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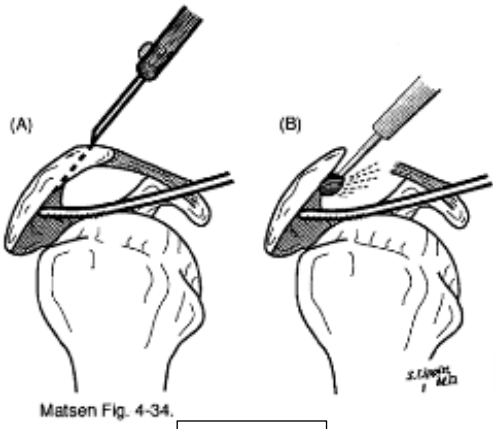
SUBACROMIAL DECOMPRESSION

This leaflet provides general information to help you understand arthroscopic subacromial decompression (ASAD) for shoulder impingement.

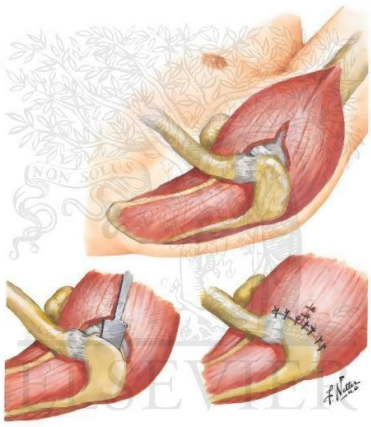
This keyhole procedure makes more room under the "roof" of the shoulder, and is usually a day case.

At the heart of my practice is **Shared Decision-Making**. Whether we pursue conservative management (Plan A) or surgical intervention (Plan B), the goal is to create a tailored treatment plan that aligns with your lifestyle, values, and functional goals.



Matsen Fig. 4-34.

Key Hole



Open Surgery

Videos of the surgery: https://www.youtube.com/c/ProfBijayendraSingh

This leaflet provides general information and does not replace individual medical advice.

Private Consulting Rooms

- **LIPS Healthcare London**
- **Spire Alexandra Chatham**
- **Practice Plus Gillingham**

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The Anatomy of the Shoulder Joint

The shoulder is one of the most complex joints in the body, relying on several structures working together:

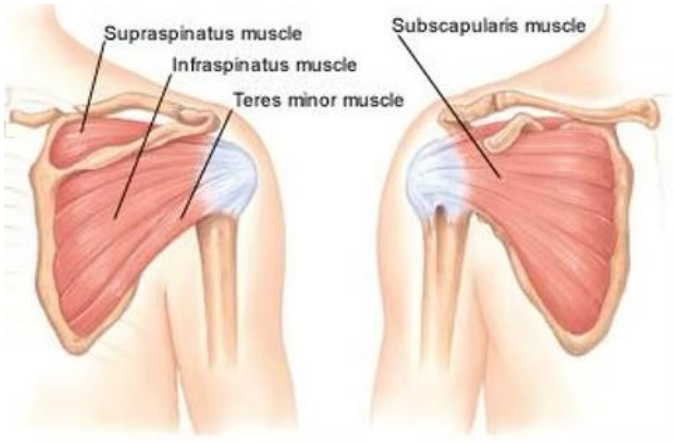
How the Shoulder Works

Three main bones form the joint:

- Humerus (upper arm bone)
- Clavicle (collarbone)
- Scapula (shoulder blade)

The Four Key Joints

- Glenohumeral Joint – the main ball-and-socket joint
- Acromioclavicular (AC) Joint – collarbone meets shoulder blade
- Subacromial Space – tunnel above the rotator cuff
- Scapulothoracic Joint – shoulder blade glides over rib cage



The Labrum (Stabilising Ring)

A rim of rubbery tissue that deepens the shallow shoulder socket — like a "bumper" or suction cup that keeps the joint stable and prevents dislocation.

The Rotator Cuff

Four deep muscles keep the ball centred in the socket and let you lift and rotate your arm:

- Supraspinatus
- Infraspinatus
- Subscapularis
- Teres Minor

About the Operation

Arthroscopic subacromial decompression (ASAD) is a keyhole day-case operation for impingement. Inflamed bursa and any bone spur are removed from under the acromion (the bony "roof"), increasing the space so the rotator cuff tendons are no longer pinched. It may be combined with a biceps tenodesis, rotator cuff repair or ACJ excision.

Benefits & Logic

The operation aims to:

- Relieve the pinching pain of impingement
- Increase the space above the rotator cuff
- Remove sharp bone spurs to prevent tendon wear
- Diagnostic clarity
- Minimally invasive

The Procedure, Step by Step

The operation, step by step:

- Assessment: a camera examines the joint and subacromial space
- Decompression: inflamed bursa and any bone spur are removed
- Space: the gap above the cuff is increased
- Closure: dissolvable stitches, strips and a sling for comfort

Before, During & After Surgery

Before Surgery

- Fasting: no food for 6 hours, no drinks for 2 hours before
- Smoking: avoid for at least 12 hours before, to aid healing
- Medications: continue as advised by the pre-op team

On the Day

- Admission: check in at main reception, then to your room
- Consultation: meet your surgeon and anaesthetist
- Preparation: timing and instructions are reviewed

Anaesthesia

- General anaesthetic with a nerve block that numbs the arm
- Nerve block alone (awake) if general anaesthetic is unsuitable

Recovery & Results

Recovery is a partnership. The timeline below is a guide — your physiotherapist and I will adapt it to you — **this shared decision-making process ensures you are fully informed and involved in your care.**

Recovery Milestones

- Sling: for comfort, briefly
- Gentle exercises: begin immediately
- Recovery: most do well by 3–4 months
- Full recovery: may take up to 12 months

Results

Most patients get good relief. A trial of physiotherapy over several months is usually recommended before surgery is considered.

After Surgery

In the first weeks

Sling: for comfort only, removed early

Pain Relief: start at home; take regularly for the first few days

Wound Care: dressings changed at 24–48 hours; showering after 3–5 days

Physiotherapy: gentle exercises immediately; ice twice daily

Follow Up: 2 – 6 weeks post op to monitor progress

Risks & Complications

Uncommon, but possible

Anaesthetic: complications are rare

Infection: fewer than 1 in 1000; treated with antibiotics

Stiffness: mild stiffness is common, improves with physiotherapy (slower with diabetes)

Pain: common early, settles over the weeks; an injection helps if it persists

Nerve: minor, temporary irritation in about 5%

Failure to Improve: 90% patients report good to excellent outcomes, a small percentage may have ongoing pain and may require further injection or surgery

Return to activities:

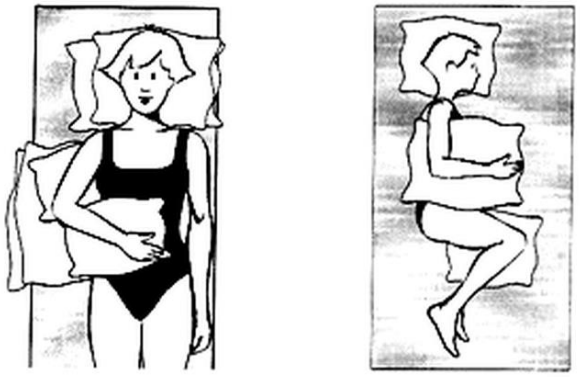
This can be extremely variable and discuss with the surgeon. These are just guidelines.

Desk work 1–2 weeks; driving once safe and out of the sling; **sport is staged** — your physiotherapist will guide the timeline. A member of the team will discuss your specific plan. **Driving:** 2 – 4 weeks when safe. A member of the team will discuss your specific plan.

Recovery Timeline & Sleeping

Recovery Timeline

Sleeping Positions



Prop up at first; when back in bed, use pillows to support the arm and avoid lying on the operated shoulder

Red Flags — When to Seek Urgent Help

Fever, spreading redness or discharge from the wound, worsening pain, or numbness and a cold hand — seek urgent assessment. If you experience any of the above, contact the practice, your GP, NHS 111, or attend your nearest Emergency Department.

Key Points to Remember

- **Makes more room under the acromion**
- **Physiotherapy is tried first**
- **Usually a day case**
- **Most people get good relief**

Questions You May Wish to Ask

- **When can I take the sling off?**
- **When can I drive and return to work?**
- **How much improvement can I expect?**
- **What happens if I don't have surgery?**

Book or Enquire Directly at Each Site

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