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ORIF of fracture proximal humerus

You've been listed for an operation ORIF (open reduction and internal fixation) of the proximal humerus (the top end of your arm bone). You should have received most of the information during your last consultation with me. While the operation is successful for the vast majority of patients, there is a small risk of complications. As part of the consent process I will explain some common and/or significant complications to you. This list doesn't include every single complication that could possibly occur, but will focus on the important ones. While it is important that you understand the risk of complications, this shouldn't put you off having the operation, as the potential benefits of successful surgery by far outweigh the small risk of complications. Please don't hesitate to get in touch with me if you've got any further questions about this.

Infection: There is always a small risk of infection following any surgery. The risk is small. If the wound should become red/hot/swollen/painful following the operation you should see myself, your GP or a Doctor in the A&E department for advice. A short course of Antibiotics will usually eradicate the infection.

Nerve damage: There is a small risk of accidental damage to nerves. Dependent on the size and function of the nerve this could leave you with an area of numbness and/or weakness in some muscles of the arm. Although some damaged nerves can be repaired, recovery is usually slow and often incomplete. Sometimes damaged nerve endings can grow a painful neuroma, this may respond to physiotherapy or may require further surgery.

Malunion: The goal of the operation is to restore the anatomy of your broken shoulder as good as possible. Dependent on the severity of the fracture it is not always possible to bring everything back to perfectly normal and the shoulder may therefore heal with a degree of deformity – this is called a malunion. For most patients this does not cause any major problems. Very few patients require further corrective surgery.

Non-union: Sometimes fractures don't heal. Even surgery doesn't guarantee successful healing. Further surgery may be required to encourage the fracture to heal.

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Avascular necrosis: As a result of the fracture it is possible that the blood supply to the humeral head (the top end of the arm bone) gets cut off. If the blood supply doesn't recover, the affected part of the bone will die. This also means that the fracture will not heal, the metalwork may fail and arthritis may develop. The only treatment then would be a shoulder replacement.

Problems with metalwork: Although I take great care to position plates and screws in the best possible place and position, sometimes there can be problems: Screws can back out and cause irritation. Screws can penetrate into the shoulder joint and can cause pain. If prominent metalwork is causing pain, more surgery to remove the implants is required. Very rarely there are cases of catastrophic failure of metalwork for example if a plate breaks. More surgery will be necessary.

Ongoing pain: Fixing a broken shoulder does not always guarantee that any pain in the area will disappear. This depends on many factors, but mainly on the severity of the injury. If your shoulder has been shattered in many pieces then surgery can only limit the damage done at the time of the injury.

Stiffness: This is a common problem. The combination of a bad shoulder fracture and the additional scarring from surgery means that few patients regain a full range of motion. Dependent on the individual circumstances the stiffness may only be mild and hardly noticeable, whereas in other patients the stiffness may be quite bad and restrict daily function. Full compliance with Physiotherapy following surgery is essential to maximise the functional outcome, but even with intensive treatment many patients have a degree of stiffness.

Scar tenderness: This can sometimes be a problem. Most patients will respond to physiotherapy.

Pain syndrome: This is a rare but potentially disabling problem. It is a poorly understood condition where patients experience pain out of proportion following surgery. In severe cases this can also cause stiffness of the fingers. While intensive Physiotherapy can help most patients to control the symptoms, very few patients can be left with severe pain and stiffness leading to long-term disability.

If you would prefer to discuss this again with me prior to treatment then please contact my secretary Jill Barton, Tel: 01625 505427, Email: jill.barton@spirehealthcare.com

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