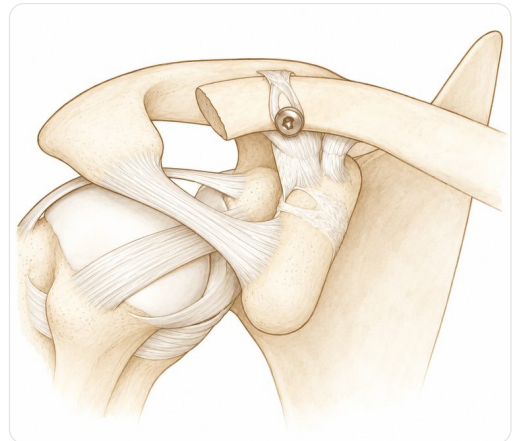


AC Joint Stabilisation

Anatomy of the shoulder. The acromioclavicular joint is the small joint at the top of the shoulder, where the outer end of the collarbone meets a bony shelf on the shoulder blade — the part that gets disrupted in an AC joint injury.

Kieran Hirpara © ⓘ ⓘ 4.0



At-a-glance recovery. Pooled from 45 published studies — your own pace will vary.

LIGHT DUTIES desk work, driving, daily tasks	MOST EVERYDAY ACTIVITIES manual work, sport, gym	FINAL OUTCOME PLATEAU pain and strength
2-6 weeks Return to desk work and light activities typically occurs within 2 to 6 weeks for nonoperative management or early postoperative phase.	4-6 months Full shoulder function and return to activity typically take 4 to 6 months after surgical stabilisation; low-grade (Type I and II) injuries managed without surgery recover much faster.	12-20 months Maximum clinical improvement and return to full contact sports or heavy labor may take 12 to 20 months, with some residual symptoms persisting long-term.

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, matches the treatment to your specific injury. The acromioclavicular joint sits at the outer end of your collarbone, where it meets the top of your shoulder. When this joint is badly torn out of place, we call it a high-grade separation. Surgery to hold the collarbone back in its normal position is called AC joint stabilisation. We usually suggest this operation for severe separations, where the collarbone has moved a long way out of place. Without surgery, these injuries often leave ongoing pain and limited shoulder function. For less severe injuries, we usually start with non-operative care such as a sling and gentle exercises. Most people with mild injuries regain full shoulder function within 4 to 6 weeks this way. Surgery comes into the picture when non-operative care has not given enough improvement, or when the injury is too severe for it to work. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. We will examine your shoulder and arrange scans to work out how severe the injury is. The aim of this operation is to ease pain, restore stability, and help your shoulder work as it should. Whether surgery is right for you is a decision we make together.

Before the operation

In the lead-up to surgery, we will give you clear instructions to follow. You will need to stop eating and drinking seven hours before your operation. We ask for this so your place on the theatre list can be brought forward if the day runs early. If you take regular medications, bring a written list of everything you use, and we will tell you which ones to pause and when. Arrange for someone to drive you home afterwards, as you will not be able to drive yourself. Wear loose, comfortable clothing that is easy to get on and off. We already have the scans of your shoulder, such as X-rays, and possibly an MRI or ultrasound, which we use to plan the operation. If you have other medical conditions, you may need blood tests or a review with the anaesthetist.

On the day

You will arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will then meet the anaesthetist, who will talk you through the plan for your comfort during the operation. This operation is done under general anaesthetic combined with a regional nerve block. The anaesthetist will meet you before the operation and talk you through both parts. Once you are ready, you will be taken into the operating theatre, where the operation is performed. When it is finished, you will wake up in the recovery area, where nurses will monitor you while the anaesthetic wears off. Once you are stable, you will either move to the ward or go home the same day, depending on the procedure and how your recovery is going.

What the operation involves

The operation is done through one cut that follows the outer end of your collarbone, at the top and front of your shoulder. Through this cut, your surgeon reaches the collarbone and the small bony hook of the shoulder blade beneath it, called the coracoid.

The repair is held with a device called the Lockdown. It is a braided synthetic ligament with a loop at each end. Your surgeon passes it around the coracoid and threads it back through itself, then takes it behind the collarbone and fixes it to the front of the bone with a small screw and washer, like a tent peg. This holds the collarbone down in its normal position. Over the following months, your own tissue grows into the braid, so the repair becomes permanent.

The cut is closed with stitches, and a dressing goes over the top. You will keep that dressing on for about 10 days.

After the operation

When you wake up, you will be in the recovery ward, and nurses will keep a close eye on you. Your arm will rest in a simple sling for comfort, which comes off for exercises and washing. You can move your hand, wrist, and elbow straight away, and gentle pendulum exercises start immediately. Most patients stay one night in hospital after this operation, though some are able to go home the same day. We will give you pain relief to keep you

comfortable, and the nursing team will check on you regularly. We leave the dressing on for about 10 days; please do not take it off before then unless we tell you to. We change or remove it when we see you. Please arrange for someone to stay with you for the first 24 hours after you get home. You will not be able to drive for at least six weeks; see our guide on [Driving after upper-limb surgery](#).

Recovery

For the first few days your shoulder will be sore and may look puffy around the incision. This settles steadily. Pain relief keeps you comfortable, and resting your arm in the sling eases the pull on the repair. Ice packs, used as your physiotherapist advises, also help.

You will move your hand, wrist, and elbow straight away, and gentle pendulum exercises begin immediately. Your physiotherapist will guide you through each stage. At first the exercises are gentle and passive, meaning your arm is moved for you. As healing progresses, you start moving the shoulder yourself, then begin strengthening work once your surgeon is happy with how the repair is settling. The sling stays on between exercises and comes off for washing and for your exercise sessions.

Everyday life adjusts around the sling. Sleeping propped up on pillows is often more comfortable early on. You can manage most things at home with your other arm, but you should not lift, push, or reach with the operated arm until your surgeon clears you. Driving waits until your surgeon clears you at your review appointment, and never while you are in a sling; see our guide on [Driving after upper-limb surgery](#).

Recovery varies from person to person. Your timeline may differ, and your surgeon and physiotherapist will guide you at each step.

What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

Sometimes the collarbone can slip partway or fully out of its corrected position. You might notice a bump returning at the top of your shoulder, or a feeling that the joint is loose or shifting when you move. Tell your surgeon at your next review if you notice this.

The repair can also fail in ways that only show on scans rather than in how the shoulder feels. Some of these changes never cause trouble and may not need any treatment at all. Your surgeon will keep an eye on them with check-up X-rays.

Small breaks in the bone around the repair can happen, sometimes weeks or months later. This usually brings sudden pain and tenderness over the collarbone or near the top of the shoulder. Contact the clinic promptly if this happens.

The small screw and washer holding the repair can cause problems, and metal implants used in some techniques can break or shift. A deep, aching pain or a new grinding feeling near the collarbone is worth reporting. Sometimes a further operation is needed to sort out a problem with the hardware.

Infection is uncommon but needs quick attention. Watch for redness spreading out from the wound, increasing swelling, warmth, or oozing. A fever with any of these signs means you should call the clinic straight away, or go to the emergency department after hours.

Nerve irritation can occur. This may feel like tingling, numbness, or weakness in part of the arm. Some nerve irritation settles on its own without treatment. Mention any new numbness or weakness at your review, or sooner if it is severe.

Extra bone can sometimes form in the tissues around the joint as things heal. This may show on scans, and it does not always cause symptoms. If the area feels stiff or achy, bring it up with your surgeon.

When a complication does happen, it can sometimes mean one or more further operations to fix it. Outcomes tend to be better when problems are caught early, so please speak up about anything unusual.

The complications table on this page lists typical rates if you want the specifics.

When to call us

Most problems are picked up early when you speak up. Call us if you have a fever, or if the wound becomes more red, swollen, or starts oozing. Call us if you get sudden severe pain over the collarbone or the top of your shoulder. Go to emergency if your calf becomes swollen or painful, or if you become short of breath. Go to emergency if you lose feeling in your arm or hand, or if you cannot move the arm at all. New numbness, tingling, weakness, or a bump returning at the top of your shoulder also deserve a call, even if they seem minor.

Where to read more about the condition

This page is about the operation itself. The condition it treats, including what the evidence shows about when surgery helps and when it does not, is covered in more detail on the [Acromioclavicular Joint Injury \(Shoulder Separation\)](#) page.

AC Joint Stabilisation

Complication rates from published literature

Pooled from 45 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
loss of reduction	56.0%	Observed in nonoperative management of Type V dislocations, resulting in a Rockwood type 3 state.
reconstruction failure	19.1%	Overall failure rate following primary coracoclavicular reconstruction, ranging from 8% to 52.6% across studies.
posttraumatic osteoarthritis	17%	Higher incidence in operative groups compared to nonoperative for Type III injuries, with some studies reporting up to 66.7% in specific cohorts.
heterotopic ossification	17%	Observed in operative groups for Type III injuries.
implant irritation	16.0%	Tenderness on pressure above the implant, often requiring unplanned removal.
revision surgery	14.3%	Rate of revision ACJ stabilization at minimum 10-year follow-up after arthroscopically-assisted anatomic coracoclavicular reconstruction.
persistent pain	5-8%	Persistent pain or discomfort after surgical stabilisation occurs in 5-8% of patients. The higher figure of 50% applies to non-operatively managed Type I/II injuries.
coracoid fracture	2-3%	Risk associated with coracoid drilling; 2.3% in the largest clinical series (n=43). Higher rates reported in early small studies and cadaveric biomechanical models.
infection	1.9%	Superficial or deep infection rates reported in surgical cohorts.
nerve injury	1%	Rare, including suprascapular nerve or brachial plexus injury.
clavicle fracture	Rare	Reported at 20% in one tunnel-free reconstruction study (n=22); rare with standard tunnel or drill-free techniques.

I have read this information and have had the opportunity to ask Dr Hirpara questions about the procedure, its expected recovery, and the complications listed above.

_____	_____	_____
PATIENT – PRINT NAME	SIGNATURE	DATE