

Shoulder Arthroscopy

In a shoulder arthroscopy, the surgeon looks inside the joint with a small camera and works through small cuts.

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At-a-glance recovery. Pooled from 80 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
2-6 weeks	6-12 weeks	12 months
Return to desk work and light ADLs typically occurs within 2 to 6 weeks, with active motion initiated within a pain-free range after 2 weeks.	Heavier manual work and sport usually take six to twelve weeks, depending on the demands.	Maximum functional improvement and plateau of pain/strength are typically observed by 12 months post-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 appointment we take a history, examine your shoulder, and arrange imaging where it is needed. That assessment tells us what is wrong inside the joint.

For long-standing problems we usually try non-operative care first. This can mean changing activities, physiotherapy, or injections. Surgery comes into the conversation when those steps have not given you enough improvement. For some structural problems, such as a torn tendon or an unstable shoulder, we may recommend surgery straight away.

Shoulder arthroscopy is a keyhole operation. A small camera is placed inside the joint, and instruments are passed through small incisions around the shoulder. It lets us see and treat problems such as labral tears, rotator

cuff tears, and biceps tendon damage in one sitting. The aim is less pain, better movement, and a steadier shoulder.

Before the operation

In the days before surgery, we will confirm which scans are needed to plan your operation. This may be an X-ray, an MRI, or an ultrasound. You will get clear instructions about your medications. Some may need to be paused for a short time. If you take blood thinners or have diabetes, tell us early so we can plan around them. On the day, bring a list of everything you take, including tablets, injections and supplements. Wear loose, comfortable clothing that is easy to put on over a bandaged shoulder. Arrange for someone to drive you home afterwards, as you will not be able to drive that day. You will need to stop eating and drinking seven hours before your operation. We ask for seven hours so we can bring your surgery 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

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 gives the anaesthetic and looks after you during the operation. 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.

After that, you are 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. Which of these happens depends on the procedure you had and how your recovery is going.

What the operation involves

Shoulder arthroscopy is a keyhole operation. Your surgeon makes a few small incisions around your shoulder, including one at the back, and passes a small camera into the joint. The camera sends a picture of the inside of your shoulder to a screen, so your surgeon can see the joint surfaces, the labrum (a rim of cartilage around the socket), and the rotator cuff tendons directly. Fluid is pumped in to hold the joint open and keep the view clear.

What happens next depends on what is found. A torn labrum can be reattached to the bone. A torn rotator cuff tendon can be stitched back onto its attachment on the arm bone using small anchors set into the bone. Loose or damaged tissue can be trimmed away, and inflamed tissue or bone spurs pressing on the tendon can be removed. Because the camera can be moved to look from different angles, your surgeon can check the whole joint and treat more than one problem in the same operation.

At the end, the instruments are taken out and the small incisions are closed with stitches. Your shoulder is covered with a dressing, which stays on for about 10 days as described in the recovery section.

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 for the night. Your arm will rest in a simple sling for comfort, which comes off for exercises and washing. The first 24 hours matter most for pain control, so we will keep on top of it with your pain medicines. Numbness and weakness in the arm are expected while the nerve block wears off, usually within about 24 hours. If you cannot move the arm, hand or fingers, or you have numbness once the block has worn off, call the clinic. Someone should stay with you for the first 24 hours. 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

The first day or two after surgery are when pain is at its strongest, so keep on top of your pain medicines from the start. The nerve block from theatre will wear off, and as it does you may feel a dull ache in the shoulder. Some swelling around the shoulder and upper arm is normal and settles as the days pass. Rest, ice and your prescribed pain relief all help ease this early discomfort.

Your arm rests in a simple sling for comfort, which comes off for your exercises and for washing. Your physiotherapist will guide you through gentle movements, then build up to strength work as your shoulder allows. You can use your hand and wrist for light tasks such as eating and writing once you feel able. Avoid lifting with the operated arm until your surgeon or physiotherapist says it is safe. Sleeping upright or propped on pillows is often more comfortable in the early days, and many people find it easier to sleep in a recliner or with extra pillows behind the back.

Recovery varies from person to person, so your timeline may differ from someone else's. Your surgeon and physiotherapist will guide you at each review. Once the swelling settles and your movement returns, everyday tasks become easier. You will not drive until your surgeon clears you, typically at the six-week review; see [Driving after upper-limb surgery](#) for the full rules. Returning to work, sport and the gym happens in stages, guided by how your shoulder feels and what your surgeon and physiotherapist agree you are ready for.

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.

Infection is uncommon after keyhole shoulder surgery. It can show as a fever, redness that spreads out from the wound, or fluid or pus leaking from it. Call the clinic the same day if you notice any of these. Pain that keeps getting worse despite your pain medicines is also a reason to call the clinic the same day.

A blood clot is rare but serious. Go to the emergency department if you have swelling or pain in your calf, or shortness of breath or chest pain. These can be signs of a blood clot.

Stiffness can develop after some shoulder operations, and the shoulder can sometimes freeze. You may notice the shoulder tightening up and losing movement, especially reaching behind your back or out to the side. Bring this up at your next review, as early treatment helps.

Nerves run close to the shoulder, and they can occasionally be irritated or injured. You might feel numbness, tingling, or weakness in the arm, hand or fingers. Numbness and weakness in the first 24 hours after a nerve block are expected. Call the clinic if you have numbness, or cannot move the arm, hand or fingers, once the block has worn off (about 24 hours). If you cannot reach the clinic, go to your nearest emergency department.

If you had surgery to steady a shoulder that dislocates, the shoulder can sometimes slip or dislocate again. You may feel the shoulder shift, give way, or slide out of place. Tell your surgeon at review, or call the clinic if it happens sooner.

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

When to call us

Most recoveries go smoothly, but some signs need quick action. Go to the emergency department if you have swelling or pain in your calf, or shortness of breath or chest pain. These can be signs of a blood clot. Call the clinic the same day if you have a fever, spreading redness around the wound, or fluid or pus leaking from it. Call the clinic the same day too if your pain keeps getting worse despite your pain medicines. Call the clinic if you have numbness, or cannot move the arm, hand or fingers, once the nerve block has worn off (about 24 hours). If you cannot reach the clinic, go to your nearest emergency department.

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.

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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
recurrent instability	8.3-23.0%	Higher rates observed in pediatric patients and those with specific risk factors like Hill-Sachs lesions.
stiffness	2-5%	Postoperative stiffness typically responds to physiotherapy; may require manipulation under anaesthesia.
readmission	1.13%	30-day readmission rate is generally low.
nerve injury	<1%	Permanent nerve injury is rare (<1%); transient traction neurapraxia of the axillary or musculocutaneous nerve is more common and typically resolves.
return to operating room	0.27-0.45%	Most common complication overall, accounting for 29% of all complications in some series.
infection	0.21-0.26%	Risk is similar to other large series, and is higher after a steroid injection in the weeks before surgery.
thromboembolism	0.21-0.26%	Includes DVT and PE; risk factors include BMI >30 and hypertension.

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