

## Resurfacing Hemiarthroplasty in Patients with Shoulder Surgery

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### Abstract

Shoulder surgery is associated with significant postoperative pain, but mobilization and physiotherapy often begin on the first postoperative day. Therefore, excellent postoperative analgesia is essential to provide a good functional recovery. A multimodal approach is required to achieve this. Analgesic options include: conventional oral and parenteral analgesia, inter-scalene analgesia or intra-articular analgesia with or without continuous infusion, or supra-scapular nerve block combined with local anaesthetic wound infiltration.

**Keywords:** Interscalene catheters; Shoulder arthroplasty; Adult rheumatoid; Bone-sparing; Corticosteroid injections; Upper limb

### Introduction

Paracetamol should always regularly be prescribed as part of a multimodal approach; this can be started intra-operatively as a parenteral preparation is now available. Non-steroidal anti-inflammatory drugs are relatively contraindicated in the first 24 h after surgery due to the increased risk of bleeding associated with this group of drugs [1]. However, they can be considered after this period if there is no other contraindication to their use. A strong opioid should be prescribed for the postoperative period, patient-controlled analgesia using morphine is entirely appropriate when regional techniques are not used. A useful alternative is oral oxycodone commenced on the first postoperative day [2]. A single-shot interscalene block is associated with shorter anaesthetic and surgical time, decreased blood loss, shorter stay in the recovery room, decreased postoperative opioid requirements and faster discharge from hospital. An interscalene block with bupivacaine provides analgesia for 15 h. Rescue analgesia, usually a strong opioid, must be available when the block regresses; as this is likely to occur overnight, a straightforward i.m. injection of opioid at this stage is appropriate.

### Methodology

Perineural inter-scalene brachial plexus catheters with local anaesthetic infusions are becoming increasingly popular in the management of postoperative pain after shoulder surgery. Not only do they prolong postoperative analgesia, they are opioid-sparing and may reduce the unwanted side effects associated with these drugs [3]. Patients can be fully ambulant while using the simple elastomeric balloon pumps. The most commonly used local anaesthetic agents for infusion are levobupivacaine and ropivacaine, infused at low concentrations to avoid prolonged motor block. An additional patient controlled component may be useful to increase efficacy further and improve patient satisfaction, although this requires a more sophisticated infusion pump. Until recently, patients were required to stay in hospital for the duration of the infusion; however, recent work from specialist centres has shown that patients may be safely discharged from hospital with the catheters in situ, connected to simple, disposable elastomeric or electronic pumps. This requires excellent and easily accessible support after discharge [4]. Intra-articular injection with bupivacaine and morphine at the end of surgery provides useful pain control and reduces morphine consumption in the first 24 h after major shoulder surgery as shown in (Figure 1). A standard epidural kit can be used by the surgeon to insert a catheter into the sub-acromial bursa at the end of the procedure. A continuous postoperative intra-articular infusion of local anaesthetic can then be used to provide analgesia of

the joint, particularly after arthroscopic surgery [5]. However, analgesia can be disappointing compared with other techniques and dilution of local anaesthetic may be a significant factor in the reduced effect of the supra-scapular nerve block. In addition, it will not provide any cutaneous analgesia; therefore, it is usually combined with local anaesthetic infiltration of the incision site. The nerve is easily blocked, usually with the patient in the sitting position, with needle insertion site 1 cm above the mid-point of the scapular spine, at an angle perpendicular to the skin [7]. It is best performed with a peripheral nerve stimulator that will elicit contraction of muscles in the scapular area. The nerve is blocked with 10 ml of



Figure 1: Pain control and reducing morphine consumption.

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