Shoulder Dislocation

INTRODUCTION

- A dislocated shoulder is an injury in which your upper arm bone pops out of the cup-shaped socket that's part of your shoulder blade. The shoulder is the body's most mobile joint, which makes it susceptible to dislocation.
- Two types:

a. Anterior shoulder dislocation (95%)

b. Posterior shoulder dislocation (5%)

ANTERIOR SHOULDER DISLOCATION (Anterior instability)

- Common shoulder dislocation
- May be associated with;

1. Capsular tear
2. Avulsion of glenoid labrum
3. Fracture of the proximal end of the humerous.

Initially there is a notable traumatic event. Subsequent dislocations require less force. The shoulder may subluxate or actually dislocate (complete separation of the joint surfaces).

CLINICAL FEATURES

- Pain
- Patient supports the arm with the opposite hand
- Arm held in slightly abduction and externally rotated.
- Flattened or absent shoulder/ deltoid contour. (prominent acromian)

X-Ray- Head is in the subcoracoid position

EXAMINATION

- On examination the shoulder has a full range of motion, but with forced abduction and external rotation the patient

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IMAGING

- The classic x-ray feature is a depression in the posterosuperior part of the humeral head (the Hill–Sachs lesion), where the bone has been damaged by repeated impact with the anterior rim of the glenoid.
- Subluxation is more difficult to demonstrate; an axillary view may show the humeral head riding on the anterior lip of the glenoid.
- MRI arthrography may reveal a detached glenoid labrum (the Bankart lesion) and/or the Hill–Sachs lesion.

TREATMENT

- If dislocation recurs only at long intervals, the patient may choose to put up with the inconvenience.
- Indications for operative treatment are:

(1) frequent dislocations, especially if these are Painful

(2) a fear of recurrent subluxation or dislocation sufficient to prevent participation in everyday activities, including sport.

- Surgery nowadays aims to restore the anatomy.

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TREATMENT

- The glenoid labrum is re-attached, together with tightening of the anterior capsule.
- This is usually achieved by open operation, although with advanced equipment and specialized sutures, arthroscopic repair is an option.

COMPLICATIONS

Nerve injury- Axillary nerve

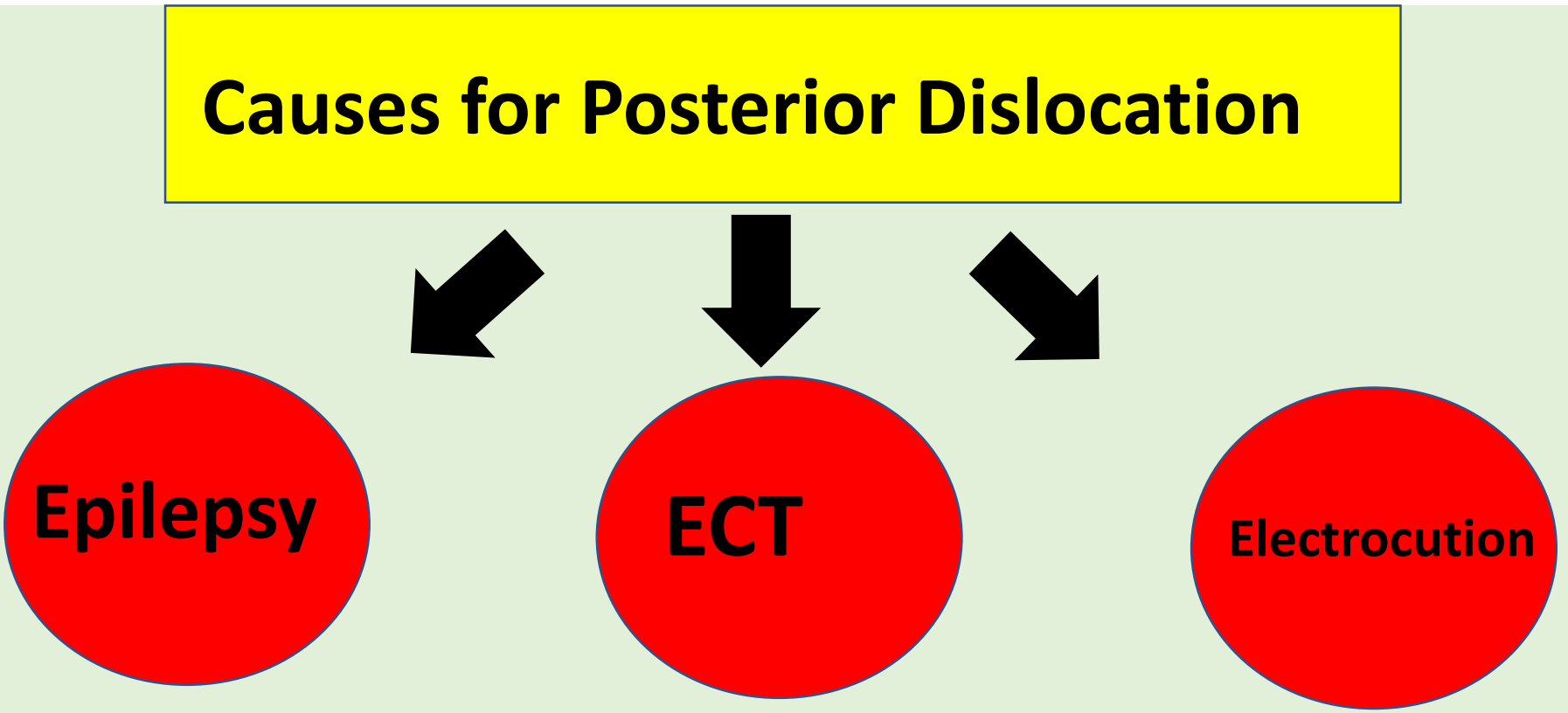
Vascular injury- Axillary artery

Recurrent disloca- tion

POSTERIOR SHOULDER DISLOCATION (Posterior instability)

- This is a rare event but is easy to miss.
- The clue is often in the history, as the patient will have either had an electric shock, had an epileptic fit, or have been subject to severe restraint when their arm has been forced up their back (a half-Nelson)– all mechanisms producing forced internal rotation of the glenohumeral joint.

POSTERIOR SHOULDER DISLOCATION



POSTERIOR SHOULDER DISLOCATION

- The patient will be in severe pain and can be difficult to examine e.g. if they are psychotic and if this is why they are being restrained.
- For the same reason, the radiographer may only be able to get an anteroposterior (AP) view of the shoulder and, on this view, the shoulder may look normal to the unwary.
- It is the high 'index of suspicion' from the history which gives the best chance of making the diagnosis.

POSTERIOR SHOULDER DISLOCATION

Clinical features

- Arm held in medial rotation
- Lateral rotation is restricted

X-Ray

- AP- Bulb sign.

TREATMENT

- Treatment is usually conservative – muscle strengthening exercises and voluntary control of the joint.
- Operative reconstruction is indicated only if disability is marked, there is no gross joint laxity and a structural abnormality is found on investigation with CT or MRI.

ATRAUMATIC INSTABILITY

- In this condition the patient complains of the shoulder going ‘out of joint’ with remarkable ease.
- This can occur in athletes such as swimmers and throwers who overload and fatigue the stabilizing muscles around the shoulder, leading to pain and subluxation in various directions.
- This is usually treated by physiotherapy to strengthen the muscles and to restore proprioception. Just occasionally surgery is needed to tighten the capsule.

ATRAUMATIC INSTABILITY

- Another form of atraumatic instability is associated with individuals who are able to voluntarily subluxate or dislocate their shoulders (often demonstrated as a ‘party trick’). This can then become involuntary.
- Treatment requires physiotherapy and sometimes even psychological counselling.
- Surgery should be avoided.