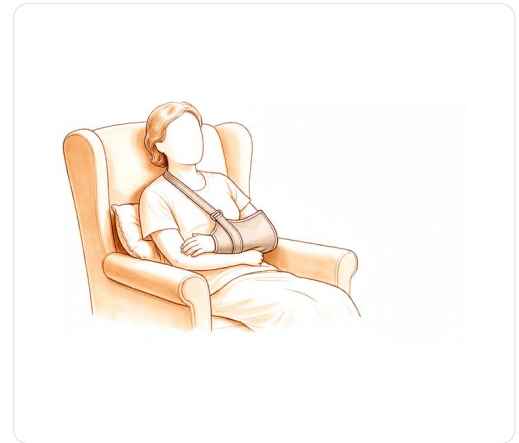


Shoulder Arthroplasty for Acute Proximal Humerus Fracture



Treatment of a complex shoulder fracture with a replacement.

Kieran Hirpara © ⓘ 4.0

At-a-glance recovery. Pooled from 80 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
6-12 weeks Most people can go back to desk work from about 6 weeks, once the sling is off. Driving is not allowed for at least 6 weeks after any shoulder operation, on either side. In a study of shoulder fracture surgery, people who had this operation drove again after an average of about five months.	4-12 months Lighter sport such as swimming and golf often starts again at 4 to 6 months. Heavier or manual work can take up to 12 months, and very heavy lifting is best avoided long term.	12-24 months Pain relief and functional plateau are typically achieved by 12 to 24 months, with long-term outcomes stabilizing after this period.

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. We start with the least invasive options that suit your condition. For many shoulder fractures this means rest, a sling and physiotherapy first. Most fractures of this type heal without surgery, and more than 90% join well with non-operative care. But some fractures are badly displaced, meaning the broken pieces have moved apart. In these cases, especially in older patients, surgery may be recommended straight away.

This operation is a shoulder replacement designed for fractures. The rounded top of your arm bone is removed and replaced with an artificial joint. It is typically offered to older patients with complex fractures where the broken pieces cannot be reliably held together. Waiting and trying non-operative care first can lead to worse function and more complications, so we may advise operating soon after the injury. The main aim is dependable pain relief. Improving how much you can move and use your arm is a further goal, though results there vary more from person to person. We will discuss all of this with you and decide together.

Before the operation

Before surgery, you will need some scans so we can plan the operation. X-rays of your shoulder come first. Sometimes an MRI (a scan that shows soft tissues such as tendons) or an ultrasound is added. We will tell you exactly which scans you need. On the day, stop eating and drinking seven hours before your operation time. We ask for seven hours rather than six so we can bring you forward if the theatre list runs early. Your surgeon will tell you which of your usual medicines to stop and when. 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 will 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. Afterwards, you will wake up in the recovery area, where nurses monitor you while the anaesthetic wears off. Once you are stable, you will go to the ward.

What the operation involves

This is a shoulder replacement designed for fractures. Your surgeon makes a single cut over the area being operated on and works through it to reach the broken shoulder joint. The rounded top of your arm bone, which is the broken piece, is removed. In its place goes an artificial joint made of metal and plastic, a bit like capping a broken stick with a smooth new ball.

The surgeon then rebuilds the parts around the new joint. The lumps of bone near the top of your arm bone, where your shoulder tendons attach, are brought back into position and held to the implant with strong stitches. Getting these pieces back in place and healed matters, because they carry the tendons that move your arm. The surgeon also balances the soft tissues around the joint and sets the new parts so the arm sits at its natural length and angle.

Once everything is in place, the wound is closed. A fine, self-adhesive mesh is laid over the closed wound first, holding the skin edges together. A liquid skin glue is then painted over the mesh, where it sets to seal the whole

thing. This stays on for roughly one to two weeks and then lifts and peels away by itself, so there is nothing to be taken out.

After the operation

When you wake up, you will be in the recovery area, and nurses will keep a close eye on you as the anaesthetic wears off. Most patients stay one or two nights in hospital after this operation. Your shoulder will be sore at first, and we will give you medicine to keep you comfortable. Your arm will rest 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. A nurse will help you get up and moving soon after surgery. Please arrange for someone to stay with you for the first 24 hours after you go home.

Recovery

Your shoulder will be sore and swollen in the first days after surgery. This is normal and settles gradually. Ice packs, rest and your pain medicine help ease the discomfort. The nerve block from theatre wears off over the first day, so take your medicine before the pain builds.

Your arm rests in a simple sling for comfort. It comes off for exercises and washing. Your physiotherapist will guide you through gentle movements early on, and these exercises matter more than anything else you do. Keep them up even when progress feels slow. You can walk around the house from day one, but you will need help with meals, dressing and shopping at first. Sleeping propped up in a chair or with extra pillows is often more comfortable in the early weeks.

Milestones come as events, not dates. When the swelling settles, everyday tasks get easier. As your movement returns, you will reach further and lift a little more. Once your surgeon clears you to drive, typically at the six-week review, you can get back on the road; see [Driving after upper-limb surgery](#). Full recovery takes time, and steady effort with your exercises gives you the best chance of a good result.

Everyone heals at their own pace. Your timeline may differ, and your surgeon and physio 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.

Infection is the most serious problem to watch for. It can show up as a deep, throbbing pain that does not ease with simple painkillers, redness spreading out from the wound, or a fever. Tell us straight away if you notice any of these signs. A deep infection needs prompt treatment, so do not wait for your next appointment.

The new joint can sometimes come out of place. You would feel a sudden clunk, followed by pain and an arm that will not move normally. If this happens, contact the clinic urgently or go to the emergency department.

The artificial parts can loosen over time. This usually builds gradually rather than suddenly. You might notice pain returning after a period of improvement, along with a clicking or grinding feeling in the shoulder. Bring this up at your next review, where scans can check the joint.

The bone around the implant can break. This may follow a fall or a knock, and it feels like a new injury with sudden pain and swelling. Go to the emergency department if this happens.

Nerve injury around the shoulder is a known risk of this operation. It can cause numbness, tingling or weakness in the arm. Most nerve irritation settles on its own, but tell your surgeon at review if it does not.

Stiffness and ongoing pain can develop after surgery. The shoulder feels tight and movement stays limited despite your exercises. Mention this at your review so your physiotherapy plan can be adjusted.

The bone fragments around the implant can sometimes fail to heal, or heal in a shifted position. This can leave the shoulder weaker or less steady than expected. Your surgeon will pick this up on your follow-up scans and discuss options with you.

Some patients need a further operation later, sometimes years down the track. Reasons include loosening, dislocation, infection or wear of the joint surfaces. Revision surgery is more complex than the first operation and recovery can be slower.

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

When to call us

Most problems show early signs, and we would rather hear from you than have you wait. Call us if you have a fever, if the skin around your wound becomes more red or starts leaking fluid, or if your pain keeps getting worse instead of easing. Go to emergency if you suddenly cannot feel or move your arm, if you have swelling or pain in your calf, or if you become short of breath. These can signal a blood clot. Sudden severe pain after a fall or a knock also needs urgent care.

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 [Proximal Humerus Fracture](#) page.

Shoulder Arthroplasty for Acute Proximal Humerus Fracture

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
tuberosity nonunion	9.6-36.8%	High variability reported; rates range from 9.6% in meta-analyses to 36.8% in specific systematic reviews of RSA.
acromial fracture	4-9.4%	Stress fractures of the acromion or scapular spine reported in 4% to 9.4% of RSA cases.
revision surgery	3.4-15%	Revision rates vary from 3.4% to 15%, often driven by instability, infection, or loosening.
pulmonary embolism	1.7%	Rare but serious complication; reported at 1.7% in one systematic review.
infection (deep)	1.6-6.8%	Deep infection rates vary by study, with some reporting as low as 1.6% and others up to 6.8% in RSA cohorts.
periprosthetic fracture	1.6-11.9%	Includes intraoperative and postoperative fractures; rates vary by study and fixation method.
hematoma	1.6-13.5%	Postoperative hematoma rates range from 1.6% to 13.5%, sometimes requiring drainage.
instability/dislocation	1.5-10.2%	Instability rates range from 1.5% to 10.2%, often requiring revision surgery.
nerve injury	0.64-1.3%	Overall nerve injury rate is approximately 1.3%, with axillary nerve injury being the most common specific type.
scapular notching	0-40%	Wide range reported (0-40%) depending on implant design and follow-up duration; common in RSA.
glenoid loosening	0-19%	Loosening rates vary widely; up to 19% reported in older aTSA studies, lower in RSA.

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