The Orthopaedic Group

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ACJ (Acromioclavicular joint) Arthritis

The Acromioclavicular Joint (ACJ) is a small joint made up of the acromion bone, which is part of your shoulder blade, and the outer end of your clavicle (collar bone). It is easily palpated with your finger as it lies 1 – 2 cm from the top outer edge of your shoulder. Because of its location, problems with the joint can give rise to pain in both the shoulder and neck.

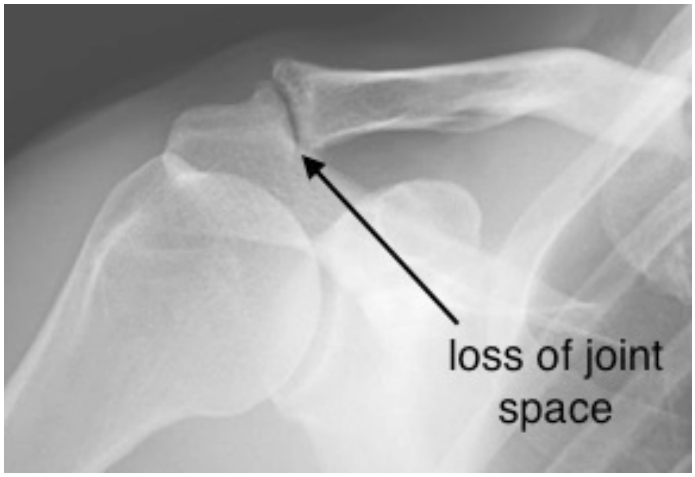
Causes

The principal cause of AC joint arthritis is use. As a person uses his/her arm and shoulder, stress is placed on the joint. This stress produces wear and tear on the cartilage, the cartilage becomes worn over time, and eventually arthritis of the joint may occur. Another cause is an old injury to the AC joint, such as ACJ Dislocation. Any activity that can put pressure on the joint, either normal or excessive, may eventually cause the arthritis condition.

Persons who must use their arms for extended periods of time are susceptible to AC joint arthritis. Constant overhead lifting, such as is engaged in by weightlifters, surfers, sailers and construction workers who work overhead, can increase the incidence of the disease. Any blunt force to the shoulder in the course of work, household activities, or accident may cause, over time, an osteoarthritic condition of the AC joint.

Treatment

- Physiotherapy – to prevent any further stiffness and regain range of motion
- Painkillers and anti-inflammatories and injections into the painful joint - this usually provides good temporary relief.
- Surgery – required for advanced disease, with pain not controlled with painkillers. Aim is to excise the ACJ either arthroscopically (through multiple small cuts with the aide of a camera) or open
    - If there is evidence other damage in the shoulder, this can be addressed at the same time



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ACJ Resection Operation

It is usual to spend one night in hospital following an acromioclavicular joint resection operation. No structures are repaired during this type of surgery, so you can rehabilitate and use your shoulder as much as comfort allows. A sling can be worn for comfort but is not essential. Exercises are commenced immediately following the procedure.

Wound dressings will be changed the day following your surgery, and all dressings can be removed 10 days postoperatively by yourself. You can then wash your skin including your wound as normal and moisturise your skin once or twice daily. It is unlikely you will have any sutures present but any sutures used are absorbable. Full recovery will take many months, but most daily activities can usually be undertaken after 6 weeks, and by 3 months the shoulder should be sufficiently recovered to allow a majority of activities.

The risks of this surgery include infection, prolonged stiffness, acromial fracture (rare), nerve and blood vessel injury (rare) and a failure to resolve symptoms.

General Guidelines

Pain

A nerve block may be used which means that immediately after the operation the shoulder and arm may feel numb. This may last a few hours. After this the shoulder may well be sore and you will be given painkillers to help this whilst in hospital and when you are home.

The Wound

This is a keyhole operation usually done through 3-4 5mm puncture wounds. These should be kept dry until healed.

Sling

You will return from theatre wearing a sling. This is for comfort only and should be discarded as soon as possible (usually within the first 2 to 4 days). Some people find it helpful to continue to wear the sling at night for a little longer if the shoulder feels tender.

Sleeping

Sleeping can be uncomfortable if you try and lie on the operated arm. We recommend that you lie on your back or on the opposite side, as you prefer. Ordinary pillows can be used to give you comfort and support.

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Pain Control

Some degree of discomfort is common after surgery. You should not have to 'put up' with pain. You will be given painkillers and anti-inflammatories from the hospital.

Driving

You may begin driving when you feel able to handle a steering wheel easily with both arms. You should be able to get your arm above shoulder level comfortably and manipulate objects at this level. For most patients this is usually about one week after surgery. If you are unsure, check with your therapist and/or surgeon.

Returning to work

This will depend on your occupation. If you are in a sedentary job you may return as soon as you feel able usually after one week.
If your job involves heavy lifting or using your arm above shoulder height you may require a longer period of absence.

Leisure Activities

You should avoid sustained, repetitive overhead activities for three months. With regard to swimming you may begin breaststroke as soon as you are comfortable but you should wait three months before resuming front crawl.

Golf can begin at six weeks. For guidance on DIY and racquet sports you should speak with your physiotherapist.

Follow-up Appointments

A follow up appointment will be made for 2-3 weeks after your operation. The amount of physiotherapy will depend on your individual needs.

Progress

This is variable. However experience shows us that by 3 weeks movement below shoulder height becomes more comfortable. By this stage you should have almost full range of movement although there will probably be discomfort when moving the arm above the head and when lying directly on your shoulder.

At three months after your surgery your symptoms should be approximately 80% better and you will continue to improve for up to a year following the procedure.

Posture

Correct posture is one of the most important things to achieve following your surgery. It allows the shoulder to move in the way it was supposed to do without placing stresses and strains on the joint and muscles.

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Complications

- **Pain** levels felt after surgery vary depending on the type of surgery, individual pain thresholds, nature of the problem for which surgery was done and various other factors. Pain beyond 2-3 months may indicate ongoing inflammation which may need injections to help improve. ACJ excisions can be sore for up to 6 months.
- **Stiffness** after shoulder surgery is common and occurs as a result of preexisting pathology, surgical scarring and prolonged post-operative protection in a sling. Most stiffness improves by 6 months, however some patients may require injections or further procedures to help the stiffness.
- **Bleeding** during or after surgery is very uncommon, occurring in less than 1% of patients. It is common to have oozing from the arthroscopic wound ports after surgery as the blood-stained sterile water used during surgery drains out.
- **Nerve injury** is rare (less than 0.5%) with most shoulder operations, but some larger operations have a higher risk and this will be discussed with you by your surgeon.
- **Infection** of the surgical wound is rare with arthroscopic surgery. Early diagnosis of post-operative infection has a significantly better outcome compared to delayed diagnosis. After your operation, you should contact the rooms immediately if you get a temperature, become unwell, notice pus in your wound, or if your wound becomes red, sore or painful.
- **Unsightly scarring** of the skin is uncommon and most surgical scars have disappeared to a thin pale line by one year after surgery. If you are concerned about your scar please discuss treatments to improve scar healing.
- **Vascular injury** is very rare (less than 0.5%) after shoulder surgery.
- **Anaesthetic related** complications such as sickness and nausea are relatively common. Heart attacks, lung infections and neurological problems such as strokes are rare, occurring at less than 1 person in 1,000, but have been reported to occur.

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ARTHROSCOPIC SUB-ACROMIAL DECOMPRESSION (ASD) +/- ACROMIO-CLAVICULAR JOINT (ACJ) EXCISION, +/- BICEPS TENOTOMY

	Rehabilitation
On Discharge	• Provide advice on sling management • Wean from sling as soon as comfortable • Educate on post-operative pain management • Hand, wrist, elbow and neck ROM (as block wears off) • Teach active assisted exercises in all planes as comfort allows • Postural awareness and scapula control • Thoracic spine ROM • **If a biceps tenotomy has been performed avoid resisted elbow flexion for at least 4 weeks**
1-3 Weeks	• Progress active ROM as comfort allows (closed chain to open chain, short lever to long) • Ensure kinetic chain involvement during all exercises and function • Begin cuff control exercise, progress through range as comfort allows • Ensure good dynamic cuff and scapula control • Monitor for compensatory movement strategies i.e at C spine/T spine
3-6+ Weeks	• Continue to progress active range of movement • Progress strengthening through range incorporating full kinetic chain • **Ensure rehabilitation is functionally specific to patient i.e occupation/sport**

Sling	Sling for comfort
Physiotherapy Follow Up	Within 2 weeks post op

Milestones	
Driving	Once sufficient ROM and strength has been regained and is safe and comfortable to do so
Week 1-3	Can return to sedentary/light work and activities such as swimming
Week 3-6	Full passive range of movement.
Week 6+	Full active range of movement and functional strength through range with good control Full AROM, full strength through range. Can return to sport as able (Not overhead). Can return to manual work
8-12 Weeks	Can return to repeated overhead activities/racquet sport as comfortable under guidance of physiotherapist

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Patient Specific Instructions/Requirements