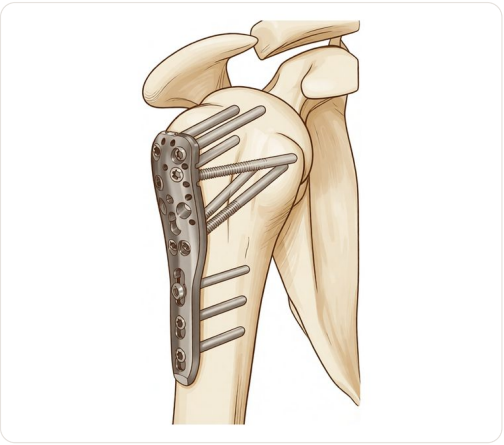
CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

INFORMATION & CONSENT

Proximal Humerus Fracture ORIF (Plate and Nail Fixation)



A fracture of the upper end of the arm bone, near the shoulder.

At-a-glance recovery. Pooled from 45 published studies — your own pace will vary.

LIGHT DUTIES desk work, driving, daily tasks	MOST EVERYDAY ACTIVITIES manual work, sport, gym	FINAL OUTCOME PLATEAU pain and strength
2-6 weeks	**12 months**	**120 months**
Early active motion rehabilitation is not inferior to restrictive protocols, with patients often returning to light activities within 2 to 6 weeks.	Patients largely return to baseline functional status by 1 year post-surgery.	Ten years after locked plating, patients show good to excellent outcomes with no relevant decline compared to 1-year function.

Why this operation has been suggested

Open reduction and internal fixation is a surgery to realign broken bones and hold them in place with plates and screws. Your surgeon may have suggested this for you because non-operative options, such as rest and immobilization, have not provided enough improvement. While many patients heal well without surgery, your specific fracture pattern likely requires mechanical stability to ensure proper healing. This approach is particularly considered for displaced fractures where the bone fragments have shifted out of their natural position.

The main goal of this operation is to restore stability to your shoulder, which helps reduce pain and improves your ability to use your arm. For patients with healthy bone density, this method can provide favorable long-term results. However, it is important to understand the risks. In patients over 60, there is a 44% complication rate and a 34% failure rate. You must remain in a sling and must not drive for at least six weeks after surgery.

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Once your surgeon clears you, typically at the six-week review, you may resume driving. For more details, see Driving after upper-limb surgery.

Before the operation

Please fast for eight hours before your surgery. Stop taking blood thinners only after your surgeon advises. Arrange a ride home, as you cannot drive for at least six weeks after any shoulder operation. Bring a list of all current medications and wear comfortable, loose clothing. You may need X-rays, blood tests, or an anaesthetic review to check your health and plan the surgery. Your surgeon will use an open approach with a single incision over the shoulder. This allows direct access to fix the fracture with a plate and screws. Follow your surgeon's specific instructions for medication changes and arrival time.

On the day

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 will arrive at the hospital and be admitted to a ward. Your surgeon will make a single conventional incision over the operative site to fix the fracture. You will then go to the operating theatre. After the procedure, you will wake up in recovery. Your arm will be in a sling. You must not drive for at least six weeks after any shoulder operation, regardless of which arm was operated on. Once your surgeon clears you, typically at the six-week review, you may resume driving. For more details, see Driving after upper-limb surgery.

What the operation involves

Your surgeon makes a single cut about 8 to 10 cm long over the front of your shoulder. This open approach gives clear access to the broken bone. Through this incision, your surgeon carefully moves tissues aside to see the fracture site.

The broken pieces of your upper arm bone are realigned into their correct position. Your surgeon then uses a metal plate and screws to hold the bone fragments together. This plate acts like an internal splint, keeping the bone stable while it heals. In some cases, a metal rod may be placed inside the center of the bone shaft to provide support. This rod is secured with screws at the top and bottom.

Your surgeon checks that the fixation is strong and secure. The cut is then closed with stitches or staples. A sterile dressing is applied to protect the wound.

The operation typically takes between one and two hours. You will have a sling to support your arm after the procedure. You must not drive for at least six weeks after this surgery, regardless of which arm was operated on.

You should wait until your surgeon clears you, typically at the six-week review, before driving again. For more details, see Driving after upper-limb surgery.

After the operation

You will wake up in the recovery ward with your arm in a sling and a dressing over the incision. Your surgeon will manage your pain to keep you comfortable. You should have someone stay with you for the first 24 hours. Most patients stay one night in hospital after this operation, though some are able to go home the same day. You must not drive for at least six weeks after any shoulder operation, regardless of which arm was operated on. You can drive once your surgeon clears you, typically at the six-week review. See Driving after upper-limb surgery for more details. Keep the dressing clean and dry until your next appointment.

Recovery

You will have a single incision over your shoulder. In the first few days, pain and swelling are normal. Your surgeon will prescribe medication to keep you comfortable. Resting with your arm supported helps reduce swelling. You will wear a sling to protect the repair. Keep it on as directed.

Your physiotherapist will guide your exercises. Early movement is important for healing. You will start gentle motions soon after surgery. This helps prevent stiffness. Do not lift heavy objects or reach overhead until your surgeon clears you. Simple tasks like eating or brushing your teeth may be possible with your non-operated arm.

Sleeping may be difficult at first. Try propping yourself up with pillows. This takes pressure off the shoulder. As pain settles and movement returns, you will gradually increase activity. You can return to driving once your surgeon clears you, typically at the six-week review. See Driving after upper-limb surgery for more details.

Your timeline may differ. Your surgeon and physio will guide you based on your healing progress. Most patients return to baseline function by one year. Consistent effort with your exercises supports the best outcome.

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 serious risk after this surgery. You might notice a deep, throbbing pain that does not ease with simple painkillers. The skin around your incision may become red, warm, or swollen. You might see pus or unusual drainage from the wound. If you have a fever or chills, contact your clinic immediately. This is a devastating complication that can affect your recovery.

Your bone may not heal properly. This is called nonunion. You might feel persistent pain at the fracture site when you try to move your arm. The bone fragments might shift, causing a clicking or grinding feeling. Your surgeon will check for this during your follow-up visits.

The blood supply to the head of your upper arm bone can be damaged. This is known as avascular necrosis. You may experience a deep ache in your shoulder that worsens over time. Your range of motion might decrease. You might notice stiffness that feels different from normal post-surgery soreness. Report any new, deep pain to your surgeon.

The hardware used to hold your bones together can fail. This includes the plate or screws loosening or breaking. You might feel a sudden change in how your shoulder feels. There could be a popping sensation or a loss of stability. If your arm feels weak or unstable, seek medical advice right away.

Reoperation is more likely if your fracture involved a dislocation. This means the ball of the shoulder joint came out of the socket. You might notice instability or a feeling that the joint is slipping. If you experience this, contact your surgeon promptly.

Older patients face higher risks from surgery itself. Inpatient adverse events and mortality are higher for those over 60. You might experience general weakness, confusion, or breathing difficulties while in the hospital. These are serious signs that require immediate attention from your care team.

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

When to call us

Call us if you have 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 or cannot move your limb. These signs need urgent assessment to prevent serious complications.

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Complication rates from published literature

Pooled from 45 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
overall complications	**44%**	Observed in patients aged >60 years treated with locking plates.
failure rate	**34%**	Observed in patients aged >60 years treated with locking plates.
tuberosity complications	**25.9%**	Complications including nonunion or malunion in reverse shoulder arthroplasty for fractures.
stiffness	**25%**	Most common complication in intramedullary nailing group for humeral shaft fractures.
hardware removal	**22.2%**	Reoperation rate for hardware removal in fracture dislocation series.
avascular necrosis	**20%**	High rate observed in patients with proximal humerus fracture dislocations.
implant failure	**20%**	Primary cause of reoperation in early locking plate series.
reoperation	**13.7%**	Overall reoperation rate reported in reviews of locking plate use.
screw cutout	**11.6%**	Common hardware complication in locking plate fixation.
varus collapse	**6-15%**	Loss of reduction into varus reported in 6-15% of locked plate fixations; risk factors include medial comminution and inadequate calcar support.
nonunion	**2.8%**	Most prevalent fracture complication in intramedullary nailing series.
infection	**1.9%**	Overall infection rate reported in systematic reviews of locking plate osteosynthesis.
nerve injury	**1.3%**	Overall nerve injury rate in reverse shoulder arthroplasty, applicable to complex fracture cases.

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I have read this information and have had the opportunity to ask Dr Hirpara questions about the procedure, its expected recovery, and the complications listed above.

PATIENT — PRINT NAME	SIGNATURE	DATE

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