

Latarjet Procedure

X-ray after a Latarjet procedure: two screws hold the transferred coracoid bone block against the front of the shoulder socket, restoring bone stock and stopping the ball from slipping out.

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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 establishes the diagnosis. For long-standing problems we usually try non-operative care first and consider surgery when that has not given enough improvement. For structural issues, surgery may be recommended straight away.

We suggest this procedure when your shoulder keeps slipping out of place (anterior instability). It is a viable alternative to standard soft-tissue repairs, offering greater stability with no significant increase in complication rates. The overall recurrence rate following a primary Latarjet procedure for anterior shoulder instability is 4.7%. This operation aims to deliver lasting stability, allowing you to return to work and sport. Approximately 98% of patients who underwent Latarjet returned to work by 2.7 ± 3.0 months postoperatively.

Before the operation

You must fast for seven hours before your anaesthetic. Stop certain blood thinners as your surgeon advises. Arrange a lift home and bring a list of all current medications. Wear comfortable, loose clothing. You will need X-rays and possibly an MRI to check bone loss. If you have other medical conditions, you may need blood tests or a review with the anaesthetist before surgery. These steps help your surgeon plan the best approach for your shoulder. Please follow all specific instructions given to you by our team. This preparation helps ensure a smooth start to your recovery journey.

On the day

You present to the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You meet the anaesthetist, who explains your care plan. This operation is done under general anaesthetic combined with a regional nerve block. You will be fully asleep for the operation, and the block – an injection that numbs the nerves supplying the arm before you wake up – provides pain relief for the first 12 to 24 hours after surgery. 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. You wake up in the recovery area, where nurses monitor you while the anaesthetic wears off. Once you are stable you either go to the ward or go home, depending on the procedure and your recovery.

What the operation involves

We perform this procedure using an arthroscopic approach, which means keyhole surgery. This involves placing several small incisions, or portals, around your shoulder. At least one of these cuts is located at the back of your shoulder. Through these small openings, we insert a tiny camera and specialised instruments into the joint space. This allows us to see inside clearly while keeping the incisions minimal.

First, we prepare the area by releasing any tight tissues that may be restricting movement. We then take a small piece of bone from the front of your shoulder blade (the coracoid process). We carefully shape this bone graft and position it against the front rim of your shoulder socket. This new bone block acts like a bumper, providing extra stability to prevent the shoulder from dislocating forward again.

We secure the bone graft in place using small screws. These screws hold the bone firmly against the socket while it heals and integrates with your existing bone structure. We also repair the surrounding capsule and ligaments to further stabilize the joint. In some cases, we may repair the capsule to the coracoacromial ligament, which does not significantly restrict your ability to rotate your arm outward.

Once the bone is fixed and the tissues are repaired, we close the small incisions with sutures. A sterile dressing is applied to protect the area. The entire procedure is performed under general anaesthesia, so you will be asleep and feel no pain during the operation.

After the operation

You will wake up in the recovery ward with your arm in a simple sling for comfort. Most patients stay one night in hospital after this operation, though some are able to go home the same day. We will manage your pain with standard medication. Keep your wound clean and dry. Do not drive for at least six weeks, regardless of which arm was operated on. You must wait until your surgeon clears you, typically at the six-week review. See [Driving after upper-limb surgery](#) for details. Someone should stay with you for the first 24 hours to help you rest and recover safely.

Recovery

You will notice swelling and bruising around the shoulder in the first few days. This is normal. The area may feel tight or tender. We manage this discomfort with prescribed pain relief and ice packs applied to the shoulder area. Keep your arm supported in the simple sling for comfort. You may remove it briefly for washing and gentle exercises as directed by your physiotherapist.

Sleeping can be tricky at first. Try lying on your back or on the unaffected side with a pillow supporting the operated arm. This helps reduce swelling. As the initial swelling settles, you will begin more structured movements. Your physiotherapist will guide you through these exercises to restore strength and range of motion without straining the repair.

Daily activities return gradually. You will not drive while in the sling or if pain limits your reaction time. Our policy requires you to wait at least six weeks before driving, regardless of which shoulder was operated on. You can drive once your surgeon clears you, typically at the six-week review. See our guide on driving after upper-limb surgery for more details.

Return to work and sport depends on your job demands and healing progress. Most patients find they can resume work duties within a few months, while sports participation often takes longer. Your timeline may differ; your surgeon and physio will guide you based on your specific recovery.

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 a risk with any surgery. You might notice increasing redness, warmth, or swelling around the shoulder. The pain may feel deeper or throb more than usual. You might also develop a fever. If you see these signs, contact the clinic right away. You may need antibiotics or further treatment.

Recurrence means your shoulder slips out of place again. You might feel a sudden pop or shift in the joint. It could feel unstable when you move your arm. If this happens, seek medical advice promptly. Your surgeon will check if the joint needs further support.

Arthritis can develop or worsen over time. This is wear-and-tear of the joint lining. You might feel stiffness or a grinding sensation when moving your shoulder. Pain may increase during activity. If symptoms persist, discuss management options with your surgeon. Most cases are mild, but monitoring is important for long-term health.

Graft-related issues involve the bone piece used to stabilize the joint. You might feel persistent pain or tenderness near the front of the shoulder. There could be a feeling of tightness or restriction. If you notice unusual discomfort at the graft site, mention it at your next review. Your surgeon can assess if the bone has healed properly.

Female patients may have a higher risk of needing emergency care shortly after surgery. You might experience sudden pain or swelling that feels severe. If symptoms escalate quickly, go to the emergency department. Your surgeon will evaluate if immediate intervention is required.

Serious complications are rare in the short term. However, staying alert to changes in your recovery is key. Report any new or worsening symptoms to your care team. Early attention helps prevent minor issues from becoming major problems.

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

When to call us

Call us if you develop a fever, increasing wound redness, or discharge. Seek emergency care for sudden severe pain, calf swelling, or shortness of breath. Contact us immediately if you lose sensation in your arm or cannot move your limb. These signs need urgent assessment to ensure your recovery stays on track.

In more depth

This section goes further than you need for your own treatment decisions. The Latarjet is worth the extra reading because it is the clearest trade-off in shoulder surgery: it is the more reliable operation for keeping the shoulder in, and it is the one with more that can go wrong. Deciding between it and a soft-tissue repair means deciding which of those you weight more heavily.

WHAT IT BUYS

Compared directly with arthroscopic Bankart repair, the Latarjet procedure produced a **lower recurrence rate**, better patient-reported outcomes, and a **faster return to sport** – while carrying a **higher incidence of complications** [1]. A long-term comparison of **3,088** patients found the same directional result: lower recurrent instability and lower revision rates after open Latarjet than after arthroscopic Bankart, with **comparable** rates of moderate-to-severe arthritis between the two [2].

That last detail matters, because the standard worry about the Latarjet is that moving bone and tendon across the front of the joint must accelerate arthritis. On this evidence, at long-term follow-up, it did not – the arthritis rates were similar.

WHAT IT COSTS

Pooling **7,175** patients, the overall complication rate after the Latarjet was **6–7%**, with **graft-related** problems the most common category [3]. There was **no significant difference** in complication rate between the open and arthroscopic versions of the operation [3].

Six to seven percent is neither trivial nor alarming, and the composition is the useful part: the complications cluster around the transferred bone – its fixation, its healing, its resorption – rather than around the joint itself. That is intrinsic to what the operation does.

WHY IT IS NOT SIMPLY THE BETTER OPERATION

If the Latarjet has lower recurrence, an obvious question is why anyone has a Bankart repair.

Part of the answer is the complication rate above. The other part is that the soft-tissue options have improved. Across **2,100** patients, adding a remplissage to a Bankart repair reduced instability recurrence compared with isolated Bankart repair **without** a significant external rotation deficit, and may reduce the risk of reoperation compared with Latarjet [4].

So the real decision is three-way rather than two-way, and it turns on your glenoid bone loss, your Hill-Sachs lesion, your sport and your age – not on which operation has the best headline recurrence figure.

DO IT FIRST, IF YOU ARE GOING TO DO IT

One finding deserves emphasis because it affects sequencing rather than technique. Pooling **1,571** patients, **salvage** Latarjet – performed after a failed previous stabilisation – produced **inferior** outcomes to primary Latarjet in terms of recurrent instability and return to pre-injury sport [5].

The Latarjet is often described as the fallback if a Bankart repair fails. This is evidence that it works less well in that role than when chosen first. For a patient with substantial bone loss and high demands, “try the smaller operation and we can always do the Latarjet later” is a plan with a measurable cost attached.

REFERENCES

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