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## **ARTHROSCOPIC SHOULDER SURGERY POSTOPERATIVE INSTRUCTIONS**

The rotator cuff is made up of four muscles in your shoulder. These four muscles (subscapularis, supraspinatus, infraspinatus and teres minor) connect your humerus to your shoulder blade and acts to stabilize the ball of your shoulder within the shoulder socket. Injury to the rotator cuff may consist of tendonitis, acute tearing or chronic tearing.

### **Rotator Cuff Tendonitis:**

Rotator cuff tendonitis is caused by shoulder overuse or injury. Often overhead activities, overuse or acute injury will cause inflammation and strain of the rotator cuff musculature. This may occur from poor posture or activities such as loading equipment onto the top of a car or repetitive baseball throwing. In addition, trauma to the shoulder such as a fall may cause inflammation of the rotator cuff. Often shoulder “impingement” is a cause or worsening factor of rotator cuff tendonitis. This occurs when the acromion (a portion of a shoulder bone) impinges upon the rotator cuff. The undersurface of the acromion can act like sandpaper and causes rotator cuff irritation. This may in time progress to a rotator cuff tear. Symptoms of rotator cuff tendonitis include pain located primarily on the top and front of the shoulder joint. This pain will often worsen with overhead activity, reaching out to the side, and during sleep. It is also common to experience weakness with shoulder activity.

Rotator tendonitis is often diagnosed by physical examination. X-ray and MRI may be used as adjuncts to diagnosis. The presence of a spur or bump on the undersurface of the acromion may be detected on x-ray. Often an MRI will be used to examine the condition of the rotator cuff and assess whether the rotator cuff is torn. Often rotator cuff tendonitis can be treated without surgical intervention. First line treatment consists of an anti-inflammatory such as ibuprofen, ice and rest. A cortisone injection may be placed into the shoulder region. Cortisone is a strong anti-inflammatory medication that works to decrease inflammation and pain within the rotator cuff and surrounding bursa tissue. Physical therapy may also be utilized for rotator cuff strengthening and pain reduction.

If these treatment measures fail, then your doctor may suggest surgery. Shoulder arthroscopy is the recommended surgical procedure for “impingement”. At the time of surgery, your doctor will insert a small camera into your shoulder through a small incision and instruments through another small incision and decompress or open up the space around the rotator cuff to allow more room for the rotator cuff. At the same time, your rotator cuff will be inspected to be sure there is no significant tearing. If there is no tearing or only partial tearing (typically less than 50% of the width of your rotator cuff tendon), then the decompression alone should provide you with pain relief. If there is significant tearing, then your doctor may elect to repair this rotator cuff tear. Usually this is discussed with you prior to your surgery.

### **Surgery:**

The length of an arthroscopic subacromial decompression will take up to 1 hour depending on the extent of damage in your shoulder. Your nurse will bring you into the pre-op area where you will have an IV placed and meet with your anesthesiologist. General anesthesia is utilized to assure a comfortable surgery. This means that you will be “asleep” and completely unaware of the surgery until you wake up in the recovery area. Most patients will have a small tube placed in there windpipe, formal intubation may not be required. Local blocks are also available to supplement pain control. Your anesthesiologist will discuss this with you prior to surgery. Like any surgical procedure, there are risks but fortunately they are rare. These risks include but are not limited to nerve injury, infection and shoulder stiffness, and blood clots

### **Post-Surgery:**

After the surgery is completed, you will awaken in the operating room with a sling on and you will be moved to the recovery area. Most patients generally recover smoothly and have minimal pain due to local pain medication that is used at the completion of the surgery.

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## **POST-OPERATIVE INSTRUCTION SHEET: SUBACROMIAL DECOMPRESSION**

### **POST-OP MEDICATIONS:**

- You will be given a prescription for **pain medication** prior to discharge. This medication may be taken as directed. Once the pain or discomfort is minimal, you may switch to over-the-counter medications, such as Tylenol.
- You should take a **stool softener** while you are taking narcotics. The pain medication can cause significant constipation. Peri-Colace can be purchased over the counter and taken twice daily.

### **ICE:**

- An ice device or an ice bag (not directly touching the skin) should be utilized to reduce swelling and pain. Please ice every 3-4 hours for about 15-20 minutes each time for at least the first 5 days or until swelling subsides.

### **SLING:**

- You will be given a sling. You may wear this sling until you are comfortable enough to discontinue wearing this. Typically, patients use the sling for about 3-5 days, but this varies patient to patient.

### **PHYSICAL THERAPY:**

- You will begin PT usually as soon as possible. Preferably, within 3-7 days after surgery A PT prescription and protocol will be given to you prior to discharge.

### **WOUND CARE:**

- Leave your surgical dressing on for 2 days. After 2 days you may remove your dressing and shower. Dry the incisions well and apply a small dressing or Band-Aid over the incisions.

### **FOLLOW UP VISIT:**

- If you do not already have a follow-up visit scheduled please call 810-953-0500 to schedule one with Dr. Nelson within 7-10 days for suture removal.

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**Phase One: 0 to 6 weeks after surgery Goals:**

1. Prevent shoulder stiffness
2. Regain range of motion
3. Ensure wound healing

**Activities:**

1. Sling  
Use your sling as needed for comfort. Remove the sling and move the arm frequently by doing pendulum exercises.
2. Use of the operated arm  
You may use your hand on the operated arm in front of your body but **DO NOT** raise your arm or elbow away from your body. It is all right for you to flex your arm at the elbow. Use of a computer or writing is all right as long as it is not painful.
3. Showering  
You may shower or bath and wash the incision area. To wash under the operated arm, bend over at the waist and let the arm passively come away from the body. It is safe to wash under the arm in this position. This is the same position as the pendulum exercise.
4. Physical Therapy  
You should make appointments to begin physical therapy the day after your arthroscopic surgery.

**Exercise program**

Days per week: 7 Times per day 1-2

- Pendulum exercises - Each direction for 2 minutes
- Supine External Rotation
- Standing External Rotation
- Supine passive arm elevation
- Seated-Standing Arm Elevation
- Behind the back internal rotation
- Supine external Rotation with Abduction
- Supine Cross Chest Stretch
- Side-lying Internal Rotation
- Prone Horizontal Arm Raises



All stretching exercises should be done slowly to maximize muscle and soft connective tissue involvement. When stretching, your goal is to reach the maximum range of motion for you. There is a reason for multiple sets and repetitions. This reason stems from “warming up” the shoulder so it can actually stretch further in the last few repetitions that you will do. The first few repetitions prepare the stiffened or swollen shoulder for initial movement.

During active stretching and upon reaching your “endpoint” of pain or movement, push the operated arm with the uninjured hand another 5—10 degrees for additional movement. This final movement is labeled “terminal stretch”. Maximum motion for each person remains the goal and terminal stretching will assist in achieving that goal.

Since there is more than one repetition per set, allow the first one or two repetitions to be warmup reps, with very little pain. Gradually work into more and more range of motion. It is also important to allow pain to be your guide. Move the arm to an “endpoint” (that endpoint is dictated by the amount of pain). Your goal is to increase the endpoint as often as possible until you have reached the full range of motion. As far as pain, you want to avoid excruciating pain, but “discomfort” is tolerated as long as the pain does not remain for a prolonged period of time. A basic rule to follow when stretching is, if the pain does not linger, you did not stretch too far.

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**Phase Two: 6 to 12 weeks after surgery Goals:**

1. Prevent shoulder stiffness
2. Regain full range of motion
3. Regain shoulder strength

**Activities:**

Use of the operated arm

You may now safely use the arm for normal daily activities involved with dressing , bathing and self-care. You may raise the arm away from the body, however, you should not raise the arm when carrying objects greater than one pound. Any forceful pushing or pulling activities could disrupt the healing of your surgery.

**Exercise Program**

Days per week: 7 Times per day 1-2

**Stretching/Active motion**

Sets 1-2 reps 10

- Pendulum exercises
- Standing External Rotation / Doorway
- Wall Climb Stretch
- Corner Stretch
- Standing Forward Flexion
- Behind the back internal rotation
- Supine external Rotation with Abduction
- Supine Cross Chest Stretch
- Side-lying External Rotation / 1 lb.
- Prone Horizontal Arm Raises / 1 lb.

**Strengthening/Theraband**

Sets: 1-2 reps 15-20

- External Rotation
- Internal Rotation
- Standing Forward Punch
- Shoulder Shrug
- Seated Row
- Biceps curl

Return to sports typically at 12-14 weeks

Call Dr. Nelson with any questions