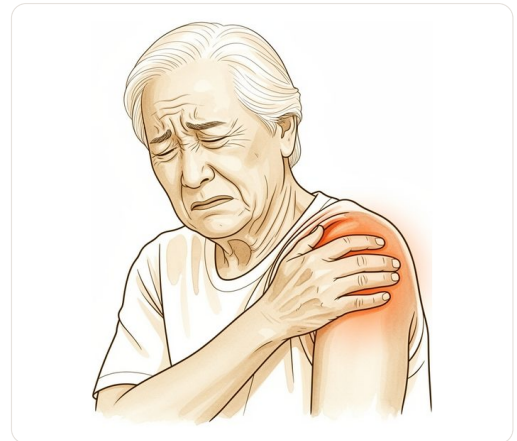


Shoulder Arthritis

Shoulder arthritis on X-ray: the cartilage that cushions the ball-and-socket has worn through, the joint space has narrowed, and bone spurs have formed around the rim.

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What you're feeling

Shoulder arthritis is a common condition where the smooth cartilage in your shoulder joint wears down. This wear-and-tear process causes the bones to rub against each other. As the condition progresses, you may notice that your shoulder feels stiff and painful. The pain often starts gradually but can become sharp or achy. It typically settles in the outer part of your shoulder and may travel down your upper arm.

Your symptoms often follow a predictable pattern. You might feel stiffness when you first wake up in the morning. This stiffness usually eases as you move around, but it can return after you have been active. Tasks that require lifting your arm above shoulder height become difficult. You may struggle to reach items on high shelves or comb your hair. Simple movements, like reaching into the back seat of a car or putting on a jacket, can trigger a flare-up of pain.

Night pain is also a frequent complaint. Many patients find it hard to sleep on the affected side because the pressure aggravates the inflamed joint. This can lead to fragmented sleep and daytime fatigue. While rest may provide temporary relief, prolonged inactivity can make the joint stiffer.

The severity of your symptoms often correlates with the stage of arthritis. If you have mild signs of arthritis on imaging, you might not feel significant pain yet, but you may still struggle to achieve meaningful improvement after surgery compared to those with more advanced disease. In some cases, particularly in older women, the pain can develop insidiously and worsen rapidly. Increased age is a main factor in how much radiological change and pain you experience.

If your shoulder feels unstable or shifts out of place, you might notice a catching sensation. This is more common if the joint has developed an eccentric pattern of wear. Understanding these specific symptoms helps your surgeon tailor a management plan. Whether you are considering non-surgical options or discussing implant designs, recognizing these signs ensures we address your specific needs.

What's actually happening

Shoulder arthritis is a common wear-and-tear condition. It affects the joint where your upper arm bone meets your shoulder blade. Think of this joint like a ball-and-socket toy. The ball is the head of your humerus. The socket is the glenoid on your shoulder blade. In a healthy shoulder, smooth cartilage covers both surfaces. This cartilage acts like a shock absorber. It lets the bones glide past each other with almost no friction.

In shoulder arthritis, this protective cartilage breaks down. It thins out or wears away completely. Without this cushion, the bones rub directly against each other. This causes pain and stiffness. Your shoulder may feel like it is grinding or catching. The joint space narrows, and the bones may change shape. This is why simple movements become difficult and painful.

Your shoulder relies on a group of tendons called the rotator cuff. These tendons act like ropes that stabilize the ball in the socket. When arthritis damages the joint, it often affects these tendons too. If the cuff is torn or weak, your shoulder loses stability. Your body then tries to compensate. It uses your large deltoid muscle to lift your arm instead. This changes how your shoulder moves. Your shoulder blade may shift position to help you move. This compensation can lead to further strain and altered movement patterns.

We understand that these changes feel confusing and limiting. Your surgeon explains that the goal of treatment is to restore smooth movement. We use advanced joint replacement designs to mimic the natural ball-and-socket structure. These implants replace the worn surfaces with smooth, durable materials. This restores the shock-absorbing function and stabilizes the joint. By addressing the root cause, we help reduce pain and improve your ability to move freely again.

What we can do about it

The approach Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, takes in our clinic focuses on matching the treatment to your specific stage of arthritis. We believe in starting with the least invasive options first. This allows us to manage pain and maintain movement without surgery, particularly if your wear-and-tear arthritis is mild to moderate.

You can begin by adjusting daily activities to avoid positions that cause sharp pain. Gentle physiotherapy helps keep the joint mobile and strengthens the muscles around it to take pressure off the bone. We usually recommend giving this non-surgical care a fair trial for several weeks to see if it provides enough relief for your lifestyle.

If movement exercises are not enough, we discuss medical management to control inflammation and pain. This may include standard pain relievers or anti-inflammatory medications. We also consider injections into the joint. Cortisone injections reduce swelling and pain for a few months. Hyaluronic acid injections aim to lubricate the joint, while platelet-rich plasma (PRP) injections use your own blood components to support healing. The duration of relief varies, but these options can buy you time or help you stay active without surgery.

Surgery is considered when conservative care has reached its limit and your quality of life is significantly affected. At this stage, we discuss joint replacement. This procedure replaces the damaged bone and cartilage with artificial components to restore smooth movement and eliminate pain. We review the specific type of replacement that fits your anatomy and activity level, ensuring you understand the long-term benefits and commitments involved in the decision.

What to expect

Shoulder arthritis is a common condition. It typically causes persistent pain and stiffness that does not settle on its own. Without treatment, symptoms often continue to worsen over time. You may notice that daily tasks become increasingly difficult as the joint wears down further.

When managed with surgery, most people experience significant improvements in pain and function. Anatomic total shoulder replacement is the standard approach for patients with an intact rotator cuff. This procedure replaces the worn joint surfaces while preserving your natural shoulder mechanics. If your rotator cuff is damaged, a reverse shoulder replacement may be recommended. This design changes how the joint moves to compensate for the torn muscles. Both approaches aim to restore your ability to use your arm comfortably.

Recovery is a gradual process. You will likely feel noticeable relief from pain within the first few weeks. However, strength and full range of motion take longer to return. It can take several months to regain normal function. Subscapularis strength, which helps rotate your arm, returns to normal in only a minority of patients at two years after surgery. While you will see significant improvement from your baseline, some weakness may persist.

Implant longevity remains a concern for more active patients. The evidence shows that implants last well for many years, but they may wear out sooner if you place high demands on your shoulder. Some patients experience continuing pain or bone erosion after ten years following humeral head replacement. Additionally, symptomatic arthritis in the acromioclavicular joint occurs in 15.9% of patients after total anatomic shoulder replacement with follow-up of up to 12 years.

Outcomes vary based on your specific anatomy and health. Patients with mild signs of arthritis have about sevenfold higher odds of failing to achieve the minimum clinically important difference after anatomic total shoulder replacement compared to patients with severe arthritis. This means those with less visible damage on scans may not feel as dramatic a change as those with advanced wear.

If left untreated, the condition rarely improves. You may eventually require more complex interventions if conservative measures fail. Your surgeon will discuss which option best fits your lifestyle and joint condition. We aim to provide clear, realistic expectations so you can make an informed decision about your care.

When to see someone

Shoulder arthritis is common and often worsens with age. See your GP if you have persistent pain that does not improve with rest. Ask for a specialist review if you experience weakness, instability, or a feeling of locking or

giving way. These symptoms can interfere with sleep or work. Sudden worsening of pain also warrants attention. While implant longevity is a concern for active patients, early assessment helps manage these issues. Your surgeon can determine if your condition is typical wear-and-tear or a rapidly destructive form. Proper evaluation ensures you receive the right care for your specific needs.

In more depth

This section goes further than you need for your own treatment decisions. Shoulder arthritis is worth the extra reading because the main decision – which type of replacement – has recently become a genuine trade rather than a clear answer, and because the trade is different depending on your age.

ANATOMIC VERSUS REVERSE, OVER 70

An anatomic replacement reproduces the normal arrangement and depends on a working rotator cuff. A reverse replacement swaps ball and socket, letting the deltoid do the lifting, and does not. Historically reverse was reserved for shoulders without a cuff; it is now used far more widely.

The comparison in patients aged **70 and over** with a competent cuff, across **1,716** patients, splits cleanly. Anatomic replacement provided **superior rotational mobility, exceeding the minimal clinically important difference** and potentially supporting activities such as dressing and toileting – while reverse offered **superior implant survivorship and lower revision** [1].

Those are two different currencies. Anatomic buys rotation you would notice day to day; reverse buys durability. Neither dominates, which is why this is now a discussion rather than a default.

REVERSE CARRIES MORE EARLY COMPLICATIONS IN THIS SETTING

The durability advantage comes with a near-term cost when reverse is used for ordinary arthritis. Across **8,846** patients, an **increased rate of early complications** was observed with reverse compared with anatomic for primary glenohumeral arthritis – **instability, scapular fracture, infection and all-cause complications** – with **no difference in revision rate** at that follow-up [2].

Read alongside the survivorship finding above, the pattern is that reverse trades a higher chance of an early problem for a lower chance of a late one. Which matters more depends heavily on how many years the implant needs to last.

REPLACING THE SOCKET AS WELL AS THE BALL

A hemiarthroplasty replaces only the ball, leaving the worn socket. It is a smaller operation and avoids the glenoid component, which is the part most prone to loosening over time.

The evidence does not favour it. In patients with primary glenohumeral osteoarthritis and an intact cuff across **1,317** patients, **total shoulder arthroplasty is favoured over hemiarthroplasty** in clinical outcome, risk of revision, and post-operative complications [3].

The explanation is that the worn socket keeps generating pain against the new ball. Avoiding the glenoid component avoids one long-term failure mode by accepting a shorter-term one.

FOR YOUNGER PATIENTS THE CALCULATION CHANGES ENTIRELY

Under about 60, every option is unsatisfactory in a specific way, and this is honestly reflected in the literature rather than resolved by it. A replacement will very likely need revising within a lifetime, and revision shoulder surgery is substantially harder than the first operation. Joint- preserving options – arthroscopic debridement, capsular release, removing osteophytes – do not halt the arthritis but can defer replacement, which for a young patient is a coherent goal in itself.

ONE FINDING FOR ANYONE WHO HAS HAD INSTABILITY SURGERY

Arthritis after shoulder stabilisation is common on imaging and mostly silent. Following arthroscopic Bankart repair, the prevalence was **60% for any arthritic change and 28% for moderate-to-severe change** – yet it is **generally asymptomatic**, with **no significant correlation** identified with the established risk factors [4].

If you have had a stabilisation and a later scan reports arthritis, that finding is common, usually not the source of symptoms, and not on its own a reason to act.

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CQ HAND + UPPER LIMB

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