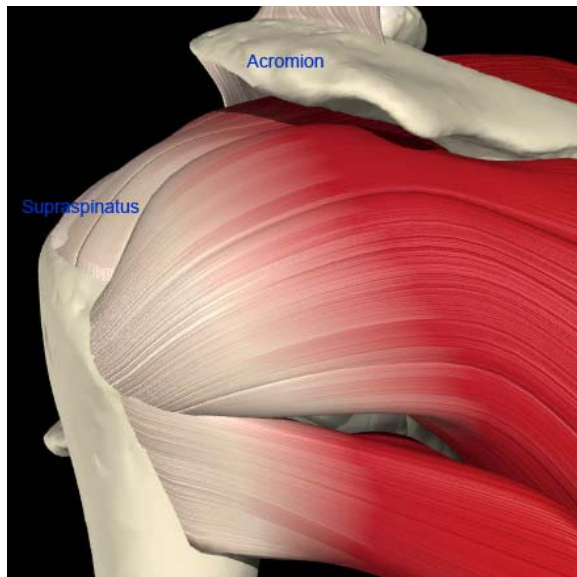


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Re: Information to patients regarding shoulder arthroscopic decompression.

The shoulder is effectively a ball in socket joint, but with the ball being four times the size of the socket. Consequently some of the important stabilising structures that move the shoulder are the tendons that lie around the shoulder, most important of which is the supraspinatus tendon.



Interactive Shoulder v1.0 © 2000 Primal Pictures Ltd.

Supraspinatus tendon runs directly under an arch called the coracoacromial arch. (acromion is the most important aspect). In patients with impingement type syndromes, the supraspinatus tendon becomes inflamed due to pressure between the acromion and the tendon, producing pain, i.e., there is a fluid around the area called a bursa. There are two reasons why this occurs.

1) In some people, they have a very hooked or peaked acromion, i.e., they are either born or develop structures that catch on the tendon as the tendon moves underneath it

2) There is a theory where the tendon itself is not strong enough to take the force that the patient is putting on it i.e., secondary to either degenerative processes or age-related changes such that the tendon becomes swollen and inflamed and then catches on the bone.

This can lead to one of several conditions.

a) In a young person, it leads to swelling around the tendon called bursitis. This presents with an acute pain around the top of the shoulder which would be worse with movements or overhead activities and can usually occur after heavy extensive use over a period of a few days. With rest, anti-inflammatories and sometimes a steroid injection it settles completely back to normal.

b) In patients between the ages of 30 to 60, it can present with a chronic inflammation or bursitis, usually associated with underlying tendon inflammation called tendonitis.

c) As this progresses, the tendon itself can slowly tear, leading to small rotator cuff tears

d) Finally this leads to instability in a joint causing wear and tear, which in the patient is known as arthritis.

Consequently, the treatment of shoulder pain and rotator cuff problems is difficult to diagnose, at which stage the patient is at then to try and restore things to normal.

The aim of surgery in a decompression is to try and prevent and settle the inflammation of the tendon and prevent it going on to a rotator cuff tear and this is done by looking inside the shoulder to assess the structures inside the shoulder and see if there is any evidence of any arthritis. The undersurface of the tendon is also inspected to see if there is a partial tear. The telescope is then looked on the outside of the shoulder and the outside of the tendons to see if there is underlying tendon tear. The inflammation is débrided called a bursectomy and the coracoacromial arch is débrided called acromioplasty. In many cases, arthritis of the acromioclavicular joint can lead to the tendon getting caught from extra bone formation and this also needs to be débrided and in other cases, arthritis on the joint itself can lead to symptoms

similar to a rotator cuff impingement and the joint has to be completely removed. All of this surgery can be done through the telescope.

If there is a tendon tear present, then, it may be best to be repaired. In much research there is evidence that tendon tears which are repaired go on to re-tear again.

However, in Mr Nimon's experience, he tries in most cases to repair tendons if at all possible. The different circumstances are if there is a partial thickness tear, then this may be purely debrided or in an elderly patient where the treatment of a repair is unlikely to benefit the patient, or in a patient who is very strongly likely to have a re-tear, then a tear may be purely debrided alone.

If a tear is requiring a repair, this may be done through the telescope, or sometimes requires an open incision. It will necessitate the use of a constrictive sling to be worn all the time for 6 weeks after the surgery. The stiffness that occurs due to this means that patients who have a cuff (tendon) repair should expect to take 3-6 months to get benefit from the surgery.

The decompression alone is usually done through a telescope, although occasionally requires an open incision, because of difficulty proceeding. Although this is rare in Mr.Nimon's experience.

Results:

The results of surgery are well known and documented in many series and throughout the literature. Mr Nimon has audited his results and over a first two year period between 2001 to 2002 inclusive, he had an 85% successful results, which is in keeping with the results in the literature. i.e., 3/20 patients do not get improvement and their symptoms either remain the same or occasionally may be worse. In a new review of having changed his practice such that he has done a more extensive bursectomy and is more aggressive in debriding the acromioclavicular joint, the results have improved to between 90 to 95% successful, which still means, however, that 1/20 to 1/10 patients may not benefit from the surgery. I would also add that the time for success can take up to one year, although the average time is three to six months before the full extent of the improvement is known. As with most orthopaedic

surgery, the condition is not life-threatening and consequently Mr Nimon cannot recommend that people must have surgery, but can only offer surgery with the aim of trying to improve the quality of life so that they can experience more to more day life activities.

Mr Nimon also emphasises the fact that to this date there is no true evidence that a decompression will stop a person going on to develop a cuff tear as the underlying pathology may be the degenerative change in the tendon itself. However, the decompression will help relieve the pain of the shoulder and certainly without the bone catching on the tendon it makes sense that it is less likely to tear as quickly. Finally one would emphasise that there are many asymptomatic cuff tears in people which do not require treatment. In fact, it has been estimated that 80% of people over the age of 80 have rotator cuff tears of which only a very small minority ever develop symptoms. One important aspect to be aware of is, however, the occasional person may present after trauma, i.e., a fall or a heavy activity with sudden loss of use of the shoulder. Should this fail to respond within weeks of the physiotherapy, then this is going to be considered a rotator cuff tear, which means that without surgery the shoulder may not regain full activities.

Risks:

First of all, the values of arthroscopic surgery involves a minimally invasive procedure done through a telescope or keyhole surgery and consequently the scarring is minimal, but is still present. There will be two to three, half to one centimetre incisions, both on the front side and back of the shoulder and in the case of an arthroscopic tendon repair, this can sometimes be up to six incisions. These are at risk of infection and should symptoms not improve on a daily basis or suddenly deteriorate, then Mr Nimon would recommend that the patient contact Mr Nimon immediately. The incidence of an infection in Mr Nimon's hands is less than one percent and is more likely in diabetic patients. Should this occur then the patient may require a further washout, in hospital but often do not affect the final outcome of the treatment. Infection is a risk, however, and the patient must be aware prior to surgery.

Secondly, any general anaesthetic has complications. These include a risk of death, heart attacks or strokes and consequently surgery cannot be taken lightly. However,

assuming the patient is fit, the chance of any complication like this is low and following appropriate assessments, none of Mr Nimon's patients have suffered any of these complications to date.

Finally, the surgery involves the use of traction on the arm. This can put stress on the nerves as they exit the the neck and can potentially lead to some numbness in the fingers, either on temporary or permanent basis. This has been well documented in series, although it has not been a significant factor to Mr Nimon's case with only one potential incidence occurring which resolved within weeks. For further information, please do not hesitate to e-mail Mr Nimon at the appropriate contact details as listed on the website.