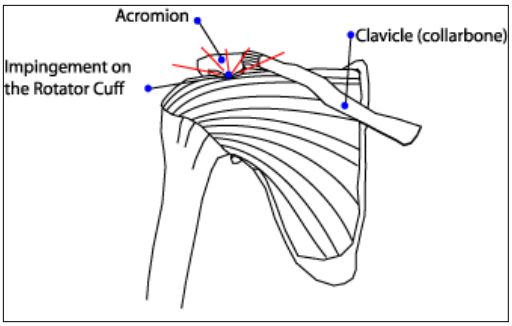
Boston Sports & Shoulder Center

Suzanne L. Miller, MD



IMPINGEMENT OF THE SHOULDER
INFORMATION PACKET

830 Boylston Street, Suite #107, Chestnut Hill, MA 02467 Phone: (617) 264-1100 Fax: (617) 264-1101
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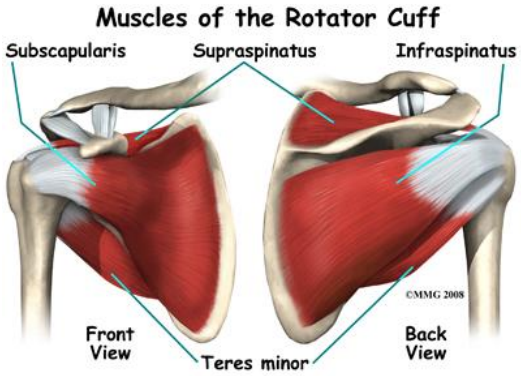
PATIENT INFORMATION SHEET: ROTATOR CUFF

The rotator cuff is made up of four muscles in your shoulder. These four muscles (subscapularis, supraspinatus, infraspinatus and teres minor) connect your humerus to your shoulder blade and acts to stabilize the ball of your shoulder within the shoulder socket. Injury to the rotator cuff may consist of tendonitis, acute tearing or chronic tearing.



Rotator Cuff Tendonitis:

Rotator cuff tendonitis is caused by shoulder overuse or injury. Often overhead activities, overuse or acute injury will cause inflammation and strain of the rotator cuff musculature. This may occur from poor posture or activities such as loading equipment onto the top of a car or repetitive baseball throwing. In addition, trauma to the shoulder such as a fall may cause inflammation of the rotator cuff. Often shoulder "impingement" is a cause or worsening factor of rotator cuff tendonitis. This occurs when the acromion (a portion of a shoulder bone) impinges upon the rotator cuff. The undersurface of the acromion can act like sandpaper and causes rotator cuff irritation. This may in time progress to a rotator cuff tear. Symptoms of rotator cuff tendonitis include pain located primarily on the top and front of the shoulder joint. This pain will often worsen with overhead activity, reaching out to the side, and during sleep. It is also common to experience weakness with shoulder activity.

Rotator tendonitis is often diagnosed by physical examination. X-ray and MRI may be used as adjuncts to diagnosis. The presence of a spur or bump on the undersurface of the acromion may be detected on x-ray. Often an MRI will be used to examine the condition of the rotator cuff and assess whether the rotator cuff is torn. Often rotator cuff tendonitis can be treated without surgical intervention. First line treatment consists of an anti-inflammatory such as ibuprofen, ice and rest. A cortisone injection may be placed into the shoulder region. Cortisone is a strong anti-inflammatory medication that works to decrease inflammation and pain within the rotator cuff and surrounding bursa tissue. Physical therapy may also be utilized for rotator cuff strengthening and pain reduction.

If these treatment measures fail, then your doctor may suggest surgery. Shoulder arthroscopy is the recommended surgical procedure for "impingement". At the time of surgery, your doctor will insert a small camera into your shoulder through a small incision and instruments through another

small incision and decompress or open up the space around the rotator cuff to allow more room for the rotator cuff. At the same time, your rotator cuff will be inspected to be sure there is no significant tearing. If there is no tearing or only partial tearing (typically less than 50% of the width of your rotator cuff tendon), then the decompression alone should provide you with pain relief. If there is significant tearing, then your doctor may elect to repair this rotator cuff tear. Usually this is discussed with you prior to your surgery.

Pre-Surgery:

- On the morning of the surgery you may have your daily pills with a sip of water
- Your surgical time will be confirmed the day before the surgery by either Dr. Miller's office or the surgical center/hospital. The original time may be adjusted based on patient needs and equipment availability. Dr. Miller's office has very little control over the time changes.
- Patients should bring their MRI and X-rays to the surgery
- If the surgery is done at our Waltham facility, the person who is accompanying you is welcome to a free one-day gym pass

Surgery:

The length of an arthroscopic subacromial decompression will take up to 1 hour depending on the extent of damage in your shoulder. Your nurse will bring you into the pre-op area where you will have an IV placed and meet with your anesthesiologist. General anesthesia is utilized to assure a comfortable surgery. This means that you will be "asleep" and completely unaware of the surgery until you wake up in the recovery area. Most patients will have a small tube placed in there windpipe, formal intubation may not be required. Local blocks are also available to supplement pain control. Your anesthesiologist will discuss this with you prior to surgery. Like any surgical procedure, there are risks but fortunately they are rare. These risks include but are not limited to nerve injury, infection and shoulder stiffness, and blood clots.

Post-Surgery:

After the surgery is completed, you will awaken in the operating room with a sling on and you will be moved to the recovery area. Most patients generally recover smoothly and have minimal pain due to local pain medication that is used at the completion of the surgery.

POST-OPERATIVE INSTRUCTION SHEET: SUBACROMIAL DECOMPRESSION

POST-OP MEDICATIONS:

- You will be given a prescription for **pain medication** prior to discharge. This medication may be taken as directed. Once the pain or discomfort is minimal, you may switch to over-the-counter medications, such as Tylenol.
- You should take a **stool softener** while you are taking narcotics. The pain medication can cause significant constipation. Peri-Colace can be purchased over the counter and taken twice daily.

ICE:

- An ice device or an ice bag (not directly touching the skin) should be utilized to reduce swelling and pain. Please ice every 3-4 hours for about 15-20 minutes each time for at least the first 5 days or until swelling subsides.

SLING:

- You will be given a sling. You may wear this sling until you are comfortable enough to discontinue wearing this. Typically, patients use the sling for about 3-5 days, but this varies patient to patient.

PHYSICAL THERAPY:

- You will begin PT usually as soon as possible. Preferably, within 3-7 days after surgery A PT prescription and protocol will be given to you prior to discharge.

WOUND CARE:

- Leave your surgical dressing on for 2 days. After 2 days you may remove your dressing and shower. Dry the incisions well and apply a small dressing or Band-Aid over the incisions.

FOLLOW UP VISIT:

- If you do not already have a follow-up visit scheduled please call 617-264-1100 to schedule one with Dr. Miller within 7-10 days for suture removal.

FREQUENTLY ASKED QUESTIONS: ROTATOR CUFF REPAIR

When do I have to wear the sling and for how long?

Unless your doctor tells you otherwise, you may stop wearing the sling as soon as you are comfortable without it. The sling is given to you for comfort only.

How do I sleep?

Sleeping in a propped or partially sitting position, such as a recliner, is usually more comfortable as your shoulder is elevated.

How long will I need to be in Physical Therapy?

This is variable and depends on the patient. In general, you should expect to be in PT for about 2-3 months. The specific PT program and goals will be per Dr. Miller's protocol. You will be provided with a prescription for PT and you can choose a facility that is a convenient location for you.

When can I drive?

You may not drive while taking narcotic medications or while wearing the sling. After that, you may drive once you feel comfortable enough to hold the steering wheel appropriately.

What signs should I look for that is suggestive of an infection?

Infection is not a common complication after this surgery but if you develop a fever of >102 degrees or if there are signs of spreading redness or increased tenderness around an incision or any drainage (other than blood) through the bandages please contact our office immediately at 617-264-1100.

When will I see the doctor again?

You will be seen 7-10 days after surgery. A follow-up visit should already be scheduled for you. If not, please call our office to schedule this.

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Suzanne L. Miller, MD
Heather Wightman, PA-C

SHOULDER ARTHROSCOPY AND SUBACROMIAL DECOMPRESSION

Patient Name:_____ Date:_____

PHYSICAL THERAPY:

Week 1: Take arm out of sling and move your elbow, wrist, and hand at least 4 times a day. You may discontinue the sling when comfortable.

Weeks 2-4: Start physical therapy; modalities to decrease pain and swelling, active elbow, wrist, and hand exercises. Active assisted ROM can begin as well as passive stretching to regain full ROM and prevent post-op stiffness.

Weeks 5-8: Start strengthening program with therabands, especially rotation to strengthen the subscapularis and infraspinatus and start closed chain exercises for scapula stabilization. Week 6 advance to pulleys and light weights.

Week 8: Sport specific training or work hardening as needed.

FREQ:_____ DURATION:_____

SIGNATURE:_____, MD/PA

ADDITIONAL COMMENTS:_____

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