Midlands Orthopaedic Centre

Trauma & Orthopaedics

Instability of the Shoulder

Patient Information Leaflet

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NHS
The Dudley Group
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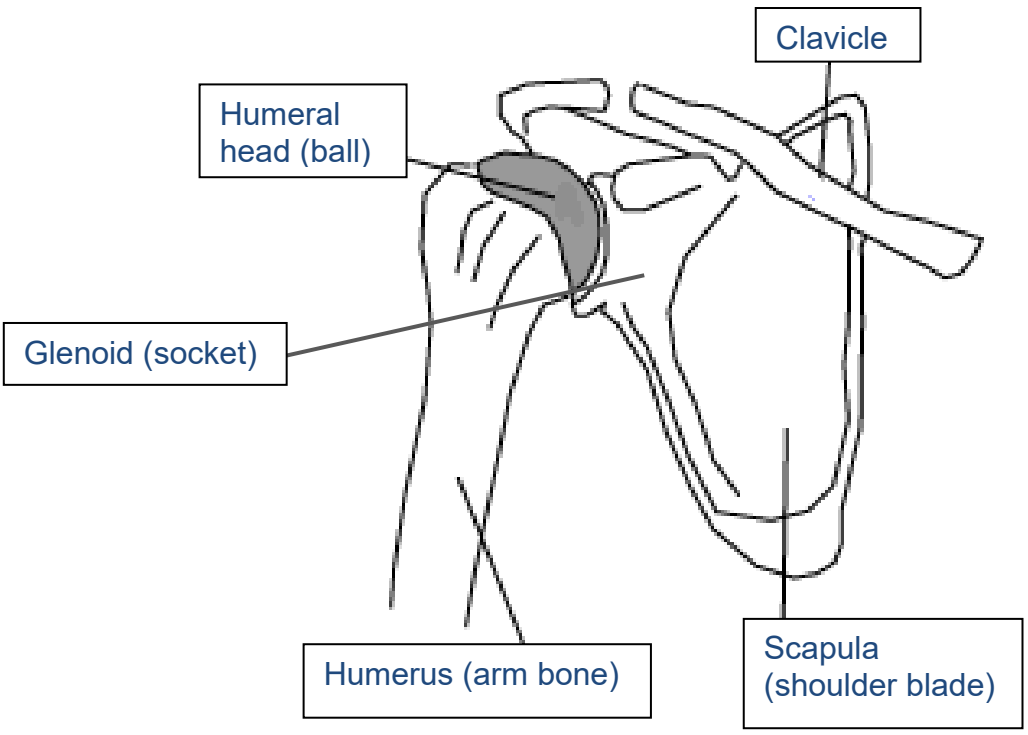
Shoulder instability

There is a balance between movements in the shoulder whilst maintaining stability. When the shoulder is moving normally, the ball stays centred against the socket. With shoulder instability this mechanism is disturbed.

When the shoulder is unstable you may feel the ball slipping or coming completely out of the joint. This may be accompanied by a feeling of a “dead arm”. You may become apprehensive of moving your arm in certain positions.

There is a wide range of instability of shoulder joint, from partial dislocation (subluxation) to a complete dissociation of the joint surfaces (dislocation).
With a dislocation you may not be able to put it back in joint yourself, and may require help at the hospital to relocate it.

A dislocation is more likely to damage the structure of the shoulder.



Types of shoulder instability

1. Traumatic: the main feature is that the shoulder dislocated as a result of a forceful injury, through contact with something, e.g. another person, the ground in a fall. Usually the ligament in the front of the shoulder is over-stretched and can pull part of the cartilage off the rim of the socket. This is called a “Bankart lesion”. Sometimes you can have a dent in the back of the ball which is termed a “Hill Sachs lesion”. Unfortunately, this type of injury tends to recur, usually when the arm is out to the side and twisted backwards. From research we know that the younger you are when you have the first dislocation, the more likely it is to recur. Rarely, the ball may be forced out backwards (posterior dislocation).

2. Atraumatic: for some people, the shoulder is not involved in a specific accident or injury, but the joint gradually becomes unstable. This may develop with specific repetitive movements of the arm (e.g. throwing, swimming). Sometimes people have “loose joints” and these can start dislocation with everyday activities.

A few people can make the muscles pull the ball out of the socket. This is known as “voluntary” dislocation. Often it starts as party trick but then the joint slips out when you don’t want it to. Our advice is to refrain from doing this.

Sometimes, it is not clear-cut as to whether it is purely a traumatic or an atraumatic instability problem. The two situations can overlap to some extent.

What tests may be done?

The main way we find out about shoulder instability is through what you tell us and by examining your shoulder. An X-ray is sometimes done, and sometimes an MRI scan will be ordered to assess what the damage to the joint is. Such scans are usually done with a dye injected into the joint.

What are the treatment options?

The treatment options are dependent on the type of instability group you are in.

Traumatic instability

If the joint is stiff or the muscles are weak, you may be sent for physiotherapy. However, if the movements are good and the muscles are working well, and the dislocation is affecting your activities, then you may be advised to have an operation. The operation is called an anterior stabilisation procedure. Sometimes, the operation is delayed until growth is complete in a teenager.

Atraumatic instability

Surgery is not recommended unless an extended and intense course of physiotherapy has been given, and has been unsuccessful. Surgery is not always a helpful option and can make some people in this category worse. It is important that you work hard at physiotherapy.

In the unlikely case that you are offered surgery, options will be discussed with you, and the most likely operation will be an anterior stabilisation procedure with tightening of the capsule.

If you show signs of both types of instability, physiotherapy may be recommended in the first instance.

Aims of physiotherapy

The broad aims of physiotherapy are to:

Retrain movement – this is probably the most important aspect of treatment.
The emphasis is on getting the optimal movement of the shoulder blade and arm bone. Sometimes abnormal movement patterns need to be corrected.

Strengthen muscles – this is not weight lifting type training! Initially the aim is to regain control of the muscles around the shoulder blade. Muscles that are weak or get tired easily need to be strengthened.

Regain position sense – the unstable shoulder loses the ability to know where your arm is in space. Certain types of exercises are given to help correct this.

Return to sport or physical activity – once the shoulder has better muscle control and balance as well as strength, you will be slowly guided back to activities that were previously making the shoulder unstable.

How often do I need to do the exercises?

You need to do the exercises at least three times a week to give them any chance of working. Ideally, try and get into the habit of doing them every day.
In addition, you need to continue with the exercises over a minimum of 12 weeks.

It is important to realise that the response to exercises takes time. You may not see any changes for six weeks.

You may also find that if you stop doing your exercises, the problem has a tendency to return. Therefore, you may find that you will need to continue with some form of exercise forever, just like cleaning your teeth.

The operation

The operation may be either done through keyhole surgery (arthroscopy) or as an open procedure. Your surgeon will explain to you which operation is advised.

Aim of the operation

The operation is aimed to stabilise the shoulder by repairing the torn ligament (Bankart lesion). In addition to this, the capsule of the shoulder joint may also be tightened by “pleating” it.

The operation may be done either through keyholes (arthroscopically) or as an open procedure depending on what the surgeon feels is the best way of repairing the damaged tissues.

After surgery

Rehabilitation after surgery is more complex. You will likely wear a sling to support and protect the shoulder for one to four weeks. A physiotherapist will direct your recovery program. Depending on the surgical procedure, you will probably need to attend therapy sessions for two to four months. You should expect full recovery to take up to six months.

The first few therapy treatments will focus on controlling the pain and swelling from surgery. Ice and electrical stimulation treatments may help. Your therapist may also use massage and other types of hands-on treatments to ease muscle spasm and pain.

Therapy after Bankart surgery proceeds slowly. Range-of-motion exercises begin soon after surgery, but therapists are cautious about doing stretches on the front part of the capsule for the first six to eight weeks. The program gradually works into active stretching and strengthening.

Therapy goes even slower after surgeries where the front shoulder muscles have been cut. Exercises begin with passive movements. During passive exercises, your shoulder joint is moved, but your muscles stay relaxed. Your therapist gently moves your joint and gradually stretches your arm. You may be taught how to do passive exercises at home.

Active therapy starts three to four weeks after surgery. You use your own muscle power in active range-of-motion exercises. You may begin with light isometric strengthening exercises. These exercises work the muscles without straining the healing tissues.

At about six weeks you start doing more active strengthening. Exercises focus on improving the strength and control of the rotator cuff muscles and the muscles around the shoulder blade. Your therapist will help you retrain these muscles to keep the ball of the humerus in the socket. This helps your shoulder move smoothly during all your activities.

By about the tenth week, you will start more active strengthening. These exercises focus on improving strength and control of the rotator cuff muscles. Strong rotator cuff muscles help hold the ball of the humerus tightly in the glenoid to improve shoulder stability.

Some of the exercises you'll do are designed to get your shoulder working in ways that are similar to your work tasks and sport activities. Your therapist will help you find ways to do your tasks that don't put too much stress on your shoulder. Before your therapy sessions end, your therapist will teach you a number of ways to avoid future problems.

This leaflet can be downloaded or printed from:

http://dgft.nhs.uk/services-and-wards/trauma-and-orthopaedics/

If you have any feedback on this patient information leaflet, please email dgft.patient.information@nhs.net

This leaflet can be made available in large print, audio version and in other languages, please call 0800 073 0510.

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Originator:	Mr M Sinha
Date originated:	March 2013
Version:	3
Date reviewed:	December 2022
Next review date:	September 2025
DGH ref.:	DGOH/PIL/00856