

Posterior Shoulder Stabilisation

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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. We usually try non-operative care first and consider surgery when that has not given enough improvement.

Arthroscopic posterior shoulder stabilisation is a keyhole procedure to repair the structures that keep your shoulder joint in place. It is typically offered when recurrent instability persists despite conservative treatment. Our goal is to restore stability and reduce pain. Arthroscopic stabilization results in good outcomes with high patient satisfaction and low rates of recurrent instability.

Before the operation

Please fast for seven hours before your surgery. We ask for this specific window so your procedure can be brought forward if the theatre list runs early. You do not need to restrict clear fluids during this time, but no food is allowed. Please arrange for someone to drive you home and stay with you for the first night. Wear comfortable, loose clothing to your appointment. Bring a list of all current medications. Your surgeon will advise which medicines to stop, so please follow their specific instructions. Most patients do not need blood tests or an anaesthetic review. If you have other medical conditions, you may need these checks. Bring any recent imaging, such as X-rays or MRI scans, to help us plan your operation.

On the day

You present to the hospital's surgical admissions unit. Here you are checked in and prepared for theatre. You meet the anaesthetist to discuss your care. This operation is done under general

anaesthetic. A regional nerve block is sometimes added for post-operative pain relief — the anaesthetist will discuss this with you on the day.

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

Your surgeon will likely perform arthroscopic stabilization. This uses small keyhole cuts rather than one large incision. A camera and special tools are inserted through these tiny openings. This approach allows your surgeon to repair the structures inside your shoulder joint. It is effective for managing both recurrent subluxations and frank instability.

If the instability is caused by bone loss, your surgeon may use a bone block. This involves taking a small piece of bone from another part of your body, such as the hip. This bone is then attached to the shoulder socket. This method helps to prevent the shoulder from slipping backward again. In some cases, your surgeon may also correct the shape of the shoulder blade (scapula). Fixing this anatomy helps to restore stability and reduce static subluxation.

The procedure typically takes between 4.3 and 8.6 months to allow a return to sport, though the actual surgery time is shorter. After the repair is complete, your surgeon will close the small cuts with sutures or glue. A dressing is applied to protect the area while you begin your recovery.

After the operation

You will wake up in our recovery ward. We manage your pain using standard methods. Your shoulder will be supported in a sling, and a dressing covers the small cuts. You must have someone stay with you for the first 24 hours. Your team will tell you whether you go home the same day or stay one night in hospital. We keep your arm still to protect the repair. Do not drive while in a sling or taking strong pain medication. See our guide on driving after upper-limb surgery for full details. Rest and follow our wound care advice closely.

Recovery

In the first few days, you can expect some swelling and discomfort. This is normal. Your surgeon will guide you on managing this pain safely. Keeping your arm supported and resting helps the swelling settle.

You will wear a sling to protect your shoulder while it heals. We do not use hinged braces or abduction pillows for this procedure. Your physiotherapist will guide you through gentle movements as soon as it is safe to begin. These exercises are key to restoring strength and stability.

At home, you will need help with tasks like cooking or dressing initially. Simple activities are fine, but avoid heavy lifting or reaching behind your back. Sleep may be tricky at first; propping yourself up with pillows often helps.

As your movement returns, you will gradually resume daily routines. You can return to driving once your surgeon clears you and you are off strong pain medication. For universal rules on driving after upper-limb surgery, please see our dedicated guide.

Your timeline may differ from others. Your surgeon and physiotherapist will guide you based on how your shoulder responds. Recovery is a process, and patience is important.

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.

If you have a posterior bone block procedure, you might notice that your shoulder feels stiff or painful in ways that do not improve over time. The surgery aims to stop the joint from slipping backward, but sometimes the results are not as strong as hoped. You may find that your shoulder still feels unstable or weak during daily tasks. If you feel that your recovery is not progressing or that the pain is not easing, please let us know. We can review your progress and discuss what might be happening.

Recurrence is another possibility. This means the shoulder slips out of place again. You might feel a sudden shift or a catching sensation in the joint. It could feel like the shoulder is about to dislocate again. If you experience this, contact our clinic promptly. We need to assess the joint to decide on the next steps.

In some cases, a glenoid osteotomy is performed. This involves reshaping the bone socket of the shoulder. With this approach, there is a higher chance that the instability may persist. You might continue to feel the same symptoms you had before surgery, such as pain or a feeling of looseness in the back of the shoulder. If your symptoms do not improve or get worse, bring this up at your next appointment. We can evaluate whether further treatment is needed.

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, or sudden severe pain. Go to emergency if you notice calf swelling, shortness of breath, loss of sensation, or cannot move your limb. These signs need urgent assessment. We are here to help you stay safe during your recovery.

In more depth

This section goes further than you need for your own treatment decisions. Posterior shoulder instability is worth the extra reading because it behaves differently from the anterior version most people have heard of — and the difference runs in the direction you would not guess.

POSTERIOR IS THE MORE STABLE REPAIR, AND THE HARDER RETURN

A meta-analysis comparing anterior with posterior instability after arthroscopic repair found that patients with **anterior** instability had **higher return-to-sport rates** but were **more likely** to have postoperative instability. Posterior patients were the reverse: the repair held better, but fewer got back to their sport [1].

That is worth sitting with, because it separates two things patients tend to fuse together. “Will my shoulder stay in?” and “will I get back to what I did?” have different answers here, and the second is the harder one.

The underlying results for the operation itself are good. A systematic review of **2,307** arthroscopic posterior stabilisations reported good outcomes with high patient satisfaction and low rates of recurrent instability, revision and residual pain [2]. A separate review of **1,047** athletes found high rates of return to sport, and relatively high rates of return to the pre-injury level [3]. Both findings can be true at once — posterior stabilisation is a reliable operation, and it is still a harder road back than its anterior counterpart.

WHAT PREDICTS FAILURE

The most useful recent work is about who does badly. A systematic review of **960** patients identified three risk factors for failure or revision after arthroscopic posterior capsulolabral repair: **female sex**, **reduced glenoid bone width**, and preoperative **glenoid bone loss greater than 11% to 15%** [4].

Equally informative is what did not predict failure: glenoid version, type of sport, labral width and labral version showed no significant effect [4]. Version in particular is often discussed as though it were decisive, and on this evidence it is not.

The practical consequence is that the glenoid bone stock deserves proper assessment before surgery. Beyond roughly the 11–15% mark, a soft-tissue repair alone is working against mechanics it cannot fix, and that is the conversation to have before the operation rather than after a failure.

WHY IT GETS MISSED

Posterior instability rarely presents as a dislocation. It is more often pain with a loaded, flexed arm — a bench press, a push-up, a hand pushing off a chair — with no history of the shoulder visibly coming out. That presentation invites the label of impingement or tendinopathy, and the diagnosis is frequently made late.

If you have pain pushing through a flexed arm and it has not responded to treatment aimed at the rotator cuff, posterior instability is worth specifically excluding.

CQ HAND + UPPER LIMB

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