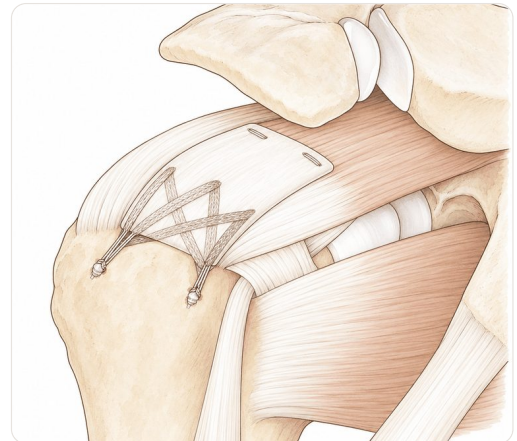


Revision rotator cuff repair

A re-torn rotator cuff, treated with a revision repair.

Kieran Hirpara © ⓘ ⓘ 4.0



At-a-glance recovery. Pooled from 45 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 Return to light activities and desk work typically occurs within 2 to 6 weeks, though pain may persist during the middle portion of recovery.	6-12 months Functional recovery reaches approximately 75% by 6 months, with maximum recovery plateauing at 1 year.	12-24 months Pain and function continue to improve up to 5 years, though outcomes remain inferior to primary repair, with re-tear risks persisting up to 2 years.

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 history, examine your shoulder, and arrange imaging where needed. For a long-standing problem we usually try non-operative care first, such as activity change, physiotherapy or injections. Surgery comes into the picture when those steps have not given you enough improvement.

A revision rotator cuff repair is a second operation to re-repair a shoulder tendon that tore again or never healed after an earlier repair. We suggest it when pain, night pain, weakness, or stiffness continue despite that earlier treatment. Scans such as an ultrasound or MRI help us check the tendon and the muscle around it before deciding. The operation aims to ease your pain and improve how your shoulder moves and works. Many people

keep that improvement at 5 years after surgery. We will talk through the benefits and the risks with you, and the decision is one you make together with us.

Before the operation

Before surgery we arrange scans to plan the operation. These may include X-rays, an ultrasound, or an MRI (a scan that shows the soft tissues around your shoulder in detail). On the day of your operation, you will need to stop eating and drinking seven hours beforehand. We ask for seven hours so we can bring your surgery forward if the theatre list runs early; your surgeon will confirm your exact time. If you take regular medicines, bring a list of them and we will tell you which ones to pause. 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 and take off. If you have other medical conditions, you may need blood tests or a review with the anaesthetist (the specialist who gives your anaesthetic).

On the day

You arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will then meet the anaesthetist. This operation is done under general anaesthetic combined with a regional nerve block. You will be fully asleep for the operation, and the block (an injection that numbs the nerves supplying the arm before you wake up) provides pain relief for the first 12 to 24 hours after surgery. 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

A revision rotator cuff repair is done through keyhole surgery. Your surgeon makes a few small cuts around your shoulder, including one at the back, and works with a small camera inside the joint. The camera shows the torn tendon and the bone it tore away from.

The usual plan is to reattach the tendon with small anchors placed into the bone. These anchors hold stitches that pass through the tendon. Anchors are placed in two rows: one row closer to the joint, and a second row further out that pulls the tendon down firmly against the bone where it needs to heal. Depending on what your surgeon finds during the operation, they may use a single row of anchors instead, or a different type of anchor closer to the joint.

A soft patch made from biological tissue is often placed under the tendon at the repair site to encourage it to heal back onto the bone. You can read more about this in our page on the [EnFix biological scaffold](#).

If the bone where the tendon attaches has worn away, your surgeon may add a small amount of bone graft to rebuild it, so the anchors have something solid to grip. If the tendon is too damaged to reattach, other options such as using a donor tendon to bridge the gap may be discussed with you before or during your care.

The cuts are closed with stitches, and a dressing is placed over the wounds. 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. You will wake up in the recovery area, then move to the ward. Nurses will check on you and give you pain relief as you need it. The nerve block from theatre often keeps the shoulder comfortable for the first 12 to 24 hours, so you may notice little pain at first. Your arm will rest in a simple sling for comfort. You can take it off for washing and for the exercises we show you. 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 sit up, stand, and walk a short distance, usually within a few hours of waking. Please arrange for someone to stay with you for the first 24 hours after you go home.

Recovery

The first days after surgery are about rest and comfort. The nerve block wears off within a day or so, and the shoulder may then ache more than before. Swelling and bruising around the shoulder and upper arm are normal and settle over the following weeks. Ice packs, rest, and the pain relief we prescribe all help ease this. Many people find sleeping upright in a chair or propped on pillows more comfortable at first, as lying flat can put pressure on the shoulder.

Your arm rests in a simple sling for comfort. You take it off for washing and for the exercises your physiotherapist shows you. These exercises start gently, with small movements to keep the shoulder from stiffening while the tendon heals. Over time the movements grow bigger and stronger, always guided by your physiotherapist and your own comfort. Day to day, you can walk, move around the house, and use your other arm freely. You will need help with heavier tasks such as lifting, carrying, and reaching overhead until your shoulder is ready.

Once the swelling settles and movement returns, everyday activities become easier. Dressing, washing, and light household tasks come back first. Driving waits until your surgeon clears you at your review, typically around the six-week mark; see our guide on [Driving after upper-limb surgery](#) for details. Work and sport come back in stages, once your surgeon and physiotherapist agree the tendon has healed well enough.

Recovery varies from person to person. 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.

The main thing we watch for is the tendon tearing again. This can feel like pain that returns after it had started to settle, along with weakness when you lift or reach. Most tears that happen again do so within the first six months, so we keep a close eye on your shoulder during that time. If your pain or weakness comes back, tell us early rather than waiting for your next review.

Infection is uncommon but needs quick attention. See your GP or go to the emergency department if you notice a deep, throbbing pain that does not ease with simple painkillers, redness spreading out from the wound, fever, or a shoulder that feels hot. Sometimes a repair that has failed can be linked to a low-grade infection that is hard to see. Severe shoulder pain or stiffness that will not settle should always lead to a check for infection, so mention it to us.

Not every revision reaches the goal of a pain-free, strong shoulder. Some people find their movement does not improve as much as they hoped, or that stiffness and weakness stay. If the tendon tissue is thin, the tear is large, or arthritis has set in, the result may be less than either of us wants. We will talk honestly with you about what your scans show before you decide.

There are also things that raise the risk of the repair failing. Certain antibiotics taken early after surgery have been linked to repairs failing and needing a second operation. If you are prescribed any new medicine in the weeks after your repair, it is worth checking with us or your GP first. Cholesterol problems in your blood can also affect how well the tendon heals, so we take your general health into account when we talk about what to expect.

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

When to call us

Call us if you notice a fever, redness spreading from the wound, discharge from the wound, or pain that keeps getting worse. Tell us early if pain or weakness returns after it had started to settle, or if your recovery milestones slip backwards. Go to emergency if you have sudden severe pain, calf swelling, shortness of breath, loss of feeling in your arm, or you cannot move your arm. Most tears that happen again do so within the first six months, so we keep a close eye on your shoulder during that time.

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 [Rotator Cuff Disorders](#) page.

Revision rotator cuff repair

Complication rates from published literature

Pooled from 45 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
re-tear	32.6-55.5%	Structural failure rates vary widely by study, with some cohorts reporting up to 55.5% re-tear rates at 2 years.
revision surgery	10.0-37.0%	Reoperation rates vary significantly, with some studies reporting up to 37% requiring further surgery.
stiffness	5.0-10.0%	Persistent stiffness is a common complication, occurring in 5% to 10% of patients.
infection	2.1-5.0%	Clinical infection rates range from 2.1% to 5.0%, though subclinical infection rates may be as high as 28.9%.
nerve injury	1.1%	Neurologic injury is a rare but documented complication.
foreign body reaction	Rare	Reactions to bioabsorbable materials or loose suture anchors can occur.

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