

Scapulothoracic bursectomy

At-a-glance recovery. Pooled from 12 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
1-4 weeks	6-12 weeks	3-6 months
The sling is for comfort only and many series stop it within the first few days; some use none at all. Gentle movement starts straight away. In one series of 20 patients, pain was back down to its pre-operative level at a median of 6 weeks (range 2 to 16), and a technique report notes most people have recovered from the operation itself by about 4 weeks.	Most series allow full activity, sport and overhead use from about 6 to 8 weeks, with strengthening of the shoulder-blade muscles from about 8 weeks and return to overhead sport at around 2 to 3 months. Time back at work varied: a mean of 4.5 weeks after keyhole surgery in one comparison (18 patients), and about a month of sick leave after open surgery in another series.	General strengthening continues to about 3 months, and one series allowed full sport at 4 months. The improvement lasts: in 66 patients followed for 5 to 15 years, the average shoulder score rose from 57 to 87 out of 100 and pain from 5.2 to 1.4 out of 10, and 38 of 42 who played sport (90.5%) returned to it in some capacity. Some clicking or ache commonly remains even when the result is good.

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. A clinic assessment, including your history, an examination and imaging where needed, establishes the diagnosis.

Snapping scapula syndrome happens when the shoulder blade grates or clicks as it moves over the ribs. It is usually caused by an inflamed bursa, a thin cushion of tissue between the blade and the ribs, sometimes with a bony prominence at the upper inner corner of the blade. Most people improve without surgery, with physiotherapy, anti-inflammatory medicine, activity change and an image-guided injection into the bursa, usually tried for several months. We suggest this operation when that care has not given you enough improvement. The operation removes the inflamed bursa in the space between the shoulder blade and the ribs,

and trims a prominent corner of the blade if one is found. It aims to relieve your pain and improve how your shoulder works.

Before the operation

By this stage you will usually have had scans to plan the operation, such as an X-ray, an ultrasound or an MRI, which shows the soft tissues around your shoulder blade in detail. Your surgeon will give you clear instructions for the day itself. You will be asked not to eat or drink for seven hours before your operation, so we can bring you forward if the theatre list runs early. Bring a list of your current medicines, and tell us about any medicines you take regularly, as some may need to be paused beforehand. Arrange for someone to drive you home afterwards. Wear loose, comfortable clothing that is easy to change out of. 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. You will then meet the anaesthetist, the doctor who looks after your sleep and comfort during the operation. This operation is done under general anaesthetic, so you will be fully asleep. At the end of the operation local anaesthetic is injected into the small wounds and the space under the shoulder blade to ease pain as you wake up. A separate nerve block is not usually needed for this operation. The anaesthetist will meet you beforehand and talk you through it.

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 stay with you and monitor you while the anaesthetic wears off. Once you are stable, you will either move to a ward or go home, depending on the operation and how your recovery is going.

What the operation involves

This is a keyhole operation. You will usually lie face down, and your surgeon makes a few small cuts along the inner border of your shoulder blade, the side closest to your spine. A thin camera is passed through one of the cuts into the space between the shoulder blade and your ribs. The operation works in this space, not inside the shoulder joint itself.

Through the other small cuts, your surgeon removes the inflamed bursa, the thin cushion of tissue that sits between the blade and the ribs. Clearing this tissue gives a clear view of the area. If the upper inner corner of your shoulder blade looks prominent, part of that corner is trimmed back as well. Whether this is needed is decided during the operation, based on what your surgeon finds.

At the end, the small cuts are closed with stitches. Local anaesthetic has already been placed in the wounds to ease pain as you wake up.

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 a ward. Your arm rests in a simple sling for comfort; it comes off for exercises and washing. Nurses will check your pain and give you medicine to keep it comfortable. Some swelling across the back and side of your chest is common in the first day or two. It settles on its own. Please arrange for someone to stay with you for the first 24 hours after you go home. 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.

Recovery

For the first few days your shoulder and the area around it will be sore and swollen. The local anaesthetic placed during the operation wears off within hours, so take the pain medicine we give you before it does. Rest, ice packs wrapped in a towel and keeping your hand moving can all ease the discomfort. The swelling across your back and chest settles on its own.

You will go home with your arm in a simple sling for comfort. It comes off for your exercises and for washing. Your physiotherapist will guide you through gentle movements at first, then build up to strength work as the soreness settles. Keep the dressing dry and leave it alone until we see you.

Everyday tasks come back in stages. You can use your hand for light activities once you feel steady, such as eating, typing and making a cup of tea. Lifting, reaching overhead and heavier housework wait until your surgeon says the healing is far enough along. Once you are out of the sling, comfortable, and can turn the wheel and look over your shoulder without pain, you can drive again. See our page on [driving after upper-limb surgery](#) for more detail.

Most people find the clicking or grating quiets down as the pain improves, though some noise can remain even when the shoulder feels much better. Recovery varies from person to person. Your surgeon and your physiotherapist will guide your timeline.

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 inflamed tissue is not fully cleared, or a rough patch of bone is left behind. If that happens, the catching or grating feeling may continue after your recovery. If the noise or discomfort does not settle the way we discussed, bring it up at your next review. Further treatment can be considered then.

Some people keep noticing the shoulder blade moving oddly, even after the wound has healed. You might feel the blade winging out from your back or catching as you reach. If this continues and limits you, tell us at your review so we can assess it.

A few people still have symptoms after the operation, such as pain or clicking that does not fully settle. Your shoulder may also not feel as strong or comfortable as you hoped. If your recovery feels slower than expected, raise it with us. We will examine the shoulder and talk through what else can be done.

Call the clinic the same day if you have a fever, redness spreading out from a wound, or fluid or pus leaking from it. Also call the same day if pain keeps getting worse despite your pain medicines. Call the clinic if you notice new numbness, or you cannot move the arm, hand or fingers.

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

When to call us

Most problems show up in the first few weeks. Go to the emergency department if you have swelling or pain in your calf, shortness of breath, or chest pain. These can be signs of a blood clot. Go also if your hand or fingers turn pale, cold, white, blue or dark.

Call the clinic the same day if you have a fever, redness spreading around the wound, or fluid or pus leaking from it. Call the same day too if pain keeps getting worse despite your pain medicines. Call the clinic if you notice new numbness, or you cannot move your arm, hand or fingers.

If you cannot reach us, for example out of hours or on a weekend, go to your nearest emergency department.

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Complication rates from published literature

Pooled from 12 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
some clicking or grating remaining	58-78%	The operation is for pain. Crepitus was still noticed by 14 of 24 (58%) after bursectomy alone and 19 of 32 (59%) when the corner of the shoulder blade was also trimmed, and by 25 of 32 (78%) in another series, although most of those patients were satisfied.
some pain or symptoms remaining	69%	Across 203 operated shoulders in a 2018 systematic review, 42 (21%) had complete resolution and 139 (69%) improved but still had some symptoms; 22 (11%) had a poor result.
a further operation	5-13%	11 of 203 (5%) in the systematic review; 8 of 74 (11%) and 8 of 66 (12%) in the two largest single series, usually for symptoms that came back; 3 of 23 (13%) in an earlier series.
swelling of the chest wall from the fluid used during the operation	6%	11 of 201 (5.5%) in the systematic review, usually settling within hours; in one patient the swelling was enough to stop the operation.
injury to the nerve that holds the shoulder blade against the chest (long thoracic nerve)	<1%	1 of 201 (0.5%) in the systematic review had a partial injury. No nerve injuries were reported in series of 20, 23 and 47 patients.
wound infection	<1%	1 of 201 (0.5%) in the systematic review, superficial.

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