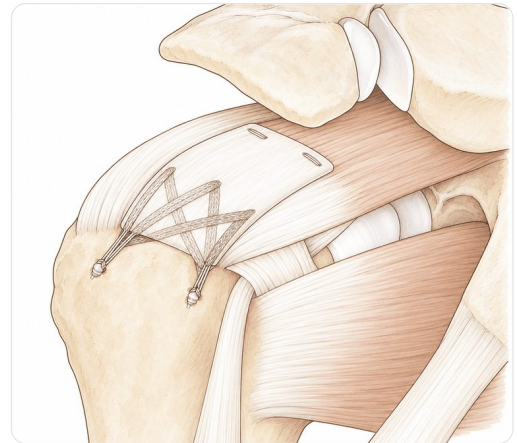


Rotator Cuff Repair

A torn supraspinatus tendon — the most common rotator cuff tear pattern. The repair operation re-attaches the torn tendon back onto the upper arm bone using small anchors.

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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 Many people return to desk work from about 6 weeks. Jobs that use the arm more can take 12 weeks, and some people need longer. You must not drive for at least 6 weeks, or while you still need the sling.	4-9 months Gym work and non-contact sport usually restart at 4 to 6 months, and heavy manual work at about 5 to 8 months. Overhead and contact sport can take 9 to 12 months, and larger tears need more time.	12 months The plateau of maximum recovery occurs at 1 year, with patient-reported outcomes degrading after this point.

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. We assess your history, examine your shoulder, and arrange imaging where it is needed to work out what is wrong.

Rotator cuff repair is an operation that reattaches a torn shoulder tendon to the bone of your upper arm. A rotator cuff is the group of tendons that holds and moves your shoulder. We usually suggest this operation when the tear is causing pain that wakes you at night, pain with lifting or overhead activity, or weakness that has not settled with non-operative care such as activity change and physiotherapy. For long-standing wear-and-tear tears we try those options first. For a tear caused by a clear injury, surgery may be recommended straight away.

The aim is lasting relief of pain and better strength and movement in your shoulder. Surgical repair offers a higher probability of substantial improvement for painful tears over the long term, and we will weigh this up with you as a shared decision.

Before the operation

We will need imaging to plan your repair. This usually includes an X-ray, and often an MRI or ultrasound scan of your shoulder. These scans show the size of the tear, how far the tendon has pulled back, and the state of the muscle. In the days before surgery, follow the instructions our team gives you. Stop taking certain medications only if we tell you to, as your surgeon will give you specifics. Bring a written list of everything you take, including tablets, drops and creams. 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 over your shoulder. Do not eat or drink for seven hours before your operation. We ask for seven hours so your surgery time can be brought forward if the theatre list runs early. If you have other medical conditions, you may need blood tests or a review with the anaesthetist before the day.

On the day

On the day of your operation, you will arrive at the hospital's surgical admissions unit. You will be checked in there and prepared for theatre. You will not go to a ward first.

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 will then be 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 either move to a ward or go home, depending on the procedure and how your recovery is going.

What the operation involves

This is a keyhole operation. 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 gives a clear view of the tear from several angles, so the whole joint can be checked and the tear cleaned up before it is repaired.

The repair itself uses two rows of small anchors set into the bone where the tendon normally attaches. The ones nearer the joint are soft suture anchors, made of suture material rather than hard plastic. Their stitches are passed through the torn tendon. Those same stitches are then held further out by a second row of strong medical-grade plastic anchors, and it is this outer row that pulls the tendon down and presses it flat against the bone. Two rows spread the hold over a broad area of tendon rather than gripping it at a single line of points.

Often, a biological scaffold is 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 section on the [EnFix biological scaffold](#).

When the repair is finished, the small cuts are closed with stitches and covered with a dressing. You will go home with that dressing in place, and our team will tell you when it comes off.

After the operation

You will wake up in the recovery area, then move to a ward. Your arm will rest in a simple sling for comfort, and it comes off for exercises and washing. Nurses will check your pain and give you medication to keep it comfortable. Most patients stay one night in hospital after this operation, though some are able to go home the same day. 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. Someone should stay with you for the first 24 hours. You can start gentle movements as our team directs, and you will be up and walking the same day. You must not drive while you are in a sling. Once your surgeon clears you, typically at the six-week review, you can drive again. Read more in [Driving after upper-limb surgery](#).

Recovery

In the first days and weeks your shoulder will be sore and may feel swollen. This settles gradually. Pain relief and rest help, and most of the discomfort eases as the early weeks pass. Most of your pain relief and improvement in movement happen in the first six months, but things keep getting better for up to two years.

Your arm rests in a simple sling for comfort, and it comes off for exercises and washing. Your physiotherapist will guide you through gentle movements first, then strength work as the tendon heals. You can walk and move around at home straight away, but you will need help with things like dressing and carrying. Sleeping can be uncomfortable at first, and many people find it easier to rest propped up. Sleep improves steadily as the shoulder settles.

Some milestones happen as events rather than dates. Once your surgeon clears you to drive, you can get back behind the wheel. When your physiotherapist is happy with your movement and strength, you can return to light activities, then heavier ones. Most people are back at work within eight months, though this depends on the type of work you do.

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 most common problem is that the repaired tendon does not hold. You might notice your shoulder pain or weakness coming back, sometimes after a stumble or a heavy lift. Tell your surgeon at the next review if this happens.

Stiffness can develop as the shoulder heals. Your shoulder may feel tight, and you might struggle to reach behind your back or above your head. Most stiffness settles with physiotherapy, so raise it with your physiotherapist or surgeon early rather than waiting.

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 wound, fever, or fluid leaking from the stitches. Contact the clinic the same day, or go to the emergency department if you feel unwell or the redness is spreading quickly.

A blood clot in a vein is rare. The signs are sudden swelling and tenderness in the calf. If you notice this, seek medical care straight away.

The small anchors holding the tendon can occasionally cause irritation. You might feel a clicking or grinding sensation, or ongoing pain that does not settle. Mention it at your review so your surgeon can assess it.

Nerve irritation near the shoulder happens rarely. It can cause tingling, numbness or odd sensations down the arm. Bring it up at your next appointment.

Some people keep having shoulder pain after the repair, even when the tendon has healed. If pain persists, your surgeon will examine you and discuss what further options might help.

If you have other significant health conditions such as diabetes, or a weakened immune system, mention these at your planning visit. They can affect healing, and we watch these patients more closely after surgery.

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

When to call us

Most problems after this operation are uncommon, but a few need quick attention. Call us if you have a fever, if the wound becomes more red or starts leaking fluid, or if your shoulder pain suddenly gets much worse. Go to emergency if you notice swelling or tenderness in your calf, or if you become short of breath, as these can be signs of a blood clot. Call us straight away if your arm feels numb, if you cannot move it, or if tingling down your arm does not settle. If you feel unwell and are worried, trust your instincts and seek care. We would rather hear from you than have you wait.

In more depth

This section goes further than you need for your own treatment decisions. Rotator cuff repair is worth the extra reading because the factors that best predict your result are largely not surgical, and two of the strongest are things you can act on before the operation.

SMOKING CHANGES THE TENDON, NOT JUST THE WOUND

Smoking is mentioned in every consent discussion and usually filed under wound healing. The tendon data are more specific than that. Pooling **73,817** patients, smokers had a significantly higher **retear** rate after rotator

cuff repair, while most clinical scores were similar between smokers and non-smokers apart from a lower Constant score [1].

That combination is the interesting part. The scores look broadly alike, but the repair is more likely to have failed structurally underneath. Smoking is not making the operation feel different; it is making it less likely to hold.

The corollary is that the weeks around surgery are the highest-value moment in a lifetime of being told to stop. The tendon is attempting to reattach to bone, and that is a blood-supply-dependent process.

DEPRIVATION PREDICTS OUTCOME AS STRONGLY AS BIOLOGY

This is the finding that most changes how the operation should be discussed. In a review of **102,372** patients, social determinants of health, the circumstances people live in, not their tendon anatomy, were associated with worse clinical and patient-reported outcomes after rotator cuff repair, including more postoperative complications and more failed repairs [2].

Rehabilitation after a cuff repair takes months, requires attending appointments, and requires being able to not use the arm. Those are conditions of life as much as decisions. When they are absent the repair does worse, and that is a fact about the treatment pathway rather than a judgement about the patient. If getting to therapy or taking time off work is going to be hard, that belongs in the pre-operative conversation, where the plan can be built around it.

STIFFNESS AFTERWARDS IS COMMON, AND THE RISK FACTORS ARE NOT OBVIOUS

Loss of movement after repair is the complication patients least expect. Pooling **23,257** patients, the available evidence pointed to **male sex** and **increased age** as probable *protective* factors against postoperative shoulder stiffness [3].

Both run against intuition, older shoulders are assumed to stiffen more readily, and that is apparently not what happens here. The practical use is expectation-setting: a younger woman having a cuff repair should be told stiffness is a real possibility for her specifically, and early motion work matters, rather than being reassured with an average.

WHAT THIS MEANS FOR YOUR DECISION

None of this argues against the operation. It argues that the published success rate is an average across people whose smoking status, circumstances and demographics differ from yours, and that your own figure is movable. Stopping smoking, and arranging in advance for the rehabilitation to be attendable, are interventions with evidence behind them, which is more than can be said for most of what patients are asked to worry about.

CQ HAND + UPPER LIMB

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Rotator Cuff Repair

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
Perianchor cyst	35-43%	Radiographic finding in 35-43% of cases; usually asymptomatic and does not require intervention.
Retear or failure of healing	15-30%	The rotator cuff repair may fail partially or completely, with most retears (94.7%) occurring 6-26 weeks post-surgery; risk increases with larger tears, age over 65, smoking, diabetes, and fatty infiltration.
Postoperative stiffness	13-44%	Stiffness is the second most common complication, with most cases responding to physical therapy; approximately 5% develop severe frozen shoulder requiring manipulation or capsular release.
Persistent pain or incomplete relief	5-10%	Incomplete pain relief despite intact repair; may relate to pre-existing arthritis, fatty infiltration, or concurrent pathology.
Reoperation rate	2-7%	Most common reasons for reoperation are symptomatic retear (88%), persistent stiffness (5%), and infection (4%).
Adhesive capsulitis	1.4-5.0%	Adhesive capsulitis occurs in a small percentage of patients; patient-reported allergies are associated with increased rates.
Nerve compression syndromes	<1%	Approximately 5% of patients develop tingling in their hand after surgery, which may be carpal tunnel or cubital tunnel syndrome, with most improving once the arm is out of the sling.
Deep venous thrombosis	<1%	Blood clots are rare complications that may require anticoagulation therapy.
Infection	0.2-0.5%	Deep infections may require multiple washouts, suture/anchor removal, and prolonged IV antibiotics; the most common organisms are Cutibacterium acnes and Staphylococcus.

COMPLICATION	REPORTED RATE	NOTES
Anchor-related complications	Rare	Anchor pullout, migration, or cartilage damage from prominent anchors; may require removal.

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