



Patch augmentation for rotator cuff repair

You've been listed for arthroscopic rotator cuff repair. While most rotator cuff tears are repairable, there can be situations where the quality of the tendon repair might be poor or where a repair is not possible. In these situations I may decide to use an artificial patch to facilitate a repair. In this leaflet I will try to answer some common question regarding the use of these patches. I will also explain the potential risks and complications specific to the use of patches (most general complications are covered in the leaflet for the arthroscopic cuff repair that you should have received as well). Please don't hesitate to get in touch with me if you've got any further questions about this.

What are the patches made of: I use patches made from human tissue. They are specially treated to avoid problems with disease transmission and graft rejection. These patches have been used for many years and have been shown to be safe.

Disease transmission: Patients are naturally concerned that a patch made from human tissue could contain bugs or viruses that can cause diseases. These patches undergo extensive treatment and tests. I'm not aware of any cases of disease transmission through the use of patches.

Graft rejection: the human immune system will automatically reject any tissues that look foreign to the body. Patches are therefore specially treated to remove any tissue components that could trigger a rejection reaction. The scientific literature has reported on very few cases where a patch has been rejected by the body. The only treatment is then further surgery to remove the patch. This is a very rare complication.

Re-tear: Even with the use of a patch there is a risk of any repair tearing again. Patches don't guarantee successful healing. They help for example in reducing the risk of a re-tear from high to moderate or low. Patches can also help bridging defects in a situation where normally a repair would not be possible. In other words: patches are used in borderline situations and therefore there is a risk of failure of any repair.

Anchors and sutures: I use suture anchors to repair the tendon and to reinforce the repair with the patch. An anchor is like a wall plug with sutures attached that gets buried in the bone. If the anchor pulls out it can cause pain and may have to be removed. If the sutures fail or become undone they may cause pain and irritation in the shoulder and may have to be removed. These are rare problems

Weakness: Repairing the torn tendon may help patients who had weakness prior to surgery, but not every patient with pre-operative weakness develops normal strength following the operation. The prognosis is best if I can repair the tendon. If all I can do is to bridge a big irreparable defect, then any weakness is unlikely to improve – the main goal in these situations is pain relief

Rehab: Your rehab will follow the same protocol regardless of whether I've used a patch or not. There are rare exceptions where I may have to slow down the rehab process in particularly bad situations.

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www.jf-ortho.co.uk

www.manchesterorthopaedicgroup.co.uk

www.advancedshoulderclinic.co.uk

www.orthobiologicsclinic.co.uk

Following Surgery: Your arm will be in a sling for 3 to 6 weeks dependent on the quality and strength of the repair. You should be able to go home on the same day.

Physiotherapy: This is all important to help making the operation a success. The Physios on the ward will give you instructions regarding simple exercises, hygiene etc. They will look after you during your Rehab and will gradually give you more exercises.

Sutures and dressings: The sutures are absorbable. There is no need to remove them. The dressing can be removed after 2 weeks and provided everything has healed well you can then have a shower or a bath without the need to cover the wound.

Pain killers: You will get some to take home from the ward. They work best when you take them early before it's really painful. Take some painkillers before you go to bed. If pain levels are high: Take painkillers regularly to keep the blood levels high. If pain levels are low: Take painkillers as and when required.

Driving: This depends on two factors: The tendon needs to be well enough healed and you have to be able to execute an emergency manoeuvre. Due to the slow tendon healing process this means that the earliest return to driving is after 8 weeks, provided you are comfortable and confident enough to be in full control of the car.

Problems following surgery: Phone the ward for advice on 01625 505416

If you would prefer to discuss this again with me prior to treatment then please contact my secretary: Tel 07935 480188, email jfortho.secretary@gmail.com

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