

Latarjet Procedure

In a Latarjet operation, a small block of bone is moved to the front of the shoulder socket and held with screws, restoring bone and stopping the ball from slipping out.

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At-a-glance recovery. Pooled from 85 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	5.5-7.4 months	30 months
Return to desk work typically occurs within 2 to 6 months, with 98% of patients returning by 2.7 months.	Clinically significant outcomes are achieved at a median of 5.5 months and average of 7.4 months post-surgery.	Excellent clinical results are maintained at 30 years of follow-up, indicating long-term stability.

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 first visit we take a history, examine your shoulder and arrange imaging if it is needed. For a shoulder that keeps dislocating or slipping out of place, we usually try non-operative care first, such as physiotherapy and changes to your activities. Surgery comes into the conversation when those options have not given you enough improvement.

The operation suggested for you is called a Latarjet procedure. It moves a small piece of bone from another part of your shoulder blade to the front of your shoulder socket, where it helps hold the joint in place. We offer it when your shoulder has come out of joint more than once, or when there is bone damage around the socket. The main aim is lasting stability, so your shoulder stays put and you can use your arm with confidence. With careful selection of who has the operation, it prevents repeat dislocation in about 99% of cases.

Before the operation

In the weeks before surgery we arrange the scans needed to plan your operation. This usually includes X-rays, and sometimes an MRI (a scan that shows soft tissues) or an ultrasound. On the day, you will need to stop eating and drinking seven hours beforehand. We ask for seven hours so we can bring you forward if the theatre list runs early; your surgeon will confirm your exact time. You may be asked to stop some of your usual medications, and we will give you clear instructions about which ones. Bring a list of everything you take. Arrange for someone to drive you home afterwards, and wear loose, comfortable clothing. If you have other medical conditions, you may need blood tests or a review with the anaesthetist (the specialist who keeps you safe and pain-free during the operation).

On the day

You arrive at the hospital's surgical admissions unit, where we check you in and prepare you 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 the operation is finished, you wake up in the recovery area. Nurses stay with you and keep an eye on you while the anaesthetic wears off. Once you are stable, you go to the ward. When you go home, someone must drive you, as you will not be able to drive yourself.

What the operation involves

Your surgeon does this operation as keyhole surgery, also called arthroscopic surgery. A small camera is placed inside your shoulder joint through small cuts around the shoulder, including one at the back. The camera sends a picture of the inside of your joint to a screen, so your surgeon can see and work inside the shoulder without opening it up.

The operation moves a small piece of bone from your shoulder blade, called the coracoid, to the front of your shoulder socket. This piece of bone is held in its new position with screws. It acts as a support that stops your shoulder from slipping out of joint towards the front. Because the transferred bone brings a piece of attached tendon with it, it also adds a brace across the front of the joint.

At the end of the operation, your surgeon closes the small cuts with stitches and covers them with a dressing. You will wake up in the recovery area with your arm supported in a sling.

After the operation

When you wake up, you will be moved to the recovery ward. Nurses will check on you regularly and give you pain relief as you need it. Your arm will rest in a simple sling for comfort, which comes off for exercises and

washing. Most patients stay one or two nights in hospital after this operation. Because you will still be feeling the effects of the anaesthetic, someone should 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. You will be able to walk around on the day of surgery, with help at first.

Recovery

Your shoulder will be sore and swollen for the first few days. This settles gradually over the following weeks. Regular pain relief, rest and ice packs help ease the discomfort. The small cuts around your shoulder heal under the dressing we leave in place for about 10 days.

You will go home with your arm resting in a simple sling for comfort. It comes off for your exercises and for washing. Your physiotherapist will guide you through gentle movements at first, then more active exercises as your shoulder settles. You will be able to walk around from the day of surgery, with help at first. Sleep can be awkward with a sore shoulder; many people find resting propped up more comfortable in the early weeks. Around the house, you will need help with tasks that need both hands, such as dressing and cooking, until your arm is ready.

Progress comes in stages rather than all at once. Once the worst of the swelling settles, everyday movements feel easier. As your range of motion returns, your physiotherapist will add gentle strengthening. Once your surgeon clears you to drive, typically at the six-week review, you can find more detail in our guide on [Driving after upper-limb surgery](#). Returning to work and sport happens in steps, guided by how your shoulder feels and what your surgeon and physio advise.

Recovery varies between individuals. Your timeline may differ, and your surgeon and physiotherapist will guide you along the way.

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 feel loose again after surgery. You might notice the same sense of the joint shifting that led you here. Tell your surgeon at your next review, or call the clinic sooner if it feels like a full dislocation.

The bone graft and the screws holding it can occasionally cause problems. You might feel a click, a catch or a grating deep in the shoulder, or a pain that does not settle the way you expected. Mention this at your review so it can be checked with imaging.

Nerves near the shoulder can be irritated during surgery. This might show as numbness, tingling, weakness or a burning feeling in the shoulder, arm or hand. Most of these settle with time. If you notice new numbness or weakness, let the clinic know so it can be watched closely.

Infection is uncommon but needs quick attention. Watch for a deep, throbbing pain that does not ease with simple painkillers, redness spreading out from the wounds, swelling that keeps growing, or a fever. Some infections stay close to the skin and settle with antibiotic tablets. Others go deeper and need a return to theatre to wash the area out, along with antibiotics through a drip. If you see any of these signs, call the clinic straight away or go to the emergency department.

Pain and stiffness that do not improve can occasionally persist. If your shoulder is not easing as the weeks pass, bring it up at your review so your recovery plan can be adjusted.

Arthritis can develop or worsen in the shoulder many years after this operation, though it is usually mild when it happens. You might notice aching, stiffness or grinding that builds slowly over time. Mention any of these changes at a later review.

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

When to call us

Most problems after this operation show up in ways you can see or feel. Call us if you have a fever, if the skin around your wounds becomes more red or starts leaking fluid, or if pain suddenly gets much worse. Go to emergency if you have swelling in your calf, shortness of breath, new numbness in your arm or hand, or if you cannot move the arm at all. These signs need checking straight away. If you are unsure, call the clinic and we will guide you.

In more depth

This section goes further than you need for your own treatment decisions. The Latarjet is worth the extra reading because it is the clearest trade-off in shoulder surgery: it is the more reliable operation for keeping the shoulder in, and it is the one with more that can go wrong. Deciding between it and a soft-tissue repair means deciding which of those you weight more heavily.

WHAT IT BUYS

Compared directly with arthroscopic Bankart repair, the Latarjet procedure produced a **lower recurrence rate**, better patient-reported outcomes, and a **faster return to sport**, while carrying a **higher incidence of complications** [1]. A long-term comparison of **3,088** patients found the same directional result: lower recurrent instability and lower revision rates after open Latarjet than after arthroscopic Bankart, with **comparable** rates of moderate-to-severe arthritis between the two [2].

That last detail matters, because the standard worry about the Latarjet is that moving bone and tendon across the front of the joint must accelerate arthritis. On this evidence, at long-term follow-up, it did not, the arthritis rates were similar.

WHAT IT COSTS

Pooling **7,175** patients, the overall complication rate after the Latarjet was **6–7%**, with **graft-related** problems the most common category [3]. There was **no significant difference** in complication rate between the open and arthroscopic versions of the operation [3].

Six to seven percent is neither trivial nor alarming, and the composition is the useful part: the complications cluster around the transferred bone, its fixation, its healing, its resorption, rather than around the joint itself. That is intrinsic to what the operation does.

WHY IT IS NOT SIMPLY THE BETTER OPERATION

If the Latarjet has lower recurrence, an obvious question is why anyone has a Bankart repair.

Part of the answer is the complication rate above. The other part is that the soft-tissue options have improved. Across **2,100** patients, adding a remplissage to a Bankart repair reduced instability recurrence compared with isolated Bankart repair **without** a significant external rotation deficit, and may reduce the risk of reoperation compared with Latarjet [4].

So the real decision is three-way rather than two-way, and it turns on your glenoid bone loss, your Hill-Sachs lesion, your sport and your age, not on which operation has the best headline recurrence figure.

DO IT FIRST, IF YOU ARE GOING TO DO IT

One finding deserves emphasis because it affects sequencing rather than technique. Pooling **1,571** patients, **salvage** Latarjet, performed after a failed previous stabilisation – produced **inferior** outcomes to primary Latarjet in terms of recurrent instability and return to pre-injury sport [5].

The Latarjet is often described as the fallback if a Bankart repair fails. This is evidence that it works less well in that role than when chosen first. For a patient with substantial bone loss and high demands, “try the smaller operation and we can always do the Latarjet later” is a plan with a measurable cost attached.

CQ HAND + UPPER LIMB

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Latarjet Procedure

Complication rates from published literature

Pooled from 85 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
Postoperative arthritis	23.5-38.2%	Some patients may develop glenohumeral arthritis years after surgery, particularly with graft malposition, intra-articular placement, or pre-existing cartilage damage.
Persistent pain or dissatisfaction	5-7%	Daily or functionally limiting pain occurs in 5-7% of patients. Mild residual shoulder ache is more common (up to 25%) but typically does not limit activity.
Nerve compression syndromes	5%	Approximately 5% of patients develop tingling in their hand after surgery, which may be carpal tunnel or cubital tunnel syndrome.
Recurrent instability	4.7-8.5%	Despite the Latarjet procedure's excellent stability, recurrent dislocation or subluxation can occur due to graft malposition, nonunion, graft resorption, or unaddressed Hill-Sachs lesions.
Loss of range of motion and stiffness	3.0%	Postoperative stiffness is common; loss of external rotation is expected (average 10-15 degrees) due to the sling effect of the transferred conjoint tendon.
Reoperation rate	2.6-5.1%	Approximately 2.6-9.2% of patients require additional surgery within the first few years, most commonly for hardware removal, recurrent instability, or stiffness.
Subscapularis dysfunction	2-10%	Subscapularis insufficiency ranges from 2% (clinical failure) to 10% (positive lift-off test), depending on split vs peel technique.
Graft resorption	1.6-30.0%	Some degree of coracoid graft resorption occurs in over 90% of Latarjet procedures, with superior resorption common as the body remodels excess bone; extensive resorption may increase recurrence risk.

COMPLICATION	REPORTED RATE	NOTES
Infection	1.5-2.6%	Surgical site infection is higher than arthroscopic procedures due to larger surgical dissection; deep infections may require graft removal and conversion to alternative procedures.
Nonunion or graft malposition	1.3-16.7%	The coracoid bone block may fail to heal to the glenoid in approximately 5-7% of cases, with risk factors including graft malposition, inadequate fixation, and smoking.
Symptomatic hardware	1.0-6.5%	Hardware prominence, irritation, or discomfort requiring screw removal, typically occurring after graft resorption makes the superior screw prominent.
Graft fracture	1.0-6.0%	The coracoid bone graft may fracture during harvesting, transfer, or fixation, potentially requiring alternate fixation techniques or bone grafting from iliac crest.
Vascular injury	1%	Vascular injuries reported at 1% in a systematic review of 2,532 cases; includes axillary artery injury.
Neurological complications	0.6-2.4%	The musculocutaneous nerve and axillary nerve are most at risk; most injuries are transient neurapraxias recovering within 3-6 months, though 8-17% of nerve injuries result in permanent deficits.
Hematoma	0.4-4.4%	Postoperative bleeding or hematoma formation requiring management.

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