

Anterior Shoulder Stabilisation

In keyhole (arthroscopic) stabilisation, the torn labrum at the front of the socket is repaired through small cuts, guided by a camera.

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At-a-glance recovery. Pooled from 80 published studies — your own pace will vary.

LIGHT DUTIES	MOST EVERYDAY ACTIVITIES	FINAL OUTCOME PLATEAU
desk work, driving, daily tasks	manual work, sport, gym	pain and strength
2-6 weeks	4-6 months	12-24 months
Return to desk work and light daily activities typically occurs within 2 to 6 weeks post-surgery.	Return to sport and full manual work is generally expected between 4 to 6 months, though contact athletes may face higher recurrence risks.	Maximum functional improvement and plateau in patient-reported outcomes are typically observed at 12 to 24 months.

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. 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. At your appointment we take a careful history, examine your shoulder, and arrange imaging if it is needed. Shoulder instability means the joint keeps slipping or coming out of place, usually towards the front. We usually try non-operative care first, such as changing your activities and physiotherapy. Surgery is considered when that has not given enough improvement, or when your shoulder keeps dislocating despite it.

Anterior shoulder stabilisation is an operation that holds the shoulder joint firmly in place so it stops slipping out at the front. It is typically offered to people who have had repeated dislocations, often after a fall or injury with the arm out to the side and turned outwards. Your surgeon may have suggested it because your shoulder

has not settled with other treatment, or because the injury pattern makes further dislocations likely. The aim is a stable shoulder that lets you move, work and play sport without fear of it coming out again.

Before the operation

In the weeks before surgery we arrange any imaging needed to plan the operation, such as X-rays, an MRI or an ultrasound scan. On the day, you will need to stop eating and drinking seven hours before your operation. We ask for seven hours rather than six so your time can be brought forward if the theatre list runs early. Your surgeon will tell you which of your usual medicines to stop and when, so bring a written list of everything you take. 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 put on over your shoulder. 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. 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.

You are then taken into the operating theatre, where the operation is performed. When it is finished, you wake up in the recovery area, where nurses monitor you while the anaesthetic wears off. Once you are stable, you either go to the ward or go home, depending on the procedure and your recovery.

What the operation involves

This is a keyhole operation. Your surgeon makes several small cuts around your shoulder, including one at the back, and works with a small camera inside the joint. The camera shows the damaged tissue on a screen.

The main problem is a ring of cartilage at the front of the socket that has torn away from the bone. Your surgeon reattaches this ring to the bone using small anchors placed into the socket, with stitches holding the tissue down. If a piece of bone has come away with the tissue, that can be repaired through the same cuts. If a dent in the ball of the joint is catching, your surgeon may also fill it by moving a small piece of nearby tissue into the joint.

The cuts are closed with stitches, and a dressing goes over them.

After the operation

Most patients stay one night in hospital after this operation, though some are able to go home the same day. You will wake up in the recovery area, then move to the ward. Nurses will keep your pain comfortable with tablets and adjust them if needed. Your arm rests in a simple sling for comfort, which comes off for exercises

and washing. A nurse will show you gentle movements to start, and you will be up and walking the same day. Please have someone stay with you for the first 24 hours. 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.

Recovery

For the first few days your shoulder will be sore and swollen, and the skin around it may look bruised. This settles gradually. Keeping your hand and elbow moving within what your sling allows helps, and resting your arm on pillows at night can ease the discomfort. Simple pain tablets, taken as directed, usually keep things comfortable.

You will wear a simple sling for comfort. It comes off for your exercises and for washing. A physiotherapist will guide you through gentle movements early on, starting with small pendulum swings and slowly building up as pain allows. Over time the exercises grow to include more active movement, then strength work with resistance. You will do these at home most days, and your physiotherapist will check your progress and adjust the program as you go.

Everyday tasks take some planning at first. You will not drive until your surgeon clears you, typically at the six-week review, and our [driving guide](#) explains this in more detail. Desk work and light daily tasks come back before heavier jobs. Sport, gym work and manual work wait until the shoulder is strong and your surgeon is happy with your movement and stability. Sleeping upright or on your back with pillows supporting the arm is often more comfortable early on, and most people find side sleeping easier as pain settles.

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

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 shoulder can slip or come out of place again, even after a repair that went well. This may happen years later, often after a fall or during sport. If your shoulder dislocates and will not go back in, go to the emergency department. If it slips out and goes back in by itself, call the clinic so we can see you. Bring it up at your next review even if it settles.

Infection is uncommon. Watch the wound for redness that spreads out from it, fluid or pus leaking from it, or a fever. Call the clinic the same day if you notice any of these. Pain that keeps getting worse despite your pain medicines also needs a same-day call.

The shoulder can become stiff after surgery. You might notice tightness that limits lifting your arm, reaching behind your back, or getting dressed. Mention it at your review, as early treatment helps movement return.

Nerves run close to the shoulder, so they can be irritated during surgery. Numbness and weakness in the first 24 hours after a nerve block are expected. Once the block has worn off, about 24 hours after surgery, call the clinic if your arm, hand or fingers stay numb, or if you cannot move them. Most nerve irritation settles on its own over time.

A blood clot is rare but serious. Go to the emergency department if you have swelling or pain in your calf, or shortness of breath or chest pain. These can be signs of a blood clot.

The small anchors and stitches used to hold the repair in place can occasionally cause problems, such as a clicking or grinding feeling, or pain from a piece of metal rubbing. Tell your surgeon at review if you notice this.

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

When to call us

Most problems show up early, and we would rather hear about them than have you worry at home. Call the clinic the same day if you have a fever, spreading redness around the wound, or fluid or pus leaking from it. Call us the same day too if your pain keeps getting worse despite your pain medicines. Go to the emergency department if you have swelling or pain in your calf, or shortness of breath or chest pain, as these can be signs of a blood clot. Once your nerve block has worn off, about 24 hours after surgery, call us if your arm, hand or fingers stay numb or you cannot move them. Numbness and weakness in the first 24 hours are expected. If your shoulder dislocates and will not go back in, go to the emergency department. If it slips out and goes back in by itself, call the clinic so we can see you. If you cannot reach us out of hours or on a weekend, go to your nearest emergency department.

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 [Shoulder Instability](#) page.

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Complication rates from published literature

Pooled from 80 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
Recurrent instability	17.0%	Recurrence of shoulder instability is the most common complication; risk is higher in young patients (under 20-25), contact athletes, those with bone loss, and patients with more than 5 preoperative dislocations.
Failure requiring revision surgery	7.8%	Approximately 2.4-5% of patients require revision shoulder stabilization surgery due to recurrent instability, persistent pain, or other complications.
Nerve compression syndromes	5%	Approximately 5% of patients develop tingling in their hand after surgery, which may be carpal tunnel or cubital tunnel syndrome, with most improving once the arm is out of the sling.
hematoma	1.6%	Postoperative hematoma requiring evacuation or observation.
Loss of range of motion and stiffness	0.32%	Postoperative stiffness is common; minor permanent loss of motion at extremes (typically 5-10 degrees of external rotation) occurs but usually does not cause functional impairment.
Persistent pain or dissatisfaction	0.17%	Some patients experience ongoing shoulder discomfort despite successful stabilization, with pain, functional limitations, or inability to return to previous activity level.
Nerve injury	0.07%	Injury to the axillary nerve is the most common nerve injury, potentially causing shoulder weakness, numbness over the lateral shoulder, and difficulty lifting the arm.
Anchor-related complications	0.05%	Suture anchors may pull out of bone, migrate, irritate the shoulder joint, or damage articular cartilage, potentially requiring repeat surgery.

COMPLICATION	REPORTED RATE	NOTES
Infection	0.03%	Deep infection after arthroscopic shoulder surgery is rare, potentially requiring multiple washouts and suture anchor removal with prolonged intravenous antibiotics.
Chondral injury	Rare	Damage to the articular cartilage of the humeral head or glenoid may occur during anchor placement or from the dislocation itself. Contributes to long-term arthritis risk.
postage stamp fracture	Rare	Small glenoid rim fracture caused by suture anchor placement; typically does not affect stability but may require anchor repositioning.

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