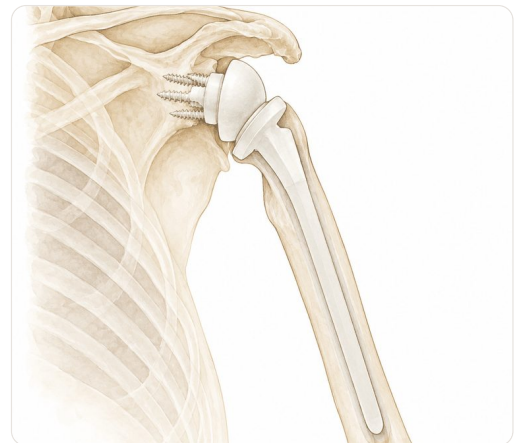


Revision Shoulder Replacement

A revision shoulder replacement. A long-stem implant bypasses bone weakened by the previous components and anchors the new joint in healthy bone further down the arm.

Kieran Hirpara © ⓘ 4.0



At-a-glance recovery. Pooled from 45 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 weeks	12 months	12 months
Very low pain scores are typically achieved within 2 weeks for the majority of patients.	Functional recovery peaks at 12 months postoperatively following shoulder arthroplasty.	Improvement usually continues through the first year after surgery.

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 where it is needed. For long-standing problems we usually try non-operative care first, such as activity change, physiotherapy, or splinting, and we consider surgery when that has not given enough improvement.

A revision shoulder replacement is a second operation that replaces some or all of the parts of an earlier shoulder replacement. We suggest it when the first replacement is no longer working well, most often because the parts have worked loose, the joint has become unstable, or the socket has worn. Severe pain and stiffness are the main reasons people come to us for this operation. The aim is less pain, better movement, and a steadier shoulder. Revision reverse shoulder replacement has an implant survival rate of 85% at ten years. We will talk through what this operation can and cannot do for you, and decide together whether it is right for you.

Before the operation

Your shoulder will need imaging so we can plan the operation. Plain X-rays from a few angles are usually enough. Sometimes an MRI (a scan that shows soft tissues) or an ultrasound is added. Before the day of surgery, you will get clear instructions from our team. You will need to stop eating and drinking for seven hours beforehand. We ask for seven hours rather than the usual six so you can be brought forward if the theatre list runs early. Bring a written list of all your current medicines, as some may need to be paused. Arrange for someone to drive you home. Wear loose, comfortable clothing. If you have other medical conditions, you may need blood tests or a review with the anaesthetist (the specialist who gives the anaesthetic).

On the day

You will 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. 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 will wake up in the recovery area. Nurses will monitor you there while the anaesthetic wears off. Once you are stable, you will move to the ward.

What the operation involves

A revision shoulder replacement is an open operation done through a single cut over the area being operated on. Your surgeon works through this one incision to reach the joint.

The exact steps depend on why the first replacement failed. Your surgeon may remove some or all of the worn or loose parts and replace them with new metal and plastic surfaces. If the socket bone has worn away, a small bone graft (a piece of bone used to rebuild a missing area) can be packed in so a new socket part can be fitted. Whenever possible, your surgeon will try to fit a new socket component rather than leave it out. If the joint has been unstable, your surgeon may change the design of the replacement to a reverse one, where the ball and socket positions are swapped to make the joint steadier. Sometimes the old cement around the arm-side part is kept and new cement is placed inside it, rather than removing every trace.

Once the new parts are in place and checked, the wound is closed. A fine self-adhesive mesh is laid over the closed wound first, holding the skin edges together. A liquid skin adhesive 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

You will wake up in the recovery area with nurses watching over you. Once you are steady, you will move to the ward. Most patients stay one or two nights in hospital after this operation. Pain relief is tailored to you, and the nerve block from theatre often keeps the shoulder comfortable at first. Your arm will rest in a simple sling for comfort; it 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 physiotherapist may visit to start gentle movements. Please arrange for someone to stay with you for the first 24 hours after you go home.

Recovery

The first days are about rest and comfort. Your shoulder will be sore and swollen, and the nerve block from theatre often keeps it quiet at first. As that wears off, you will feel more of the ache. Pain relief tailored to you, rest, and gentle movement all help. The swelling settles gradually over the early weeks.

Your arm rests in a simple sling for comfort. It comes off for exercises and washing. A physiotherapist will guide you through gentle movements early on, then build up your strength and range of motion as your shoulder allows. Around the house, you will need help with heavier tasks at first, but light use of your arm returns steadily. Sleeping upright or propped on pillows is often more comfortable in the early days.

Recovery happens in stages rather than all at once. Once your surgeon clears you to drive, typically at the six-week review, you can get back on the road; see our guide on [driving after upper-limb surgery](#). As movement returns, everyday tasks like dressing and cooking become easier. When your shoulder is strong enough, most people get back to work and many return to a sport or activity they enjoy. Many people notice their shoulder keeps improving over the first year.

Your timeline may differ from someone else's. Your surgeon and physiotherapist will guide you at each review and adjust the plan to suit how your shoulder is healing.

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 new parts work loose or the joint becomes unstable. You might feel a return of the pain you had before, or a new ache that was not there after the operation. Some people notice a clicking, grinding, or clunking feeling, or a sense that the shoulder is shifting out of place. If this happens, bring it up at your next review, or call the clinic sooner if the pain is getting worse.

Infection is a risk with any replacement surgery. Watch for a deep, throbbing pain that does not ease with simple painkillers, redness that spreads out from the wound, warmth over the shoulder, or a fever. If you notice any of these, call the clinic straight away. If you feel unwell with a fever or the redness is spreading quickly, go to the emergency department.

Sometimes a break can happen in the bone around the new parts, most often picked up on early X-rays after the operation. You would feel sudden sharp pain, worse than the usual postoperative ache, sometimes with a crack or give. Tell your surgeon or the clinic if this happens.

Some health conditions and circumstances raise the chance of problems. These include Parkinson disease, poor nutrition before surgery, a fragility fracture (a break from a minor fall) before the operation, previous shoulder surgery, inflammatory arthritis (arthritis caused by an overactive immune system), needing blood-thinning medicine after surgery, and having both shoulders operated on close together. If any of these apply to you, we will factor them into the plan and watch you more closely.

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

When to call us

Call the clinic if you have a fever, increasing redness or discharge from the wound, or pain that keeps getting worse. Go to the emergency department if you feel suddenly short of breath, have swelling or pain in your calf, or your shoulder pain becomes sudden and severe. Call us straight away if you lose feeling in your arm or hand, or you cannot move it. If in doubt, call us. We would rather hear from you early.

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 [Shoulder Arthritis](#) page.

Revision Shoulder Replacement

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
Heterotopic ossification	28.0%	High rates of HO are reported, though only 2.0% require revision surgery.
Hematoma	15.0%	Hematoma is reported as a significant complication in revision rTSA cohorts.
Reoperation rate	11.0-41.2%	Common indications include instability, infection, loosening, fracture, and persistent pain; each subsequent revision has progressively worse outcomes.
Stiffness or reduced range of motion	10-20%	Common due to extensive soft tissue releases and scarring; functional gains are limited compared to primary surgery.
Scapular notching or stress fracture	5-36%	Scapular notching rates vary widely (5-77%) depending on implant design; scapular spine stress fractures occur in ~5%.
Iatrogenic humeral fracture	3.5-40%	Accounts for 40% of intraoperative complications, occurring during implant removal or insertion; requires cerclage wiring, plates, or long stems.
Periprosthetic fracture	2.0-18.0%	Includes humerus, glenoid, scapular spine, or acromion fractures; treatment ranges from conservative to surgical fixation.
Nerve injury	2.0-9.0%	Axillary nerve most common (deltoid weakness, lateral shoulder numbness), caused by traction, direct trauma, or cement extravasation; most recover over 3-6 months but permanent deficit is possible.
Baseplate failure	1.7-9.2%	Baseplate failure rates are significantly higher in revision arthroplasty compared to primary.
Persistent pain	1-3%	Persistent pain despite successful revision reported in 1-3%; may relate to nerve injury, scarring, or altered biomechanics.
Wound complications	1-8%	Wound complications including dehiscence and delayed healing; elevated in patients on therapeutic anticoagulation.

COMPLICATION	REPORTED RATE	NOTES
Instability or dislocation	0.9-22.0%	Most common complication (26% of all complications), caused by inadequate soft tissue tension, component malposition, or abductor insufficiency.
Infection	0.5-3.9%	Significantly higher than primary surgery (0.5-3%); <i>Propionibacterium acnes</i> is common but difficult to diagnose; treatment includes debridement, staged revision, or permanent implant removal.
Glenoid component loosening	0.3-6.0%	Presents with pain and component migration, requiring revision with bone grafting or larger baseplates.
Vascular injury	0.1%	Rare but serious, more common during scar dissection or infection revision, requiring immediate vascular surgery.

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