SSC

SPORTS SURGERY CLINIC

Specialists in Joint Replacement, Spinal Surgery, Orthopaedics and Sport Injuries

The Latarjet Procedure (coracoid transfer) – Shoulder Stabilisation Surgery

Ms. Ruth Delaney

Consultant Orthopaedic Surgeon

Joint Commission International Quality Approval

Introduction

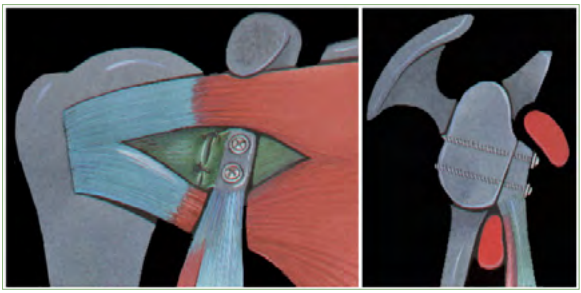
The shoulder is a very mobile joint but is therefore susceptible to instability. Instability occurs when the 'ball' (the head of the humerus bone) comes out, or partially comes out of the 'socket' (the glenoid). The socket is shallow and has a cartilage 'bumper' around its circumference called the labrum, which helps deepen the socket and increase stability. The capsule of the shoulder joint is made up of strong ligaments, which blend with the labrum and contribute to shoulder stability. When a dislocation or subluxation (partial dislocation) event occurs, the labrum and/or the ligaments tear. In association with this injury, especially with repeated dislocations or subluxations, the bone at the rim of the socket may sustain damage.

Each patient's shoulder is unique, and Ms. Delaney will discuss the details of your individual situation with you.

The following are some general guidelines.

Latarjet Procedure Surgery

The surgery is performed under general anaesthesia. This is performed as an open surgery, through an incision in the front of the shoulder. Often, the decision to perform this surgery rather than a soft tissue repair (Bankart or labrum repair) is made at surgery when Ms. Delaney examines the shoulder under anaesthesia and with an arthroscope (camera) in the joint, therefore it is common to undergo a diagnostic arthroscopy ("keyhole" surgery) at the beginning of the procedure. This is a more accurate method than MRI or CT scan of assessing the injury to the structures of the shoulder.



Images courtesy G. Walch.

In the Latarjet procedure, a piece of bone is taken from part of the front of the shoulder blade or scapula called the coracoid, and transferred to the front of the socket of the shoulder, the glenoid. It is passed through a split in a tendon at the front of the shoulder for added stability, before being secured to the front of the glenoid, typically with two screws.

Risks

There is a small risk of damage to nerves or blood vessels, or infection. You will receive antibiotics from the anaesthetist at the beginning of surgery to minimise the risk of infection. Stiffness can occur but is rare with adherence to the rehabilitation protocol. This surgery is successful in 90-95% of patients. Further trauma to the shoulder can lead to recurrence of instability in a small number of patients and may require further surgery.

Post-operative Care

Pain Control

The shoulder will usually be sore and painful immediately after surgery. You will be sent home from the hospital with prescription pain medication. The post-operative pain should be controlled by pain medicine and ice. Apply ice, in the form of ice packs or crushed ice/frozen peas wrapped in a damp cloth, to the shoulder frequently (approximately 20 mins at a time, at least 2-3 times a day).

Avoid anti-inflammatory medication (Neurofen, Difene etc.) for the first 30 days after surgery.

Sling

You will be placed in a sling at the end of your surgery. The sling is to be worn at all times, including during sleep, for a period of 2 weeks. The physiotherapist will instruct you on managing with the sling while protecting your repair. Elbow, wrist and hand motion are allowed and encouraged.

Wounds

Your incisions will be covered with waterproof dressings. Leave the waterproof dressings in place for 10 days to allow wound healing. You may shower 72 hours (3 days) after surgery, but do not soak the shoulder in the bath or go into a pool until you are cleared to do so at your follow up appointment with Ms. Delaney. All skin stitches are absorbable and do not need to be removed.

Follow up Appointments

An appointment will be made for you to see Ms. Delaney approximately 2 weeks after surgery.

Ring the office at 01-526 2335 to confirm this appointment.

Rehabilitation

At your first post-operative visit, Ms. Delaney will give you a prescription for physiotherapy and a detailed post-operative protocol for you and your physiotherapist to follow. At 2 weeks, you may resume cardio training on an exercise bike if desired. In general, for the first 2 weeks after surgery, all movements with the shoulder will be passive. Active movements will begin as you transition out of the sling. The initial focus will then be on regaining your shoulder motion, while maintaining shoulder stability. No strengthening will be allowed until 12 weeks typically.

Driving

You must not drive while in the sling or while taking narcotic pain medication. Ms. Delaney will advise when you may begin driving.

Return to Work

Return to work depends on the nature of your occupation. You need to discuss this with Ms. Delaney.

Return to Sports

Return to sports will depend on the type of sport and your progress with physiotherapy. Ms. Delaney and your physiotherapist will advise you on the timing of your return to sport. The transferred bone graft typically takes 8-12 weeks to completely heal. Return to sport is dependent on that and on regaining good range of motion, strength and scapular stability. In general, contact athletes return to full contact at about 4 months post-operatively.

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Santry Demesne, Dublin 9
Telephone: 01 526 2335
E-mail: ruthdelaney@sportssurgeryclinic.com
www.shouldersurgeon.ie