

Posterior Shoulder Stabilisation

At-a-glance recovery. Pooled from 48 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
—	4.3-8.6 months	12 months
	Return to sport after arthroscopic posterior shoulder stabilization typically occurs between 4.3 and 8.6 months post-surgery.	Clinically significant improvements in patient-reported outcomes are sustained and plateau by 12 months, with durability confirmed at long-term follow-up.

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 assessment we take a history, examine your shoulder and arrange imaging if it is needed. Posterior shoulder instability means the top of your arm bone slips or feels like it will slip out the back of the shoulder socket. It is an uncommon problem, and it is often missed at first, which can delay the right diagnosis.

For many people we try non-operative care first, such as activity change and physiotherapy. Surgery is considered when that has not given enough improvement, or when your shoulder keeps giving way. We may suggest this operation if your shoulder is painful or unstable despite other treatment, or if the shape of the bone in your socket needs attention. The operation is a keyhole repair that tightens the soft tissues at the back of the shoulder to hold the joint in place. It aims to relieve pain, restore stability and help you return to your usual activities, including sport.

Before the operation

Before your surgery, we will confirm the scans needed to plan your operation. Plain X-rays of the shoulder are often enough on their own. A CT scan gives a clearer picture of the bone in your socket, and an MRI or ultrasound can show the soft tissues such as the labrum and rotator cuff. You will not need every test, only the ones that answer a question about your shoulder.

On the day, stop eating and drinking seven hours before your operation time. We ask for seven hours rather than six so your surgery can be brought forward if the theatre list runs early. Your surgeon will tell you which of your regular medicines to skip. Bring a written 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.

On the day

You arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will meet the anaesthetist, the doctor who puts you to sleep and keeps you comfortable during the operation. This operation is done under general anaesthetic. A regional nerve block is sometimes added for post-operative pain relief; the anaesthetist will discuss this with you on the day.

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

What the operation involves

The most common form of this operation is a keyhole repair. Your surgeon makes two or three small cuts, each about 1 cm, around the shoulder. A thin camera is placed through one cut so the inside of the joint can be seen on a screen. Small instruments go through the other cuts.

Inside the shoulder, the surgeon repairs the ring of cartilage at the rim of the socket where it has torn away, and tightens the loose pouch of tissue that lines the joint. This tightening can be done with a stitching method that folds and holds the slack tissue, and it can sometimes be done through a single small cut. The repair is held with small anchors placed into the bone. The small cuts are closed with stitches and covered with a dressing.

Some people need more than soft tissue repair. If a piece of bone at the back of the socket is worn or missing, your surgeon may add a small block of bone to rebuild the rim and hold the arm bone in place. This can be done as a keyhole procedure using a guiding frame and small buttons to hold the bone block while it heals. In other cases the angle of the socket itself is corrected. Your surgeon will explain which approach suits your shoulder and why.

The position you lie in during the operation, either sitting up slightly or on your side, is chosen by your surgeon for your procedure.

After the operation

You will wake up in the recovery area, where nurses watch over you while the anaesthetic wears off. Your shoulder will be sore, and the nurses will give you medicine to keep you comfortable. Your arm will rest in a sling, which protects the repair while it heals. The small cuts around your shoulder are closed with stitches and covered with a dressing. 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. A nurse will help you get up and moving, usually within a few hours. Please have someone stay with you for the first 24 hours after you get home. Your team will tell you whether you go home the same day or stay one night in hospital.

Recovery

Your shoulder will be sore and swollen for the first days and weeks. This is normal after a keyhole repair. Rest, ice packs and the pain medicine your team prescribes will ease the discomfort. The swelling settles gradually as the tissues heal.

You will wear a sling at first to protect the repair while it heals. Your physiotherapist will guide you through gentle exercises to bring back movement, then strength. At home you can move around, dress yourself and do light tasks with your other hand. You will not lift anything heavy with the sore arm, and you will not push, pull or reach above your head until the repair is ready. Sleeping can be awkward for a while; many people find it easier to sleep propped up in a chair or with pillows behind them.

As the soreness fades and your movement returns, you will do more with the arm. Your physiotherapist will add harder exercises as the shoulder allows. When your surgeon is happy with your progress, you will be cleared to drive again. The rules are simple: no driving while you are in a sling, and you must be able to hold the wheel with both hands and react in an emergency stop, off strong pain medicine. Our guide to [driving after upper-limb surgery](#) explains more.

Returning to sport takes longer than everyday recovery, because the repair needs time to become strong. Your timeline may differ from other people's; your surgeon and physiotherapist will guide you step by 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.

The main concern after this operation is that the shoulder becomes unstable again. You might notice the same slipping or giving-way feeling you had before surgery, or a sense that the joint is about to pop out the back. If this returns, bring it up at your next review. Sometimes a further operation is needed to hold the joint in place.

If a block of bone was added to rebuild your socket, a few things can occasionally go wrong as it heals. The bone block might not join to your own bone, or the small screws holding it can bend or break. You could feel a sharp catch, new clicking or grinding, or pain deep in the shoulder that does not settle. The block can also shrink or

wear away over time, leaving the metal prominent, and the joint can slowly develop wear-and-tear arthritis. Tell your surgeon about any of these changes so they can check the shoulder with scans.

The nerves around the shoulder sit close to the area where a bone block is placed. If a nerve is irritated during surgery, you might notice numbness, tingling or weakness in the arm, or trouble lifting the wrist and fingers. Most nerve irritation settles on its own, but report it straight away rather than waiting for your review.

A bone block repair can also leave the shoulder stiffer than before. You might find it harder to reach behind your back or lift your arm out to the side. Your physiotherapist will work on this with you, but mention it if movement is not improving.

Some patterns of instability, where the shoulder slips during certain movements without a clear injury, do not respond well to surgery. If that sounds like your shoulder, your surgeon will discuss this with you before any operation.

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 us if you have a fever, if the wound becomes more red or starts to leak fluid, or if your pain suddenly gets much worse. Call us about numbness, tingling or weakness in the arm, or if you cannot move it. Go to emergency if your calf is swollen or painful, or if you become short of breath. If your shoulder feels like it is slipping out the back again, let us know rather than waiting for your next review.

In more depth

This section goes further than you need for your own treatment decisions. Posterior shoulder instability is worth the extra reading because it behaves differently from the anterior version most people have heard of, and the difference runs in the direction you would not guess.

POSTERIOR IS THE MORE STABLE REPAIR, AND THE HARDER RETURN

A meta-analysis comparing anterior with posterior instability after arthroscopic repair found that patients with **anterior** instability had **higher return-to-sport rates** but were **more likely** to have postoperative instability [1]. Posterior patients were the reverse: the repair held better, but fewer got back to their sport [1].

That is worth sitting with, because it separates two things patients tend to fuse together. “Will my shoulder stay in?” and “will I get back to what I did?” have different answers here, and the second is the harder one.

The underlying results for the operation itself are good. A systematic review of **2,307** arthroscopic posterior stabilisations reported good outcomes with high patient satisfaction and low rates of recurrent instability, revision and residual pain [2]. A separate review of **1,047** athletes found high rates of return to sport, and relatively high rates of return to the pre-injury level [3]. Both findings can be true at once, posterior stabilisation is a reliable operation, and it is still a harder road back than its anterior counterpart.

CQ HAND + UPPER LIMB

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WHAT PREDICTS FAILURE

The most useful recent work is about who does badly. A systematic review of **960** patients identified three risk factors for failure or revision after arthroscopic posterior capsulolabral repair: **female sex**, **reduced glenoid bone width**, and preoperative **glenoid bone loss greater than 11% to 15%** [4].

Equally informative is what did *not* predict failure: glenoid version, type of sport, labral width and labral version showed no significant effect [4]. Version in particular is often discussed as though it were decisive, and on this evidence it is not.

The practical consequence is that the glenoid bone stock deserves proper assessment before surgery. Beyond roughly the 11–15% mark, a soft-tissue repair alone is working against mechanics it cannot fix, and that is the conversation to have before the operation rather than after a failure.

WHY IT GETS MISSED

Posterior instability rarely presents as a dislocation. It is more often pain with a loaded, flexed arm, a bench press, a push-up, a hand pushing off a chair, with no history of the shoulder visibly coming out. That presentation invites the label of impingement or tendinopathy, and the diagnosis is frequently made late.

If you have pain pushing through a flexed arm and it has not responded to treatment aimed at the rotator cuff, posterior instability is worth specifically excluding.

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Posterior Shoulder Stabilisation

Complication rates from published literature

Pooled from 48 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	7.4%	Reported in a systematic review of 2307 shoulders undergoing arthroscopic stabilization; risk is higher with glenoid bone loss.
revision surgery	5.2%	Overall revision rate in a systematic review of 2307 shoulders; long-term studies suggest rates may increase over 10 years.
stiffness requiring intervention	—	Postoperative stiffness is a known complication, sometimes requiring capsular release or manipulation under anesthesia; reported in tennis players and military cohorts.
hardware complications	11.1%	Most common complication in bone block augmentation procedures, including symptomatic hardware, screw breakage, or migration.
graft complications	2.75%	Includes graft non-union, resorption, or lysis, particularly in bone block augmentation for posterior instability.
residual pain	16.6%	Reported in 99 of 598 shoulders in a systematic review; can persist despite stable shoulder.
infection (superficial)	0.5%	Rare complication in bone block procedures, typically resolved with antibiotics.
nerve injury	0.5%	Risk to musculocutaneous, axillary, or suprascapular nerves during glenoid bone augmentation; lateral femoral cutaneous nerve injury possible during graft harvest.
osteoarthritis	33.0%	Radiographic degenerative changes reported in long-term follow-up of bone block procedures; may be related to recurrent instability or natural aging.
pneumothorax	0.5%	Rare complication during bone block harvest or placement, treated with intercostal drain.

COMPLICATION	REPORTED RATE	NOTES
hematoma	0.5%	Reported as a minor complication in bone block procedures.
suture reaction	—	Reaction to intraarticular suture material may require reoperation for removal once healing is adequate.

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