

Distal Clavicle Excision (Mumford Procedure)

The outer end of the collarbone, at the acromioclavicular joint.

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At-a-glance recovery. Pooled from 146 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	3-6 months	12 months
Most patients return to work within 6 weeks; driving resumes from 6 weeks (after any shoulder operation), once cleared at review.	Significant pain reduction and functional improvement are typically observed by 3 to 6 months, with full return to activities often achieved by 6 months.	Maximum improvement in pain and function is typically noted within the first post-operative year.

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. Our assessment, which includes your history, an examination and scans where needed, works out what is causing your pain. For this kind of long-standing joint wear we usually try non-operative care first, such as changing your activities and physiotherapy, and we consider surgery when that has not given enough improvement.

This operation removes a small piece of bone from the outer end of your collarbone, the joint where it meets the top of your shoulder. It is offered to people whose pain comes from wear at that joint, or from the bone breaking down after repeated heavy lifting, and only when the ligaments holding the joint steady are sound. Removing that small piece of bone stops the rough surfaces grinding on each other. The aim is less pain and freer movement of your shoulder, and both keyhole and open forms of this operation bring significant pain reduction at 1 year.

Before the operation

Your surgeon will plan the operation using scans you have already had, such as an X-ray, MRI or ultrasound of the shoulder. These show the joint clearly and help decide how much bone needs to be removed. On the day, stop eating and drinking seven hours before your operation. We ask for seven rather than six so you can be brought forward if the theatre list runs early. Your surgeon will tell you which of your usual medicines to skip and which to take. Bring a written list of everything you take. Arrange for someone to drive you home afterwards. Wear loose, comfortable clothing that is easy to get on and off. If you have other medical conditions, you may need blood tests or a review with the anaesthetist.

On the day

You arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. The anaesthetist will meet you before the operation and talk you through both parts. This operation is done under general anaesthetic combined with a regional nerve block. You are then taken into the operating theatre, where the operation is performed.

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 keyhole surgery. Your surgeon makes a few small cuts around your shoulder, including at least one at the back, and works with a small camera inside the joint. The camera shows the joint on a screen, so no large incision is needed to see it.

Through these small cuts, your surgeon removes about 5 mm of bone from the outer end of your collarbone. This is enough to stop the rough, worn surfaces at the joint grinding on each other. Your surgeon takes care to remove a controlled amount of bone, enough to relieve pain while protecting the ligaments and capsule that keep the joint steady. Protecting these structures matters, because removing too much bone can leave the collarbone unstable.

The small cuts are closed with stitches. A dressing goes over the top, and you keep that dressing on for about 10 days.

After the operation

Most patients stay one night in hospital after this operation, though some are able to go home the same day. Please arrange for someone to stay with you for the first 24 hours after you get home. You will have pain for the first day or two; we will give you medicine to keep it comfortable, and the shoulder may feel numb for a while because of the nerve block. Numbness and weakness in the first 24 hours after a nerve block are expected. Call

the clinic if you cannot feel or move the arm, hand or fingers once the nerve block has worn off, at about 24 hours. Your arm rests in a simple sling for comfort, which comes off for exercises and washing. 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 day or two your shoulder will be sore and may feel swollen. The pain medicine we give you keeps this comfortable, and the numbness from the nerve block helps at first too. Resting with your arm supported and doing your exercises gently usually settles the discomfort. Most people find the soreness eases steadily over the first couple of weeks.

Your arm rests in a simple sling for comfort. You take it off for your exercises and for washing, and your physiotherapist will show you which movements to start with. These begin gently and build up as the pain settles. You can use your hand for light tasks at home, such as eating or writing, once you feel steady. Avoid lifting anything heavy or pushing through pain.

As movement returns, everyday activities get easier. Getting dressed, reaching overhead and sleeping on that side all improve gradually. Sleeping propped up with extra pillows can be more comfortable in the early days. Once your surgeon clears you to drive, typically at the six-week review, you can get back behind the wheel; see [Driving after upper-limb surgery](#) for more detail. Desk work and light daily tasks usually come back within 2 to 6 weeks, and heavier activity such as sport or gym work takes longer, from 3 to 6 months.

Everyone heals at their own pace, so your timeline may differ. Your surgeon and physiotherapist will guide you at each review.

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 pain continues after the operation. This is the most common problem with this surgery. It can happen if slightly too much or too little bone was removed, or if a small piece of bone grows back. If your shoulder still aches the way it did before, or the pain returns after a period of relief, bring it up at your next review. Sometimes a further operation is needed to fix it.

Removing too much bone can cause a different problem. The ligaments and capsule that hold the collarbone steady can be disturbed, leaving the joint loose or unstable. You might notice the collarbone feeling like it shifts or clicks, or a sense that the joint is not secure when you move your arm. If the joint was already loose before surgery, this risk is greater. An unstable joint may need further surgery to rebuild the ligaments. Tell your surgeon at your next review if the joint feels loose or moves in a new way.

Other problems are uncommon but worth knowing about. These include infection, stiffness, fracture, the joint fusing on its own, and a lasting pain condition called complex regional pain syndrome. Infection signs to watch

for are fever, spreading redness around the wound, or fluid or pus leaking from it. 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 to the clinic. The joint coming out of place after keyhole surgery has also been reported. If your shoulder suddenly changes shape, drops forward, or feels very painful and unstable after a knock or fall, contact the clinic straight away.

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 tell us about them. Call the clinic the same day if you have a fever, spreading redness around the wound, or fluid or pus leaking from it. Call the clinic the same day too if 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. These can be signs of a blood clot. Go to the emergency department as well if your fingers or hand turn pale, cold, white, blue or dark. Call the clinic if you cannot feel or move the arm, hand or fingers once the nerve block has worn off, at about 24 hours. If you cannot reach the clinic, go to your nearest emergency department.

Where to read more about the condition

This page is about the operation itself. The two conditions it treats have their own pages, each covering what the evidence shows about when surgery helps and when it does not: wear at the joint is covered on the [AC Joint Osteoarthritis](#) page, and the weightlifter's form, where the end of the collarbone breaks down, on the [Distal Clavicle Osteolysis](#) page.

COMPLICATIONS & CONSENT

Distal Clavicle Excision (Mumford Procedure)

Complication rates from published literature

Pooled from 146 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
persistent pain	26.7%	Persistent acromioclavicular pain after distal clavicle excision; may relate to insufficient or excessive resection, or instability of the remaining joint.
surgical site infection	1.2-1.9%	Superficial infections are the most common, with rates ranging from 1.2% in large database studies to 1.9% in arthroscopic cohorts.
return to operating room	1.0%	Short-term return to the operating room is reported at 1.0% in large database studies.
over-resection	Rare	Excessive bone removal can destabilise the AC joint and cause persistent pain or instability.
under-resection	Rare	Insufficient resection leaves residual impingement and ongoing AC joint pain, potentially requiring revision.
AC joint instability	Rare	May occur if the superior capsule or coracoclavicular ligaments are compromised during resection.
stiffness	Rare	Postoperative shoulder stiffness typically resolves with physiotherapy.

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