

Total Shoulder Arthroplasty

A total shoulder replacement: a metal ball is fixed to the upper arm bone and a plastic socket is anchored to the shoulder blade — recreating the natural ball-and-socket shape.

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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 months	12-24 months
Return to desk work and light activities typically occurs within 2 to 6 weeks postoperatively.	Return to sports and manual work is generally possible between 6 and 12 months, with strength continuing to improve up to 12 months.	Maximum functional recovery and plateau of strength typically occur at 1 year, with continued subtle improvements up to 2 years.

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. For wear-and-tear problems like arthritis (the smooth cartilage covering the joint wears away), we usually try non-operative care first: activity change, physiotherapy, and splinting. We consider surgery when that has not given enough improvement.

Total shoulder arthroplasty means shoulder joint replacement: the worn surfaces of your shoulder joint are removed and replaced with artificial parts. We suggest it when shoulder pain and stiffness limit your daily life and other treatment has not helped enough. The operation aims to relieve pain and improve how your shoulder moves and works. Pain is relieved in approximately 90% to 95% of all patients undergoing this operation. Over 80% of shoulder replacements last more than 10 years, and 75% last more than 20 years. Shoulder replacement

is considered as safe as other major joint replacements. We will talk through your options with you and decide together whether this operation suits your shoulder and your goals.

Before the operation

Your surgeon will plan your operation using X-rays of your shoulder, and sometimes an MRI (a scan that shows soft tissues) or an ultrasound (a scan using sound waves). These pictures show the shape of the joint, the amount of wear, and the condition of the tendons around it. That detail helps your surgeon choose the right replacement parts for your shoulder.

In the days before surgery, you will be given clear instructions to follow. You will need to stop eating and drinking seven hours before your operation. This longer gap lets us bring you forward if the theatre list runs early. Some medications may need to be paused, and your surgeon will tell you which ones and when. Bring a written list of everything you take, including tablets, drops and natural remedies. Arrange for someone to drive you home, as you will not be able to drive yourself. Wear loose, comfortable clothing that is easy to put on and take off. If you have other medical conditions, you may need blood tests or a review with the anaesthetist (the doctor who gives the anaesthetic) before the day of surgery.

On the day

You will arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will meet the anaesthetist before the operation and talk through the plan with them. 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 are then taken into the operating theatre, where the operation is performed.

When you wake up, you will be in the recovery area. Nurses will monitor you while the anaesthetic wears off. Once you are stable, you will move to the ward. If you are going home, the person you arranged to drive you will take you there.

What the operation involves

Your surgeon makes a single cut over the front of your shoulder to reach the joint. Through this opening, they remove the worn-out joint surfaces: the rounded ball at the top of your arm bone and the shallow socket it moves against. These are replaced with artificial parts made of metal and plastic, fitted to match the shape of your own joint.

One tendon in front of the joint, the subscapularis (a muscle-tendon unit that helps rotate your arm inward), is gently moved aside to give access, then repaired back into place at the end. Your surgeon takes care throughout to protect the soft tissues around the joint and to position the new parts accurately.

Once the new parts are in place and the tendon is repaired, the wound is closed. A fine self-adhesive mesh is laid over the closed wound first, holding the skin edges together. A liquid skin adhesive is then painted over the mesh, where it sets to seal the whole thing. This stays on for roughly one to two weeks and then lifts and peels away by itself, so there is nothing to be taken out.

After the operation

When you wake up, you will be in the recovery area, then move to the ward. Most patients stay one or two nights in hospital after this operation. Your arm will rest in a simple sling for comfort. It comes off for exercises and washing. Pain control is planned for you before you leave theatre, and your care team will keep checking how you are feeling and adjust things as needed. 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. A physiotherapist will usually see you on the ward to start gentle movements. Please arrange for someone to stay with you for the first 24 hours after you go home.

Recovery

Everyone's recovery follows its own path, and your timeline may differ. Your surgeon and physiotherapist will guide you at each visit.

In the first days and weeks, expect some pain and swelling around the shoulder. This settles gradually for most people. Your care team will plan pain relief before you leave hospital and adjust it as needed. Many people manage well with a simple, non-opioid pain plan. Keeping your arm in the sling between exercises helps with comfort. Rest, gentle movement as your physiotherapist shows you, and following the plan will ease the discomfort.

A physiotherapist will usually see you on the ward to start gentle movements. At home, you will keep doing these exercises as directed. The sling comes off for exercises and washing. You will need help with some daily tasks at first, such as dressing, since the operated arm will be limited. Sleep can be disturbed early on, but most people find their sleep improves as the shoulder settles.

Movement and strength return in stages. As the swelling settles and your movement grows, everyday tasks become easier. Once your surgeon clears you to drive, typically at the six-week review, you can get back behind the wheel. See our guide on [Driving after upper-limb surgery](#). Returning to work and sport depends on your job, your activities and how your shoulder is healing. Your surgeon and physiotherapist will talk you through what is safe at each stage.

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 the most serious problem to watch for. It can show up as a deep, throbbing pain that does not ease with simple painkillers, redness that spreads out from the wound, or a fever. Tell the clinic straight away if you notice any of these signs. Some infections appear months later, so mention anything unusual at your reviews, even if it seems minor.

A clot can form in a vein after this operation. This may cause sudden swelling and tenderness in the calf. If a piece of that clot travels to the lungs, you might feel sudden breathlessness or chest discomfort. Go to the emergency department if this happens.

The nerves around the shoulder can be stretched or bruised during surgery. You might notice numbness, tingling or weakness in your arm or hand. Many of these recover fully, some only partly. Mention it at your next review so it can be tracked.

A fracture near the new joint is uncommon but can happen, either during the operation or afterwards. You would feel sharp pain and lose the ability to move the arm normally. Call the clinic if this occurs.

The artificial parts can loosen over time. This usually feels like a return of pain, sometimes with a clicking or grinding feeling in the shoulder. Bring this up at your review, as scans can show what is happening.

The shoulder can also become stiff or unstable, or the new parts can come out of place. You would notice a sudden loss of movement, or a feeling that the joint has shifted. Contact the clinic promptly.

If you have had shoulder surgery before, some of these risks are higher. Your surgeon will discuss this with you before the operation.

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

When to call us

Trust your instincts. If something feels wrong, contact us. Call the clinic if you have a fever, increasing redness or discharge from the wound, or pain that keeps getting worse. Go to emergency if you have sudden swelling in your calf, shortness of breath, or chest discomfort. These can be signs of a clot. Call us straight away if you lose feeling in your arm or hand, or you cannot move it at all. Most problems are easier to sort out early.

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 [Shoulder Arthritis](#) page.

Total Shoulder Arthroplasty

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
Stress shielding	36.4%	Radiographic finding associated with stem length and alignment; clinical impact varies.
Rotator cuff tear	5.6-29%	Progressive rotator cuff insufficiency or tear can develop after TSA, potentially leading to pain, weakness, or instability; severe cuff failure may require conversion to reverse shoulder arthroplasty.
Revision rate	3.2-41.2%	Approximately 5-10% may require revision surgery within 10 years for various reasons.
Nerve compression syndromes	3-5%	Approximately 3-5% develop carpal or cubital tunnel syndrome postoperatively; the majority improve once the arm is out of the sling.
Loss of motion or stiffness	1.5%	Some patients develop adhesive capsulitis or significant stiffness (approximately 2-5%) requiring manipulation under anesthesia or capsular release.
Dislocation or instability	0.91-30%	Risk factors include subscapularis insufficiency, rotator cuff deficiency, component malposition, or inadequate soft tissue tensioning.
Infection	0.71-1.9%	Deep infection requiring multiple washouts, prolonged antibiotics, and potentially component removal with staged revision; risk is higher in diabetes and immunocompromised states.
Neurological complications	0.7-2.4%	The axillary nerve and musculocutaneous nerve are most at risk; most are temporary neurapraxias recovering within 3-6 months.
Periprosthetic fracture	0.46-1.40%	Intraoperative fractures occur during humeral preparation or component impaction particularly in osteoporotic bone; late fractures can occur after falls.

COMPLICATION	REPORTED RATE	NOTES
Glenoid component loosening	0.45-24%	The most common long-term complication occurring within 10 years; may cause pain, clicking, or functional decline requiring revision surgery.
Hematoma	0.3-15%	Incidence varies; higher rates reported in revision cases.
Medical complications	0.18-1.4%	Systemic complications including pulmonary embolism, myocardial infarction, stroke, or pneumothorax are rare.
Humeral component loosening or subsidence	—	Stemless designs preserve bone stock but loosening or subsidence can occur particularly with poor bone quality or early overloading.
Conversion to reverse shoulder arthroplasty	—	Approximately 3-8% of patients may require conversion within 10 years due to rotator cuff failure, glenoid loosening, instability, or progressive arthropathy.
Component failure	—	Polyethylene wear, humeral component disassembly, baseplate failure, screw breakage, or glenoid component fracture may occur over time.
Persistent pain or dissatisfaction	—	Some patients experience residual symptoms such as pain radiating into the neck, difficulty lying on the operated shoulder, or clicking sensations.

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