**DISLOCATION OF THE SHOULDER JOINT.**

**By Evans Nyakundi.**

**KMTC KISII CAMPUS.**

**Among the large joints, the shoulder is the one that most commonly dislocates. Factors contributing include:**

* **Shallowness of the glenoid socket.**
* **Extra ordinary range of movements.**
* **Ligaments laxity**
* **Glenoid dysplasia**
* **Vulnerability of the joint during stressful activities of the upper limb.**

**ANTERIOR DISLOCATION.**

**Mechanism of injury:**

**A fall on the hand. The head of the humerus is driven forward, tearing the capsule and producing avulsion of the glenoid labrum. (the Bankart lesion). Occasionary the posterior lateral part of the head is crushed. Nearly always the arm drops, bringing the head to its Subcoracoid position.**

**Clinical features.**

1. **Severe pain**
2. **Patient supports the arm with the opposite hand.**
3. **Flattened lateral outline of the shoulder.**
4. **Bulge felt below the clavicle.**

**NOTE.**

**The arm must always be examined for nerve and vessel injury before reduction is attempted.**

**INVESTIGATIONS.**

**>History**

**>Clinical examination**

**>X-ray Anterior posterior and Lateral views confirms the diagnosis.**

**TREATMENT.**

**Reduction is always done under General Anaesthesia>GA.**

**TECHNIQUES:**

1. **Stimson’s technique>The patient left prone with the arm hanging over the side of the bed. After 15-20 minutes the shoulder may reduce.**
2. **Hippocratic method>Gentle traction applied to the arm with the shoulder in slight abduction, while an assistant applies firm counter traction to the body (a towel slung around the patient’s chest under the axilla is helpful). COMMONLY USED.**
3. **Kocher’s method >Elbow bent 90 degrees and held close to the body, no traction should be applied. The arm is slowly rotated 75 degrees laterally, the point of the elbow is lifted forwards and finally the arm is rotated medially. This technique carries the risk of nerve, vessel and bone injury and is not recommended.**
4. **The patient sitting on a reduction chair and with gentle traction of the arm over the back of the padded chair the dislocation is reduced.**

**Do a check X-ray to confirm reduction and exclude any fracture?**

**Arm sling applied for 1 to 3 weeks.**

**Analgesics.**

**COMPLICATIONS:**

**Early.**

* **Rotator curve tear**
* **Nerve injury>Axillary----supplies the deltoid muscle. Others, Radial, Musculocutaneous, Median or Ulna nerves.**
* **Vascular artery> Axillary artery.**
* **Fracture dislocation>Fracture proximal humerus can occur. In this case open reduction is required to avoid later subcromial impingement.**

 **Late.**

* **Shoulder stiffness. Common in patients over 40 years of age.**
* **Unreduced dislocation>May be undiagnosed----In unconscious or old patients. (6weeks injury attempt closed reduction). More than 6weeks on the young operative reduction is done.**
* **Recurrent dislocation>Arthroscopic operation is done.**

**POSTERIOR DISLOCATION OF THE SHOULDER.**

**It is Rare accounts for less than 2% of all the dislocations.**

**Mechanism of injury.**

**Very severe indirect force>Fit or Convulsion or Electric shock.**

**A fall on the flexed, adducted arm or on the outstretched hand.**

**Direct blow to the front of the joint.**

**Clinical features.**

**1.Arm is held in internal rotation.**

**2.Front of the shoulder looks flat with a prominent coracoid.**

**3.Pain.**

**4.May be missed. (Frequently).**

**INVESTIGATIONS**

**X-ray Ap and Lateral views.**

**CT SCAN.**

**TREATMENT.**

**Patient under general anaesthesia(GA). The arm is pulled with the shoulder in adduction, rotate arm gently laterally while the humeral head is pushed forwards.**

**Arm sling 3-6 weeks**

**Physiotherapy**

**Analgesics**

**COMPLICATIONS.**

**1.Un-reduced dislocation.**

 **Open reduction indicated.**

**2.Recurrent dislocation or subluxation.**

**INFERIOR DISLOCATION OF THE SHOULDER [LUXATIO ERECTA].**

 **Rare but it demands early recognition because the consequences are potentially very serious. The humeral head is levered out of its socket and pokes into the axilla. The arm remains fixed in abduction.**

**Mechanism of injury.**

 **A severe hyper abducted force causes the injury. Soft tissue injury may be severe and includes avulsion of the capsule and surrounding tendons, rupture of muscles fracture of the glenoid. Proximal humerus and damage to the brachial plexus and axillary artery can occur.**

**CLINICAL FEATURES.**

* **Pain.**
* **Arm locked in almost full abduction (confirms the diagnosis).**
* **Humeral head may be felt in or below the axilla.**
* **Always examine for neurovascular damage.**

**INVESTIGATIONS.**

**Ap/X-ray shows the dislocation.**

**TREATMENT.**

**Patient under GA.**

**Pull upwards in the line of the abducted arm, counter traction downwards over the top of the shoulder.**

**Open reduction.**

**Arm sling for 3 weeks.**

**Analgesics**

**Examine again after reduction for evidence of neurovascular injury.**

**SHOULDER DISLOCATION IN CHILDREN.**

**Traumatic dislocation of the shoulder is exceedingly rare in children. The shoulder slips out unexpectedly during everyday activities’—ray may confirm the diagnosis.**

**Most of these children have generalized joint laxity and some have glenoid dysplasia or muscle patterning disorders.**

**TREATMENT.**

**a. Physiotherapy.**

**b. Reconstructive surgery.**