction time and stamina must have returned to normal. Discuss driving with your therapist to see if you are ready to return to the road on your own.

RETURN TO WORK

Going back to work is dependent on the type of job you perform. Most people take at least 1-2 weeks off from work after surgery. If you have a “desk” job”, you may return to work whenever you feel comfortable to do so as long as you are able to wear your brace and adhere to the restrictions for your shoulder. Jobs that require heavy lifting/pushing/pulling/etc... may not be performed until much later in your recovery and may require 3+ months off of work before it is safe to return. Please discuss with your employer what (if any) light duty you may be able to perform during this time. Any paperwork required for missing time off work including FMLA should be directed to ThonCareTeam@occ-ortho.com

Work Restrictions can be found at <https://www.stephenthonmd.com/pdfs/work-restrictions-labral-repair.pdf>

PHYSICAL THERAPY

Physical Therapy (PT) will start within 1-2 weeks of your surgery. You should go to PT at least once per week for the first 6 weeks. PT may increase after this time point. In addition, they should provide you with exercises to perform on your own at home. You may notice some increase in pain after your PT sessions, this is normal to experience. It should go back down with rest. PT is slow by design during the early phase and then ramps up. This is necessary to give your tissues the proper time to heal as strong as possible.

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EXPECTED RECOVERY

Full recovery is expected to be 4 - 6 months. If you are a contact athlete returning to sports like hockey, football, rugby, etc.,, you should expect it to be the full 6 months. Your recovery is slow at first, accelerates in the mid-point, and then levels out as you reach full recovery. In general, we would expect you to complete 20% of your recovery after the first two months, get up to 80% recovery between 2 - 4 months, and the final 20% of your recovery past 4 - 6 months. You should expect to have stiffness (especially with rotation) for at least 6 months after surgery. As long as it is steadily improving, this is normal.

Note: This is approximate. Your recovery may be different depending on the extent of your tear

FOLLOW UP APPOINTMENTS

You will be seen a total of 6 times after your surgery to ensure your recovery is going smoothly. Full recovery from Shoulder Stabilization Surgery is dependent on how severe your injury was to begin with, but is expected to be at least 4 to 6 months in total with gradually increasing times between each visit. The recovery is long, but stick with it to get the best result possible!

You will be seen at the following intervals after surgery:

- 2 weeks
- 2 months
- 4 months
- 6 months
- 9 months*
- 12 months*.

If necessary

THINGS TO LOOK OUT FOR AFTER SURGERY?

Continue to look out for any fevers greater than 100.4 degrees F (38.0 degrees C) or if your incisions/shoulder becomes increasingly swollen, red, warm to the touch, or having drainage that is thick or chalky. In addition, your pain should continue to decrease with time.

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FAQ'S

Q: How long with the surgery take?

A: The surgery will take about ~2-2.5 hours, but expect to be away from your loved ones longer as it takes time to go to sleep, position you for surgery, and give you time to wake up and become alert in the recover area.

Q: What implant/prosthesis do you use and what is it made of?

A: For labral repairs and remplissage we use suture anchors to reattach the labrum to the bone. These are made of all sutures or a biocomposite material that will get completely replaced by bone within 24 months. If you undergo a Latarjet, distal clavicle, or distal tibial allograft we will secure the bone graft with cortical buttons on both sides of the bone.

Q: Will I need to stay in the hospital overnight?

A: No. This is an outpatient procedure.

Q: Will I need to take any antibiotics after the surgery?

A: Generally no, antibiotics are not needed. We will give you a dose of antibiotics through your IV within 1 hour prior to your procedure at the surgery center/hospital. Please notify the team if you have an antibiotic allergy. In most cases, you will not go home with a prescription for antibiotics. **IF YOU ARE PRESCRIBED AN ANTIBIOTIC AFTER SURGERY, DR. THON WOULD LIKE YOU TO TAKE IT.**

Q: What are the risks associated with surgery?

A: As with all surgery, there are risks of anesthesia complications, infection, damage to nerves and/or vessels, fracture, failure of the repair and need for further surgery. As with any instability surgery, there is always a risk of repeat dislocation. These risks are thankfully exceedingly low.

Q: Do I need to be in a sling?

A: Yes. The sling will be required for minimum 6 weeks after surgery. You will be allowed to take it off to shower, get dressed, and for physical therapy, but otherwise you will need to keep this on.

Q: What medication will I go home with after surgery?

A: You will be prescribed an opioid sparing multimodal medication protocol. In multiple randomized controlled trials, this regimen provided improved pain control over standard opioid narcotics with improved pain scores, less constipation, and less upset stomach.

Q: What if I am on chronic pain medication?

A: We do not manage chronic pain medication. Please set up a plan with your prescribing provider **PRIOR** to your scheduled surgery date to help manage post---operative pain. We are happy to help execute this plan for both your safety and adequate pain control.

Q: Will I be offered anything else for pain management after surgery?

A: Yes. The anesthesiologist will offer you a nerve block to help with post---operative pain. This can provide relief for about 12---24 hours after surgery. In addition, ice will help with pain and swelling after surgery. Please make sure you have started taking your prescribed medications prior to the nerve block wearing off.

Q: What about sleeping after surgery?

A: Sleeping is the most challenging part of the recovery. Most patients find comfort sleeping in a Lay-Z-Boy or Barcalounger type chair. If you do not have access to these types of chairs, laying in bed with multiple pillows propping you up seems to help.

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Q: When can I drive?

A: Recent studies have shown that it is safe to drive for most people after 2-3 weeks after surgery. You **MUST** be off all narcotic or sedating medications prior to any driving and your range of motion must be adequate enough to grip/turn the steering wheel. This is different for everyone.

Q: What clothing should I have for after surgery?

A: Most people will prefer button down shirts or jackets with zippers. Women may want to get a bra that clasps in the front.

Q: When can I go back to work?

A: It depends on what your job is. If it involves you mainly sitting throughout the day, most patients will go back to work around 1-2 weeks post---op. If you are on your feet throughout the day, expect this to be longer. For work that requires heavy lifting, pushing, or pulling you will not be able to perform this work for a minimum of 8-12 weeks more than likely. The surgical team can provide you with a letter explaining your absence and/or restrictions if needed.

Q: When to call your doctor?

A: If you experience any of the following, call your doctor:

- Severe or increasing pain
- Cold, pale, or numb fingers
- Cloudy/Thick Drainage from your surgical site (clear/red drainage is usually normal)
- A fever over 101° for over 4 hours, abnormal redness of your incision, or a bad odor from your dressing. All of these symptoms could indicate an infection.

Disclaimer:

Everyone's recovery is different. The above information is merely a guideline and your individual recovery may be different based on your own unique situation and circumstances. It is important to continue to see Dr. Thon at the scheduled intervals. As always, if you have any questions or concerns with any of the above information, please call our office.

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