Reverse Shoulder Replacement

Shoulder arthritis

Shoulder arthritis alone is relatively rare, but with an aging population, it is apparent that long standing torn tendons in the shoulder can lead to arthritis. Pain and weakness are the common reasons orthopaedic surgeons are approached for treatment. The inability to move the arm is called pseudo-paralysis.

Non-operative treatments can include physiotherapy, paracetamol, anti-inflammatory tablets, activity modification, and moving objects from overhead cupboards and into easily accessible ones. The use of a clothes dryer and clothes horse may save overhead lifting.

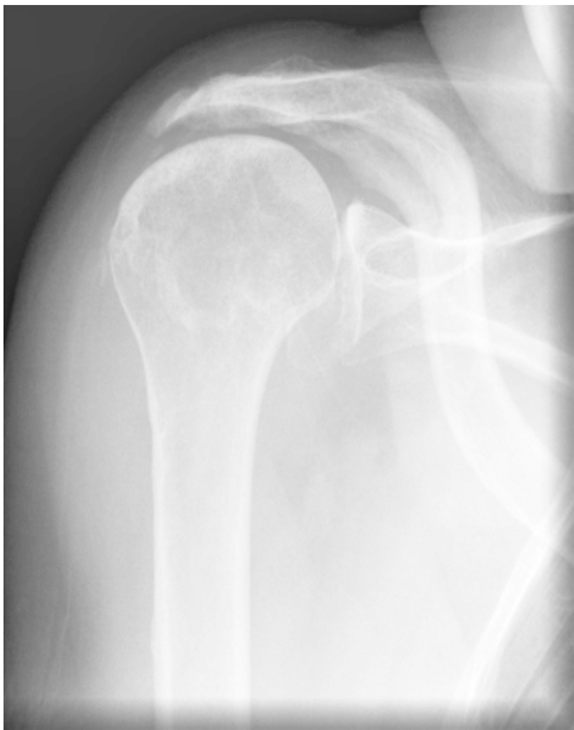

Figure 1. CUFF ARTHROPATHY
This x-ray demonstrates the ball part of the joint has migrated upwards. The tendons that usually keep it in place must have torn many years ago. Arthritis develops between the humeral head and the bone directly above it. Weakness is a common problem because the deltoid muscle doesn't have a well-centred joint (or fulcrum) to work against.

Before having a shoulder replacement it's important to have a severe enough problem that the surgery is likely to improve the problem, and the benefit exceeds the risk.

Reverse Shoulder

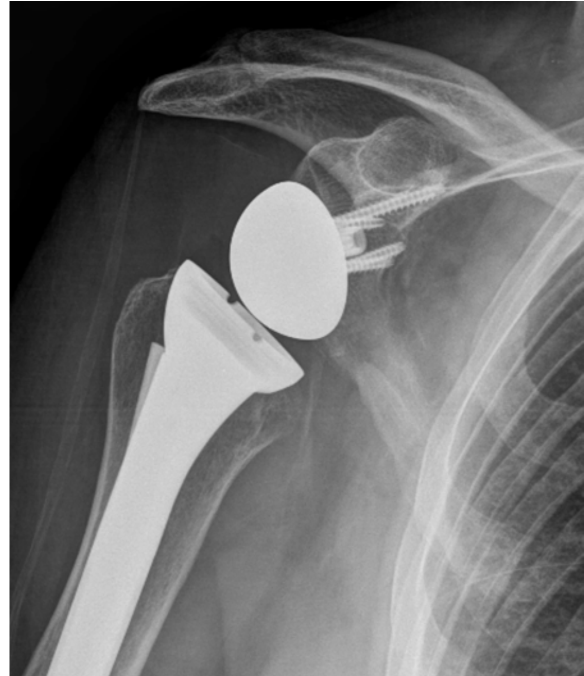

Figure 2. DELTA REVERSE REPLACEMENT.
A ball replaces the socket, a socket replaces the ball, and the arm has a fulcrum again.

Traditional shoulder replacements require the tendons that maintain the shoulder joint centred to be normal. In people over 80 years it is most unlikely the tendons can be repaired. Some people even in their mid 60's might not be suitable for a regular shoulder replacement. The functional improvement can be tremendous. A good proportion of people requiring this operation can't even get their arm to move forward enough to turn on or off a tap. After surgery, most people are able to get their hand up enough to brush their hair. Some can get to overhead cupboards and washing-lines.

Delta is a design that has been barely been changed since 1991 and is doing well in the Australian Joint Replacement Registry. In the 2016 report, the revision rate at seven years is 3.0%

BallaratOSM
orthopaedics | sports medicine | active recovery

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 **www.ballaratosm.com.au**

Alternate brands & concepts

Standard shoulder replacements are appropriate for patients where the rotator cuff tendons are functioning normally. The younger the patient, the more likely surgeons will try to maintain the normal anatomy. Sixty is young for a shoulder replacement, conversely at eighty, a reverse shoulder replacement is the more likely implant used.

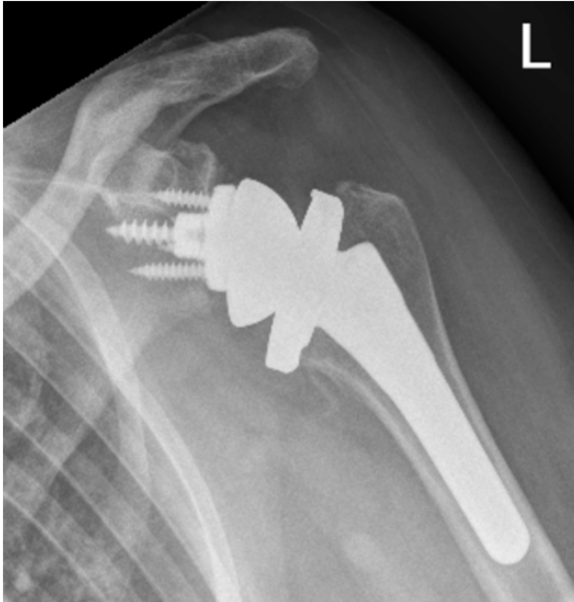

Figure 3. This is a Zimmer-Biomet implant - it uses a screw in the centre of the glenoid and a standard humeral component on which a ringloc plate holds the socket.

Bone grafting defects.

Bone grafting involves remodelling a piece of bone from the head of the humerus - which is usually discarded, and using it to rebuild the defect. It requires a longer central peg for the glenoid baseplate, and a meticulous technique.

The difficulty is that the graft does not always incorporate, even in expert hands. If the bone graft fails, the glenosphere moves, the shoulder replacement becomes unsatisfactory. In the younger patient requiring a reverse replacement - it makes sense. But in old patients who often have some osteoporosis, it is an un-necessary risk.

Custom Metaglenoids

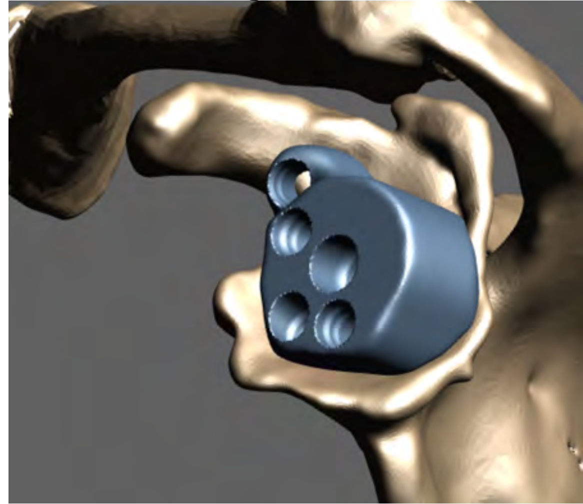

Figure 4. A computer model of a custom glenoid baseplate. The usual 4mm thick baseplate has been 3D printed to a thickness of 15mm at the deepest point..

The feature of all modern components is the titanium plate that is screwed onto the glenoid of the shoulder-blade. A potential problem in severe cases is that significant bone loss may have occurred and the plate cannot be put in a good position. Zimmer-Biomet offer a service to build custom implants that fit the patient's bone perfectly, and the screws that will be inserted can be planned.

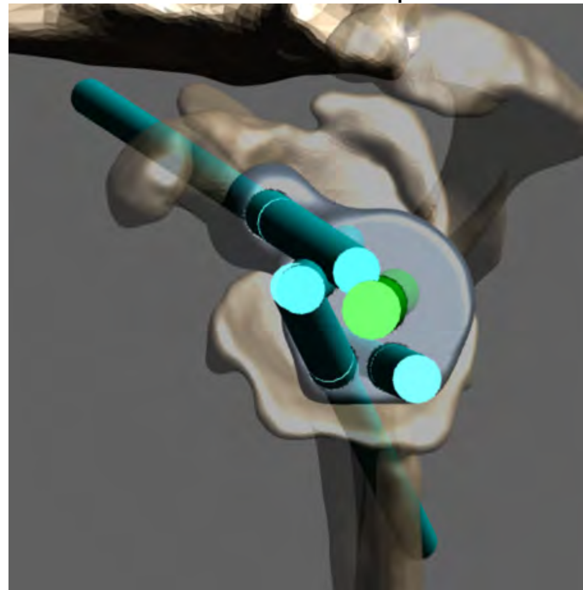

Figure 5.Same patient as figure 4 showing the computer designed screw trajectories into best quality bone.

The results of custom glenoid components is currently exceeding the results of bone grafted defects in journal articles. It will be some time before we have data from the Australian Joint Replacement Registry to confirm this.

Ref: Bull Hosp Jt Dis (2013) 2015 Dec;73 Suppl 1:S129-35

BallaratOSM
orthopaedics | sports medicine | active recovery
109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 www.ballaratosm.com.au

Why explore other options?

Firstly, shoulder replacements are not as good as a normal shoulder. In particular, the tendons on the front & back of the shoulder are needed for turning the arm in (eg reach a hip pocket or to do up a bra) and these tendons may be completely deficient.

In the Australian Joint Replacement Registry 2016 - the revision rate at seven years is 4.7% for reverse shoulders. Dislocations and infections may occur with a revision operation being recorded, and our registry data probably under-estimates the number of implants removed but not replaced.

Dislocation of the shoulder joint can occur. Just putting it back in place may not be enough treatment, and further surgery may be required. If the problem can't be rectified, the ball might be removed, and a ball put on top of the humeral head again. The desired functional improvement will not occur.

Infections seem more common after this surgery than traditional joint replacement surgery. Ideal circumstances to do this surgery is when there is no other infection in the body, the use of laminar flow operating theatres and "space suits" for the surgical team.

The surgery intentionally makes the arm longer. This is required to make the shoulder stable. This puts the deltoid muscle under increased stretch compared with a normal shoulder. It is said after 7 years, the deltoid muscle may fail.

In patients who have no pain prior to the surgery, we take a risk that the improvement in function justifies the pain of surgery.

BallaratOSM
orthopaedics | sports medicine | active recovery

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 www.ballaratosm.com.au

In patients that use a walking frame or wheeled walker, there is a risk that early return to this use might damage the shoulder replacement. By three months, that risk is gone, but most people needing a mobility aid need it immediately after surgery.

Non operative treatment

There is a physiotherapy program that in some patients restores sufficient strength that surgery is avoided. In elderly patients with an acute injury to the shoulder tendons, this regime is usually tried first.

Other non-operative treatments can include injections around the shoulder, paracetamol, anti-inflammatory tablets, activity modification, and moving objects from overhead cupboards and into easily accessible ones. Using a clothes dryer or clothes horse may save overhead lifting.

Alternate operations

Repair of rotator cuff

Small tears can be repaired. That treatment would have been offered if obvious. The recovery from a small cuff tear is typically six weeks of not lifting your arm using the muscles of that arm to do so, but it is OK to do things with your arm by its side.

Repair of large cuff tears have perhaps a 20% chance of obvious failure at the time of surgery, and the success of "tight" repairs is doubtful to be 50%. The arm would need to be in a sling for six weeks, and might be 4 months before useful function returns. Typically, surgeons and patients prefer operations with a 90% or higher success rate. Rotator cuff repair in the elderly is nothing like this.

Arthroscopic clean up

Where pain and catching are the main problem, this might have some benefit.

The Process of having a Shoulder replacement

Other health issues before surgery
Dental infections / planned dental clearance should be addressed well prior to surgery.
Unless you have already seen a physician, we may not have fully been informed of your history of angina, strokes, peptic ulcer symptoms and recent infections. If you are aware of any health issues that may impact on the surgery – let us know!

Physician Assessment
Physicians are doctors specializing in adult internal medicine, like I specialize in orthopaedic surgery. Most patients having a shoulder replacement will not need a physician unless they have other serious health issues.

Getting your house ready for going home
Remove tripping hazards - mats & rugs. A handrail in the shower may be beneficial if balance is an issue. Sitting options include using slightly higher chairs to make it easier to get out of. The pre-admission clinic will go over these again to check all is well.

Preadmission clinic @ St John of God
Most patients attend the pre-admission clinic to ensure all the required tests have been done (including an ECG for the anaesthetist) and that you are familiar with the hospital, and where to go. Sometimes this is arranged by telephone alone.

Preadmission clinic - Ballarat OSM
Please bring anyone who will have an opinion about you going home after surgery. We write your in-hospital medication chart, go through our checklist, and advise any medication changes prior to surgery. We will give you a bottle of Powerade to drink on day of surgery, and a Somac prescription if needed.

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 www.ballaratosm.com.au

What to bring to hospital
You will only be staying a few days, so don't bring too much. Wear to hospital the clothes you will wear home. Baggy pyjamas allow for access to dressings and having the wound attended to & topped up with local anaesthetic agents. A second set of night attire allows for any drama like needing to wash the first set. Bring some magazines, but don't bother with laptops. There a both negatives & positives to bringing your mobile phone. Aim not to bring any jewellery.

Admission to hospital
Typically patients are admitted on the day of surgery to the hospital through the Surgical Admission Unit. Same day admission has successfully reduced post-operative infections. You will be advised when to "fast" from prior to admission, it is important to have an empty stomach for safe anaesthesia. No solid food is permitted for six hours, but Powerade and clear fluids 2 hours.

Anaesthesia
Most patients have a combination of general and regional anaesthesia to ensure minimal pain after you wake from the general anaesthetic. The anaesthetist will meet you before you go to the operating theatre to discuss any concerns. If you are a 'high risk' patient, it may be appropriate to meet the anaesthetist some weeks prior to surgery.

Recovery room
Typically you will wake up in the recovery room, adjacent to the operating theatre. The nurses there closely monitor you. Ice packs may be applied to your shoulder. They might ask you "do you have any pain" – unless uncomfortable – you should answer "NO" or "minimal". If you wish to speak to your surgeon – say so, rather than saying you have pain! The recovery nurses have a protocol allowing them to give you A LOT of drugs if you say you have pain. These drugs may make you feel sick or vomit.

Shoulder block
The anaesthetist will probably have used a technique of anaesthetic called a shoulder block. This usually means when you wake up from the anaesthetic, the whole arm is numb, and usually the muscles don't work. It wears off in 12-24 hours. During that time, a sling is useful to give you some control of the arm.

Tubes
We aim to have the minimum number of tubes connected to you. The drip is usually left in until the day after surgery. Oxygen may administered in the first 24 hours, but is not required all of the time. Occasionally a urinary catheter is required if you have trouble voiding.

Orthopaedic Ward
You are moved to the ward on your bed. When you are alert, start getting some Powerade drink into your stomach. A light diet only for the day after surgery is recommended.

Physiotherapy
Typically our intention is to have you out of bed on the day of surgery to minimize the risk of chest infection and blood clots. 90% of people are independent by 24 hours from surgery. If you usually use walking aids (eg a wheeled frame), your surgeon will confirm if it is acceptable to use these after surgery.

The physiotherapist will show you exercises to get the arm going. The physiotherapist might not see you until the day after surgery, as the arm is usually weak & numb for the rest of the day after surgery.

Getting on with recovery
Using your hand is acceptable, indeed preferable. It helps reduce the swelling in the arm. Although some tendons may have been stitched back to the bone, it is most unlikely that light activity will disrupt the stitches.

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 www.ballaratosm.com.au

Do I need to go to inpatient rehabilitation?
The majority of people DO NOT need inpatient rehabilitation. We have found that even people over 80 years old are right by 4 days to go directly home – if there will be someone with them. We use a system called RAPT score to check that you'll be OK.

Going to a friend's house is not always ideal, as it may not have a rail in the shower to hang on to. Preferably the shower can be walked directly into, rather than needing to step into a shower/bath.

Going home

Tablets & things to take home
You will take home some tablets – some as background pain killers, and some to top up with if having significant pain.

Older patients may need a raised toilet seat, handrail in shower and higher sitting options such as carver chairs.

Living Alone?
Everyone is best to have someone stay with them for the first night. You will need to stock up the freezer before going to hospital, and someone to check on you daily (help with basic supplies-milk/bread/newspaper/etc). Obviously if the corner shop is an easy walk away, you can do this quite soon after the surgery. A Safety Link necklace could theoretically be used for a couple of weeks after the surgery.

Back up plan
A key part to going home is that you can call me if there is a problem. During office hours you can contact the rooms on **5332 2969**. Out of hours you can call the St John's Orthopaedic Ward on **5320 2140**, or if your surgery at - Ballarat Base Hospital - the ward number is **5320 4640**.
Most problems only require advice, but perhaps one person per year needs to go to the emergency department. Your

surgeon's mobile phone number might be on you appointment card or sheet.

Bowels

Constipation is a problem best avoided by eating plenty of fruit and walking frequently. Avoid Panadeine Forte, a common painkiller, although all painkillers can do it. Prune or cloudy pear juice is a classic remedy and probably should be taken on day two after surgery. If your bowels haven't worked within three days of surgery please seek advice from your local Pharmacy. If they still haven't worked the next day – contact your surgeon.

The wound dressing

Typically when people go home after shoulder replacement a spare dressing is provided. I recommend doing this in the shower recess on a plastic chair. If the dressing is leaking blood out the edge, remove it, shower, and pat the wound dry. Put the new dressing on. It should not need changing again.

What will the arm be like?

The arm will be swollen and bruised underneath the bandaging. When the bandaging comes off there will be indentations from the bandaging.
The edges of the wound are usually a bit pink for about a centimetre – this is normal healing and not infection. The shoulder will be warm, even hot – as part of the healing reaction. Ice packs (or frozen peas) are very helpful in the first week.

What to do in the first week:

Take the Panadol four times a day, Mobic 7.5mg twice a day. Leave the patch on until the clips are removed. If soreness is worse on the Wednesday after the surgery, phone the surgeon in the morning so an additional patch can be arranged. Most people do not need it though.

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 www.ballaratosm.com.au

You should walk every hour when awake. It is preferred that you use your arm – not to do heavy things, but light activity.

Second week:

You should walk every hour. You should use your hand. Gripping things (eg a stress ball) helps pump excess fluid back into the circulation & out of your arm. The swelling is usually at its worst about a week after the surgery.

The metal staples holding the skin together are removed at about ten days from the surgery. This is typically at the consulting rooms at 707 Mair Street, but sometimes we arrange a district nurse to visit you, or the rehab department will attend to it.

Third week

Hopefully at this stage you have "cut even". You will still have some pain, but hopefully better function with the shoulder than before surgery.

Resuming Life!

Having a shoulder replacement is to improve your pain and disability. Now you've had it done, you should get on with life. Walking up and down the street should be undertaken as soon as possible, probably the day you go home from hospital. Then you know you can do it, and know that you will be able to do a bit more the next day. Some people feel they should stay inside their house – this makes no sense. We would rather that you walked every hour to help minimise complications (clots in legs, chest infections).

Obviously the first time, someone should be with you. A mobile phone if you are going a distance is wise.

In short, it is possible to resume "life" as soon as you go home. If you want to tinker in the shed, fine. If you want to cook, fine. If you want to go and visit a friend, fine. If you need to take a tablet to achieve these things, fine. It is better to be active, even though it will make you tired.

Sleeping

In Bed-a pillow under your elbow takes the stretch off the deltoid muscle and should be done in the first 10-14 days. Usually the Tramal helps get some sleep if pain is the issue.

An occasional patient can't use Tramal. The use of Endone may be an alternative. Sometimes we use Temazepam to help people sleep. About 5% of people have pain or disturbed sleep that warrants the use of Endep 10-20mg at night, or Lyrica 75mg twice a day.

Driving after a Shoulder Replacement

TAC regulations prevent you from driving for six weeks. Strong painkillers such as Endone tablets cannot be used in people driving. The first time you drive should be at a quiet time, the radio and mobile phone turned off, and do NOT tailgate anyone as your reaction time will be slowed from the surgery for eight weeks.

For a left shoulder, an automatic car is easier.

By the Sixth week:

It is now the time to start work on strengthening the shoulder. In particular lifting a small weight in front of you, like lifting a 1kg bag of sugar into an overhead cupboard.

Stretching exercises should be increased. Trying to get your hand behind your back, using the opposite hand to help pull it around. Use a broom-stick to help rotate the hand away from the body.

By the 3rd month

Strengthening the muscles that get your hand behind your back, and the ones that help you rotate the hand away from the body.

By the 6th Month

Unrestricted activities. The tendons that were expected to heal should have healed by now.

When will my shoulder be normal?

Shoulder replacement is a major operation. It is basically right at SIX MONTHS from surgery. It will continue to improve until 3 years, but even by three months it should be better than pre-operatively.

A small number of people are never satisfied with their shoulder replacement. These fall into the categories of wrongly selected for surgery, wrong expectations of the patient, complications, and a group where no reason is ever found.

What to ring us about…

Nausea / vomiting
Constipation not fixed by three days
Black bowel motions
Increasing redness or discharge from the shoulder wound

Avoiding Sources of Infection

Dental Procedures

Some dental work is particularly risky for getting infection into a joint replacement. Dental infections can get into a joint. The most common recommendation is to take 2-3g of amoxicillin one hour prior to procedures where there is a risk. (Aust Dent J 2005:50 Suppl 2S45-S53)

Skin wounds

Rose thorns, shin cuts and open foot injuries are all high risk. Gardening is somewhat hazardous. The risk never completely goes away. Gardening gloves are essential and long sleeves add safety for pruning. Mowing should be done in trousers.

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 www.ballaratosm.com.au

Pain Management after Orthopaedic Surgey

Pain scores & discomfort
Nurses in recovery and the ward will ask you whether you have any pain, and to score it out of ten. If you can get basically comfortable by moving yourself, the score is probably 2 or less. It is important that you tell them if the pain is somewhere different than where the operation site!

Most patients look comfortable in recovery. But if you report pain at 5/10 you are likely to get morphine like injections, which might trade the pain for nausea. At 7/10 people are visibly in pain – teeth clenched, pale appearance, sweaty brow. 10/10 pain is rarely seen and described as "screaming pain"

Local Infiltration Analgesia
This is a key technique that we are expert with in Ballarat. Local anaesthetic mixed with anti-inflammatories – Torodol & dexamethasone is infiltrated around the wound by the surgeon. The surgeon leaves a wound catheter buried in the bandaging so that extra drugs can be injected around the joint replacement the following morning. It has a filter on it to avoid any contamination.

Pain Patch.
Norspan, a narcotic patch, is applied to the skin and gradually releases analgesia. If the patch is too hot, you may become nauseous or drowsy. If your joint is sore you can warm up the patch by giving it a rub, or put on a jumper. The Norspan patch is typically changed 6-7 days after surgery.

Background tablets
Mobic
Panadol
Somac

Top up medications
Tramal is the preferred drug. Typically 1-2 tablets, 4 hourly as required. Tramal is not always perfect, it can cause nausea or hallucinations, and can't be used with high doses of some anti-depressants. It seems more effective and less habit forming than Endone.

Swelling control reduces pain
Rest means not bending it too much in first two days. It is still permissible to walk and exercise your feet up and down.
Ice packs are first applied in recovery, or as soon as possible after the surgery. Be a little careful with areas that have local anaesthetic that you may not be able to feel how cold it is. Do NOT apply ice directly to the skin, and apply it only 20 minutes at a time.
Compression is initially a bulky bandage extending to the foot. This stays on for a minimum of one day. It is then replaced with Tubigrip, and a Venosan stocking.
Elevation. In the first two weeks, put your leg up when you can. Lying on the couch is much better than sitting.

Avoiding nausea and vomiting
Our aim is to have you drinking fluid and food as soon as possible after the surgery. We generally try to avoid fruit juices for the first day as these sweet & acidic drinks can make you vomit. Powerade is a sugar & salt drink – this can be used up to two hours before surgery, and when you are alert after surgery. If you feel sick tell the nursing staff. It is easier to control nausea early, rather than allowing vomiting.

Night pain & Chronic pain
If pain prevents sleeping it needs treatment to avoid becoming chronic. Amitriptyline 10mg at night, increasing to 20mg may suffice. It is described an anti-depressant, but in this instance it is prescribed in a comparatively small dose that helps with "neuropathic pain".

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 **www.ballaratosm.com.au**

Complications following shoulder replacement

A joint replacement is a major surgical procedure. It replaces an arthritic joint with an artificial one. It carries substantial risks. This list cannot be complete, but does deal with more common problems. Accepting and minimizing these risks is a responsibility of both the patient and the surgeon. If the patient doesn't accept that a joint replacement occasionally goes wrong, they should not submit themselves to surgery.

Scar pain and numbness

Shoulder replacement involves cutting a number of layers to do the surgery. It is common for an area on the outer (lateral) area of the skin scar to be numb. The area may become smaller with time (years) but it is usually permanent.

Scar tenderness

The scar is expected to be tender for three months, a little pink and inflamed initially. The scar takes some months to smooth out. Rubbing cream into the scar and the skin at the front of the shoulder helps.

Stiffness or Weakness

Shoulder replacement does not guarantee a normal range of movement or full strength. This is typically most obvious when trying to hang out clothing. Less than 90 degrees of forward elevation will be very disappointing to both the surgeon and the patient. Getting on with using the hand and arm as soon as possible after the surgery may reduce the risk. Some people have a fracture of the acromion, the tip of the shoulder, either prior to or after the surgery and this contributes to weakness.

Neurovascular injury

Passing near the shoulder are nerves and arteries. Rarely the artery could block, or a nerve be injured. That injury can result in permanent loss of function or viability of the limb.

Fracture

A fracture of the acromion can occur at the time of surgery, or after an injury. There may not be a treatment for this, and the full function of the shoulder is unlikely to be achieved.

Urinary catheterisation

As a general rule, urinary catheters are not used routinely. Since using local anaesthetic and early mobilization, most patients have been able to use their bladder normally. However, a small number of patients may still require a urinary catheter. It is usually left in overnight.

Thrombosis & pulmonary embolism.

Clots can occur within the veins of the leg and pelvis before, during or after surgery. They are associated with a risk of dislodging and moving up to the lung. It can be fatal. Even if they remain in the leg, a "post phlebetic syndrome" can leave permanent swelling of the leg and can cause ulcers to develop. If you have had a blood clot before, you must tell your surgeon to ensure additional steps are taken if required.

Infection.

Infections can occur directly after an operation, or even occur out of the blue many years later. The infection rate seems to be higher in shoulder surgery than hip or knee replacement. Some patients may carry additional risk factors – tell us you have been exposed to MRSA or a bad staph infection. To minimize the risk of infection, we prepare the operation site with antiseptics, use antiseptic impregnated drapes, and use intravenous antibiotics at the time of and after surgery. At St Johns we have laminar flow operating theatres, and we use "space suits" at both hospitals.

In the first two years following surgery you must tell doctors & dentists before any procedure.

BallaratOSM
orthopaedics | sports medicine | active recovery

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 **www.ballaratosm.com.au**

Bleeding from the stomach

We have seen this in patients who probably had an undiagnosed stomach ulcer prior to their shoulder surgery. Where a risk is perceived, Somac is given. There is clear evidence than Mobic used in combination with Somac has virtually no risk even with a history of stomach ulceration.

Bowel obstruction

Pain relieving drugs such as morphine can slow the gut action. On occasions the gut gets worse, becomes distended and may require surgical treatment! This is usually a "pseudo-obstruction" and occurs in 0.5% of cases. Since using our local anaesthetic cocktails, we haven't seen this problem.

Complex Regional Pain Syndrome

This rare diagnosis (previously know as Reflex Sympathetic Dystrophy) contributes to poor outcomes with pain and stiffness. If you have ever had this condition diagnosed in you, tell your surgeon so additional steps can be undertaken to minimize the risk. Our techniques of local infiltration analgesia and post-operative pain management minimise the risk of it occurring with this operation.

Dislocation

Shoulder replacements rely on your soft tissues to hold them in place. If it pops apart, you will need to attend hospital urgently. Obviously we have solutions to the problems, but it is unlikely the shoulder will be returned to normal, or as good as it could have been.

Scapular notching

This complication is specific to reverse shoulder replacements and occurs if the socket swings around too far under the shoulder blade. In a recent series, 70% of cases had this. It may not cause a problem, but accelerates wear and might cause fracture.

Loosening

For a variety of reasons, the fixation between the shoulder replacement and the bone may fail. This loosening may cause pain and require re-operation. An average re-operation is unlikely to be as good as an average first time operation.

Wear

The plastic insert between the humerus and shoulder blade can wear. Typically the wear rate is low enough that most people will never have a problem. Rare cases though may wear faster and require further surgery.

Dexamethasone

We administer this to help with pain & nausea after surgery. So far we haven't had anyone "manic" or have avascular necrosis of their hip, but these are known risks.

Renal failure

To minimise pain after the surgery we use anti-inflammatory medications. Patients that have had renal failure previously are at particular risk. Dialysis was required for a week in one such patient, although it was not an elective case, nor a shoulder replacement.

Stroke

A stroke occurs in 0.2% of patients having major joint replacements, causing possibly permanent weakness, and one in four die as a result.

Other

It is not possible to provide a full list of complications. Some patients may be unhappy even if nothing can be identified as being wrong with the shoulder replacement. In these circumstances, it may be better for the patient to make the "best of a bad lot" rather than have more surgery.

BallaratOSM
orthopaedics | sports medicine | active recovery

109 Webster Street, Lake Wendouree VIC 3350

Financial Consent for Joint Replacement

Insurance generally pays for the “spare parts” and most of the hospital expense, but only covers a fraction of the doctors’ fees. This is because Medicare hasn't adjusted their schedule to match CPI since 1983, or at all since 2014, Medicare is now worth less than one third of the real value of 1983. So there will be out of pocket expenses for doctors.

Doctors involved in the operation are: the surgeon, anaesthetist, surgical assistant, and if any medical problems occur, or are anticipated, a physician. The surgical assistant is a skilled nurse, doctor, or surgeon or a combination of these working alongside your main surgeon. The surgical assistant's billing will occur through Ballarat OSM. Typically there will be an out of pocket expense, which contributes to paying the salaries of our nurses and our fellow. If a physician is required, please discuss his fees with him. The anaesthetist will arrange his/her own financial consent. Typical out of pocket expense after Medicare & private health insurance rebates (estimates) are $500 for hospital, $400 for anaesthetist, and $400 for surgical assistant.

Included in the **surgeon’s fee** is performing the surgery, follow-up in the hospital and consulting rooms for three months, to take responsibility for the whole process, and to solve whatever problems occur. The surgeon takes personal responsibility for the post-operative pain control – including extensive local anaesthetic infiltration around the wounds. For patients off-track, the surgeon intervenes, or supervises interventions. The surgeon takes personal responsibility for achieving a low infection rate. If an infection does occur, aggressive surgical and antibiotic treatment is required.

The AMA calculates annually the change in cost of medical practice, covering practice staff, insurance, rent etc, which roughly follows the CPI. Following the AMA fee recommendations, the surgeon’s fee for major joint replacements & the reinjection technique is $4560 (item number 48918, 47966 & 18222). The majority of insurers expect surgeons to discount well below the AMA fee, and are only required by law to pay $440 towards the surgeon, Medicare pay $1320.

ESTIMATED FEES	Insured	Medicare only	No Medicare
Surgeon	$ 3,657	$ 4,097	$ 5,417
Total	$ 6,010	$ 22,100	$25,000

Included in the package of estimated fees are:

- Hospital, surgeon, assistants, anaesthetist, prosthetic implants
- post operative ward rounds, usual blood tests and XRs
- followup phone call(s) after discharge, access to Ballarat OSM nurses for advice
- 2 & 6 week appointment at rooms, and any other visits to the consulting rooms required.
- 12 months follow-up appointment related to the shoulder
- Long term surveillance of the joint replacement by XR & phone for younger patients

Excluded:

- Physician involvement
- Other orthopaedic or surgical problems

If you are experiencing personal financial hardship, please discuss this well prior to the surgery so an amicable arrangement can be made. The out of pocket expenses will be required to be paid two weeks prior to surgery to avoid cancellation.

109 Webster Street, Lake Wendouree VIC 3350
tel. 03 5332 2969 **www.ballaratosm.com.au**