

Shoulder Instability

The labrum is a soft cartilage rim that deepens the shallow shoulder socket. When it tears — often during a dislocation — the joint loses its key restraint and starts to feel unstable.

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What you're feeling

You may notice a sense of looseness or slipping in your shoulder joint. This is not always painful, but it can feel unsettling. Your shoulder might feel like it is about to pop out of place, especially when you reach overhead or rotate your arm. In some cases, the shoulder actually slips out (dislocates) and then pops back in on its own. You might feel a sharp catch or a dull ache deep in the joint during these moments.

Pain is often your body's signal that something is wrong inside the shoulder. You may feel this pain when you lift your arm above your head, such as when placing a heavy bag on a high shelf or reaching for a book on a top cupboard. It can also flare up when you push against a door frame or perform a push-up. Many patients find that their shoulder hurts more at night, particularly if you sleep on the affected side. The pain might wake you up or make it hard to find a comfortable position to rest.

Daily tasks can become difficult if your shoulder feels unstable. Simple actions like putting on a jacket, buttoning a shirt, or drying your hair after a shower may feel awkward or unsafe. You might avoid using that arm for lifting because you are worried it will slip. If you have had previous dislocations, you may feel a constant low-level discomfort or stiffness. This can make it hard to return to sports or activities that require overhead reaching or sudden movements.

Sometimes, the pain is not from the joint slipping, but from other structures getting pinched. You might feel a sharp pain on the front or side of your shoulder when you move it in certain ways. This can happen even if your shoulder does not dislocate. You may also notice that your shoulder feels stiff or tight in the morning, which loosens up as you move around during the day. If you have had recurrent issues, you might feel a general weakness or lack of confidence in your arm when you try to use it for heavy lifting.

What's actually happening

Your shoulder is a ball-and-socket joint designed for wide movement. The ball of your upper arm bone sits in a shallow socket on your shoulder blade. This setup gives you freedom but sacrifices stability. To keep the ball centered, your body relies on soft tissues like ligaments and tendons. Think of these tissues as a gasket or a seal that holds the joint together.

When you experience instability, this seal is compromised. The most common issue involves the labrum, a ring of cartilage that deepens the socket. If this ring tears, it acts like a worn-out gasket. The ball can no longer stay securely in place. It may slip partially out of the socket (subluxation) or pop all the way out (dislocation). This movement is often painful and can feel like your arm is giving way.

The problem often starts with a specific injury. A fall or a forceful twist can stretch or tear the supporting ligaments. Over time, repeated episodes can stretch these tissues further. Your shoulder then becomes looser with each incident. This creates a cycle where minor movements trigger instability. You might feel clicking, grinding, or a sense of looseness when raising your arm.

In some cases, bone loss contributes to the issue. If the socket is worn down or the ball is dented, there is less surface area for the joint to rest on. This makes dislocation more likely. Your surgeon will look at the extent of this damage to decide on the best path forward. Understanding exactly what is torn or worn helps us tailor your treatment to restore stability and protect your long-term shoulder function.

What we can do about it

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. We start by understanding your specific situation. For many patients, we begin with non-operative care. This includes activity changes to avoid positions that cause the shoulder to slip out. You will also work with a physiotherapist to strengthen the muscles around the joint. This helps stabilize the shoulder and improves your control over the arm. We usually give this conservative approach a fair trial to see if it reduces your symptoms.

If pain or stiffness remains, we discuss medical management options. These may include pain medication or anti-inflammatory drugs to help you stay active. In some cases, we consider injections. Cortisone injections can reduce inflammation and pain for a limited time. Hyaluronic acid or platelet-rich plasma (PRP) injections are also options to support joint health. These treatments aim to manage symptoms while you continue with your rehabilitation. They do not fix the underlying structural issue, but they can provide relief.

Surgery is considered when conservative care has not given enough improvement, or if you have a structural problem that requires immediate attention. For example, if you have recurrent instability with bone loss, we may refer you to a high-volume specialist. Arthroscopic stabilisation is now the treatment of choice for traumatic anterior shoulder dislocation in the 17- to 25-year age group. This procedure uses small cameras and instruments to repair the damaged tissues inside the joint. It aims to restore stability while minimising loss of motion. The success of treating anterior glenohumeral instability relies on multiple factors, including glenoid

bone loss. We use imaging like magnetic resonance arthrography to assess soft tissue abnormalities and bone defects. This helps us determine the best surgical indication for you.

We also evaluate posterior shoulder instability. Arthroscopic treatment is an effective means to improve symptoms associated with recurrent posterior subluxation. With modern arthroscopic management, reliable and lasting recovery may be achievable. For multidirectional instability, the inferior capsular shift procedure can be effective. It involves tightening the joint capsule to prevent movement in multiple directions.

Your surgeon will perform a thorough clinical exam to determine the indication for surgery. This is the most important factor in deciding your treatment path. We balance restoring joint stability with minimising loss of motion. For patients with primary, traumatic, anterior shoulder instability, surgical treatment results in reduced rates of recurrence compared with nonsurgical treatment at 10-year follow-up. This data supports our recommendation for surgery in appropriate cases.

We present these options as a shared decision. You will have the opportunity to discuss the risks and benefits with us. We ensure you understand the expected outcomes, such as the potential for reduced recurrence rates. Your surgeon will tailor the plan to your lifestyle and goals. Whether you choose non-operative care or surgery, we support you through every step of your recovery.

What to expect

Shoulder instability often follows a pattern of coming and going. Without treatment, first-time dislocations frequently lead to further episodes. In young patients under 40, roughly one-third experience recurrent instability after their initial injury. Over time, these repeated dislocations can cause wear-and-tear arthritis in the joint. This long-term damage is a common natural history of untreated instability.

With modern surgical stabilisation, the outlook improves significantly for many patients. Surgery reduces the risk of recurrence compared to non-surgical management over ten years. For anterior instability, arthroscopic repair offers long-term benefits in stability and function, even for high-risk patients. The Latarjet procedure is a reliable option that provides durable protection against future dislocations. For posterior instability, modern arthroscopic techniques also offer reliable and lasting recovery, allowing for sustained athletic participation.

Recovery is a gradual process. At mid-term follow-up, about 30% of patients may experience recurrent instability after primary arthroscopic anterior repair. However, many others see continued improvement in function compared to their preoperative state. If you have significant bone loss or severe capsular deficiency, your surgeon may recommend more complex reconstruction. In such cases, nearly half of patients remained completely stable at nearly four years.

Your surgeon will tailor the plan to your specific pathology, age, and activity demands. Proper evaluation of bone loss is critical in determining the best path forward. While some variability exists in how first-time dislocations are managed, evidence supports surgical stabilisation for those at high risk of recurrence. The goal is to restore stability so you can return to your daily activities and sports with confidence. Long-term data suggest that the benefits of these procedures are durable, helping you maintain a stable shoulder for years to come.

When to see someone

See your GP if you have persistent shoulder pain that does not improve with rest. Ask for a specialist review if you feel weakness, instability, or if your shoulder locks or gives way. These symptoms may interfere with your sleep or work. Sudden worsening of symptoms also warrants attention. A thorough clinical exam is the most important factor in determining if you need surgery. Proper evaluation of bone loss helps determine the best treatment path. Early assessment ensures you receive tailored care based on your specific condition and activity needs.

In more depth

This section goes further than you need for your own treatment decisions. Shoulder instability is worth the extra reading because the decision that matters is not really “operate or not” – it is which operation, and that turns on a measurement of bone rather than on how the shoulder feels.

BONE LOSS IS THE VARIABLE THAT DECIDES

A soft-tissue repair reattaches the torn labrum and tightens the capsule. It cannot replace missing bone from the front of the socket, and once enough of that rim is gone the shoulder can slide out over the defect no matter how well the soft tissue is repaired.

A systematic review of **19,307** patients identified the established risk factors for recurrence after arthroscopic Bankart repair: **younger age**, **glenoid bone loss**, and **off-track Hill-Sachs lesions** – with contact and competitive sport, number of fixation devices and sex also commonly reported [1].

“Off-track” is worth translating. The Hill-Sachs lesion is the dent punched into the back of the humeral head as it dislocates over the socket rim. Whether it matters depends on whether it stays in contact with the glenoid through range – on-track – or falls off the edge and engages. It is the interaction between the two defects, not either alone, that predicts failure.

WHAT THE BIGGER OPERATION BUYS, AND WHAT IT COSTS

Where bone loss is significant, transferring bone solves the problem the repair cannot. Compared directly, the Latarjet produced a **lower recurrence rate**, better patient-reported outcomes and faster return to sport than arthroscopic Bankart repair, while carrying a **higher complication rate** [2]. A long-term comparison of **3,088** patients found lower recurrent instability and revision after open Latarjet, with **comparable** arthritis rates between the two [3] – which addresses the usual objection that moving bone across the joint must accelerate wear.

The cost is quantified: pooling **7,175** patients, the overall complication rate after Latarjet was **6–7%**, mostly graft-related, with no significant difference between open and arthroscopic versions [4].

THE MIDDLE OPTION

The choice is not binary. Across **2,100** patients, adding a **remplissage** – filling the Hill-Sachs defect with capsule and tendon so it cannot engage – reduced recurrence compared with isolated Bankart repair **without** a significant loss of external rotation, and may reduce reoperation compared with Latarjet [5].

That matters for throwing athletes and anyone whose sport depends on the last few degrees of external rotation, where the traditional worry about stabilisation has always been trading instability for stiffness.

READ THE OUTCOME LITERATURE SCEPTICALLY

Two findings should temper any confident number quoted to you.

A review of **19,156** patients concluded that a large proportion of studies reporting Bankart repair outcomes are of **low methodological quality and low level of evidence** [6].

And access is not evenly distributed: across **43,054** patients, minority race or ethnicity, public insurance, lower income and greater social deprivation all **reduced the likelihood of undergoing** Bankart repair, with public insurance also associated with longer waits [7]. Some of the variation in published outcomes reflects who reached surgery and when, not what the operation does.

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CQ HAND + UPPER LIMB

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