

Scapulothoracic bursectomy

At-a-glance recovery. Pooled from 12 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
1-4 weeks	6-12 weeks	3-6 months
The sling is for comfort only and many series stop it within the first few days; some use none at all. Gentle movement starts straight away. In one series of 20 patients, pain was back down to its pre-operative level at a median of 6 weeks (range 2 to 16), and a technique report notes most people have recovered from the operation itself by about 4 weeks.	Most series allow full activity, sport and overhead use from about 6 to 8 weeks, with strengthening of the shoulder-blade muscles from about 8 weeks and return to overhead sport at around 2 to 3 months. Time back at work varied: a mean of 4.5 weeks after keyhole surgery in one comparison (18 patients), and about a month of sick leave after open surgery in another series.	General strengthening continues to about 3 months, and one series allowed full sport at 4 months. The improvement lasts: in 66 patients followed for 5 to 15 years, the average shoulder score rose from 57 to 87 out of 100 and pain from 5.2 to 1.4 out of 10, and 38 of 42 who played sport (90.5%) returned to it in some capacity. Some clicking or ache commonly remains even when the result is good.

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, including your history, an examination and imaging where needed, establishes the diagnosis.

Snapping scapula syndrome happens when tissue in the space between your shoulder blade and your ribs becomes inflamed, or when a bony prominence on the blade catches as it moves. This is called a bursectomy: removal of an inflamed bursa, a thin cushion of tissue that normally helps the shoulder blade glide smoothly. We usually try non-operative care first, such as activity change, physiotherapy for the muscles around the shoulder blade, anti-inflammatory medicine, and an injection into the bursa, usually for 3 to 6 months. Surgery is considered when that has not given enough improvement.

The aim of this operation is pain relief. In published series, more than half of people still noticed some clicking or grating even when their pain had improved.

Before the operation

Before surgery is planned, you will have had scans such as X-rays, an ultrasound or an MRI. These show the space between your shoulder blade and your ribs and help plan your operation. Most people need no other tests. If you have other medical conditions, you may need blood tests or a review with the anaesthetist.

In the days before your operation, we will confirm the details with you. You will need to stop eating and drinking seven hours before your operation. We ask for seven hours rather than six so you can be brought forward if the theatre list runs early. Bring a list of your current medicines, as some may need to be paused. Arrange for someone to drive you home afterwards. Wear loose, comfortable clothing that is easy to change out of.

On the day

You arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will then meet the anaesthetist, the doctor who puts you to sleep and looks after you during the operation. This operation is done under general anaesthetic, so you will be fully asleep. At the end of the operation local anaesthetic is injected into the small wounds and the space under the shoulder blade to ease pain as you wake up. A separate nerve block is not usually needed for this operation. The anaesthetist will meet you beforehand and talk you through it.

You are then taken into the operating theatre, where the operation is performed. When it is finished, 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

This operation is done through a few small cuts along the inner border of your shoulder blade, the side closest to your spine. You lie face down. Your surgeon works with a camera in the space between your shoulder blade and your ribs, not inside the shoulder joint itself.

Once the camera is in place, your surgeon removes the inflamed bursa, the thin cushion of tissue that has been causing pain as your shoulder blade moves. If the upper inner corner of your shoulder blade is found to be prominent, part of that corner is trimmed back as well. Whether this is needed is decided during the operation, based on what your surgeon sees.

The small cuts are closed with stitches. A dressing goes over the wounds, and local anaesthetic placed during the operation helps ease discomfort as you wake up.

After the operation

You will wake up in the recovery ward, where nurses keep a close eye on you as the anaesthetic wears off. Your arm rests in a simple sling for comfort; it comes off for exercises and washing. Pain relief is planned for you before you leave, and the local anaesthetic placed during the operation helps ease discomfort at first. You may notice swelling across the back and side of your chest from the fluid used during the operation; this is common and settles within hours to a day or two. Most patients stay one night in hospital after this operation, though some are able to go home the same day. We leave the dressing on for about 10 days; please do not take it off before then unless we tell you to. We change or remove it when we see you. Please have someone stay with you for the first 24 hours. You will be up and walking on the day of surgery, and most people manage light daily tasks within 1 to 4 weeks.

Recovery

For the first few days your shoulder and the area around your shoulder blade will feel sore and swollen. The swelling across your back and chest settles within hours to a day or two. Simple pain relief, as planned before you leave hospital, keeps you comfortable while this settles. Your arm rests in a sling for comfort; it comes off for exercises and washing.

You will start gentle movements early, guided by your physiotherapist. At first the exercises may feel awkward and the area around the small cuts may be tender. This eases as the swelling goes down. You can walk around the house from the day of surgery and manage light daily tasks as your comfort allows. You will need help at home for the first day or so, and someone should stay with you for the first 24 hours.

Once you are out of the sling, comfortable, and can turn the wheel and look over your shoulder without pain, you can usually drive again. Patients in a sling must not drive. Our page on [driving after upper-limb surgery](#) explains this in more detail. When your pain and strength have settled enough, you can return to desk work and light tasks, and later to heavier work, sport and the gym as your physiotherapist clears you.

Recovery varies from person to person. Your timeline may differ, and your surgeon and physiotherapist will guide you along the way.

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.

Because the operation works in the space between your shoulder blade and your ribs, the lung on that side sits close by. Very rarely, air can escape into the space around the lung. You would notice sudden breathlessness or sharp chest pain. Go to the emergency department if this happens.

The nerves and blood vessels running down your arm travel near the operation area. If one is affected, your fingers or hand may turn pale, cold, white, blue or dark, which can be a sign of a circulation problem. Go to the

emergency department if you notice this. New numbness, or not being able to move the arm, hand or fingers, also needs review: call the clinic.

The aim of the operation is to remove all of the inflamed tissue. Sometimes some is left behind, and the catching or grating feeling can continue. If your symptoms feel much the same after your recovery period, bring it up at your next review.

The same snapping feeling can also come back after a period of relief. Call the clinic if this happens, so we can assess whether further treatment would help.

Some people still notice clicking or grating after the operation, even when the pain has settled. This is common and does not always mean something has gone wrong. Mention it at your next review if it bothers you.

Some people continue to have symptoms after the operation, and scores measuring comfort and function can stay lower than expected. If your shoulder is not improving the way you hoped, raise it at your next review so we can look at what else might help.

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

When to call us

Call the clinic the same day if you have a fever, spreading redness around a wound, or fluid or pus leaking from it. Call us too if your pain keeps getting worse despite your pain medicines. Go to the emergency department if your calf becomes swollen or painful, or if you have shortness of breath or chest pain. These can be signs of a blood clot. Go to the emergency department as well if your fingers, hand or thumb turn pale, cold, white, blue or dark. Call the clinic if you notice new numbness, or cannot move your arm, hand or fingers. If you cannot reach us out of hours or on a weekend, go to your nearest emergency department.

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Complication rates from published literature

Pooled from 12 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
some clicking or grating remaining	58-78%	The operation is for pain. Crepitus was still noticed by 14 of 24 (58%) after bursectomy alone and 19 of 32 (59%) when the corner of the shoulder blade was also trimmed, and by 25 of 32 (78%) in another series, although most of those patients were satisfied.
some pain or symptoms remaining	69%	Across 203 operated shoulders in a 2018 systematic review, 42 (21%) had complete resolution and 139 (69%) improved but still had some symptoms; 22 (11%) had a poor result.
a further operation	5-13%	11 of 203 (5%) in the systematic review; 8 of 74 (11%) and 8 of 66 (12%) in the two largest single series, usually for symptoms that came back; 3 of 23 (13%) in an earlier series.
swelling of the chest wall from the fluid used during the operation	6%	11 of 201 (5.5%) in the systematic review, usually settling within hours; in one patient the swelling was enough to stop the operation.
injury to the nerve that holds the shoulder blade against the chest (long thoracic nerve)	<1%	1 of 201 (0.5%) in the systematic review had a partial injury. No nerve injuries were reported in series of 20, 23 and 47 patients.
wound infection	<1%	1 of 201 (0.5%) in the systematic review, superficial.

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