Arthroscopic Rotator cuff repair + Subacromial Decompression +/ - long head of biceps tenotomy for rotator cuff Tendons of the shoulder joint) tear / wear

These options will only apply if a professional has diagnosed you.

Options for management

1) To manage with the painkillers as it is and continue with the exercises.

2) The second option is subacromial steroid injection, which acts as diagnostic and therapeutic injection. Injections **do not heal** the tendon.

   Potential risks with steroid injection include- Infection, Incomplete benefit from symptoms, local or rarely systemic effects of steroid, increased pain initially, skin discolouration, nerve damage owing to injection.
   In diabetics, can rarely cause deranged blood sugar.

The largest study in UK was UKUFF trial, which established that there is improvement in symptoms with surgery. Some studies have suggested that in young/ middle aged patients there is risk of arthritis in shoulder over approximately 8-10 years, if tear causes imbalance in movement of shoulder.

3) Whether to proceed for surgery or not is shared care decision between patient and surgeon. The surgical option is the arthroscopic (Key hole) Rotator cuff repair (repair of the tendon) if they are repairable+ subacromial decompression (clearance of space for easy mobilization of tendon). This operation is done under general anaesthesia with or without block. It is day case surgery (you are discharged on the day of operation).

   I do most of my operations by Arthroscopic (keyhole) surgery only unless tendons are irreparable.

   The benefits of the operation i.e. pain relief can take from 6 weeks to 3 months to start and can up to a year to get good pain relief and patient will have to do the exercises to strengthen the tendon.

   Risks include bleeding, infection, about 5% risk of getting a frozen shoulder, small risk of nerve damage (worst case scenario-permanent loss of sensation and movement), the risk of incomplete symptom relief or rarely no relief, retear of the tendon, dislodgement of the anchor, blood clot in veins, and anaesthetic risks (e.g. heart attack, stroke, chest infection).

I do not close the holes for arthroscopy so they may ooze for some days after operation as we use fluid for arthroscopy.

If biceps tenotomy (cutting of long head of biceps tendon) is performed additional risks include biceps buldge (“popeye sign”) and risk of muscle cramps. Although theoretically it decreases some strength but if biceps tendon is worn out and is painful, clinically patient feels much better owing to pain relief.

Any pain below your elbow or pins and needles / numbness in your hand is not usually because of your shoulder and will not get resolved.
Patients who smoke will not have similar results. So if you can ***stop smoking completely****, it aids in management.*
After procedure the rehabilitation will include sling for 2-3 days until comfortable but there will be no restrictions to movement. Early movement should be encouraged and gradually progress to rotator cuff strengthening.
Surgery will be offered depending on pre-anaesthetic check-up.