



Mr Harry Clitherow

MBChB, FRACS (Orth), FAOrthA

Orthopaedic Surgeon Upper Limb Specialist

Mr Clitherow specialises in

- Shoulder problems
- Elbow conditions
- Wrist problems
- Hand problems
- Upper Limb Nerve problems

TAC and Workcover referrals
accepted

Urgent appointments available

Consulting at

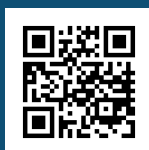
- Melbourne Shoulder and Elbow
Centre Brighton
- St John of God Hospital Berwick

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Shoulder Dislocation

Shoulder dislocation refers to the **glenohumeral** (ball and socket) joint of the shoulder. This is distinct from the acromioclavicular (AC) joint on the top of the shoulder. Shoulder dislocation usually occurs following an injury such as a fall, or in a collision during sports such as AFL, basketball, or rugby. The most common direction of dislocation is anterior.

The most common injury associated with a traumatic shoulder dislocation is tear of the fibrous labrum that surrounds the glenoid (**Bankart lesion**).

There are some other associated injuries that are important to identify:

- Fracture of the rim of the glenoid (**bony Bankart lesion**).
- Impaction fracture on the back of the humeral head (**Hill Sachs lesion**).
- A tear of the rotator cuff tendons that surround the humeral head. This is more common in patients 40 years and older.
- Nerve injury (most commonly the axillary nerve).
- These injuries can cause permanent shoulder dysfunction if they are not identified and properly treated.
- The main problem to be aware of after a shoulder dislocation is recurrent instability.
- Patients under 30 years of age, and those that play collision or overhead sports, have a 70-95% risk of recurrent instability, unless they have surgery.

Presentation

Patients with recurrent instability have difficulty with sport or overhead activity because the shoulder feels weak or unstable in the overhead position, even if it does not frankly dislocate. Recurrent dislocations also increase the chance of developing shoulder arthritis.

Investigations

1. Plain x-ray of the shoulder (AP view and axillary lateral view).
 - Will show whether the humeral head is sitting properly on the glenoid.
 - Will demonstrate important fractures.
2. Ultrasound scan must be performed if your patient is aged over 40 years, to rule out a rotator cuff tear.
3. A CT is generally only required to further define a fracture that has been seen on the plain x-ray.
4. An MRI is usually only required if the diagnosis is in doubt.

Treatment

Physiotherapy is the first line treatment for most cases, even though it does not address the labral tear.

- The aim is to improve the strength and coordination of the muscles that surround the glenohumeral joint and help keep it stable.
- The patient should rest their arm in a sling for 2-3 weeks following a first time dislocation. Physiotherapy can begin in the first week following injury.

Surgery is generally reserved for patients who either have had recurrent dislocations, or are at high risk of developing recurrent instability. The decision whether to have surgery or not is based on the patient's unique combination of age, symptoms and functional requirements.

When to refer to a shoulder surgeon

ANY of the following:

- First dislocation in a patient under 30 years AND playing contact or high risk sport.
- Any associated fracture, rotator cuff tear or nerve injury.
- Second (or greater) traumatic dislocation.
- Persistent pain, weakness, or lack of confidence in the shoulder despite physiotherapy.