STEVEN CHUDIK MD
SHOULDER, KNEE & SPORTS MEDICINE

Glenohumeral Shoulder Dislocation

Glenohumeral shoulder dislocations are injuries where the humeral head (ball) of humerus (upper arm bone) is no longer articulating (in contact) with the glenoid (socket) of the shoulder joint. The most common dislocation is anterior (more than 90 percent), where the humeral head dislocates out in front and below the glenoid socket. Because the shoulder has more motion than any other large joint in the body, it is the most commonly dislocated large joint.

X-ray of anterior shoulder dislocation

There are many structures that work together to provide shoulder stability and includes the bone of the humeral head and glenoid, the glenoid labrum (a thickening of soft tissue surrounding the glenoid socket), the capsule and ligaments which connect the humerus to the glenoid, and the tendons of the rotator cuff muscles which surround the shoulder. Any or all of these anatomic structures may be damaged with a shoulder dislocation and may require repair.

Frequent Signs and Symptoms

- Apprehension, feeling like the shoulder is going to “pop out”
- Pain with moving the shoulder, especially when reaching overhead; pain with heavy lifting; pain with carrying objects with the arm at the side; pain that awakens you at night
- Loss of shoulder strength and function
- Tenderness and occasionally swelling
- Numbness or paralysis in the upper arm and deltoid muscle from pinching, stretching, or pressure on the blood vessels or nerves
- Feeling and sound of crepitation (“crackling”) when the injured area is touched or with shoulder motion
- Repeat dislocations

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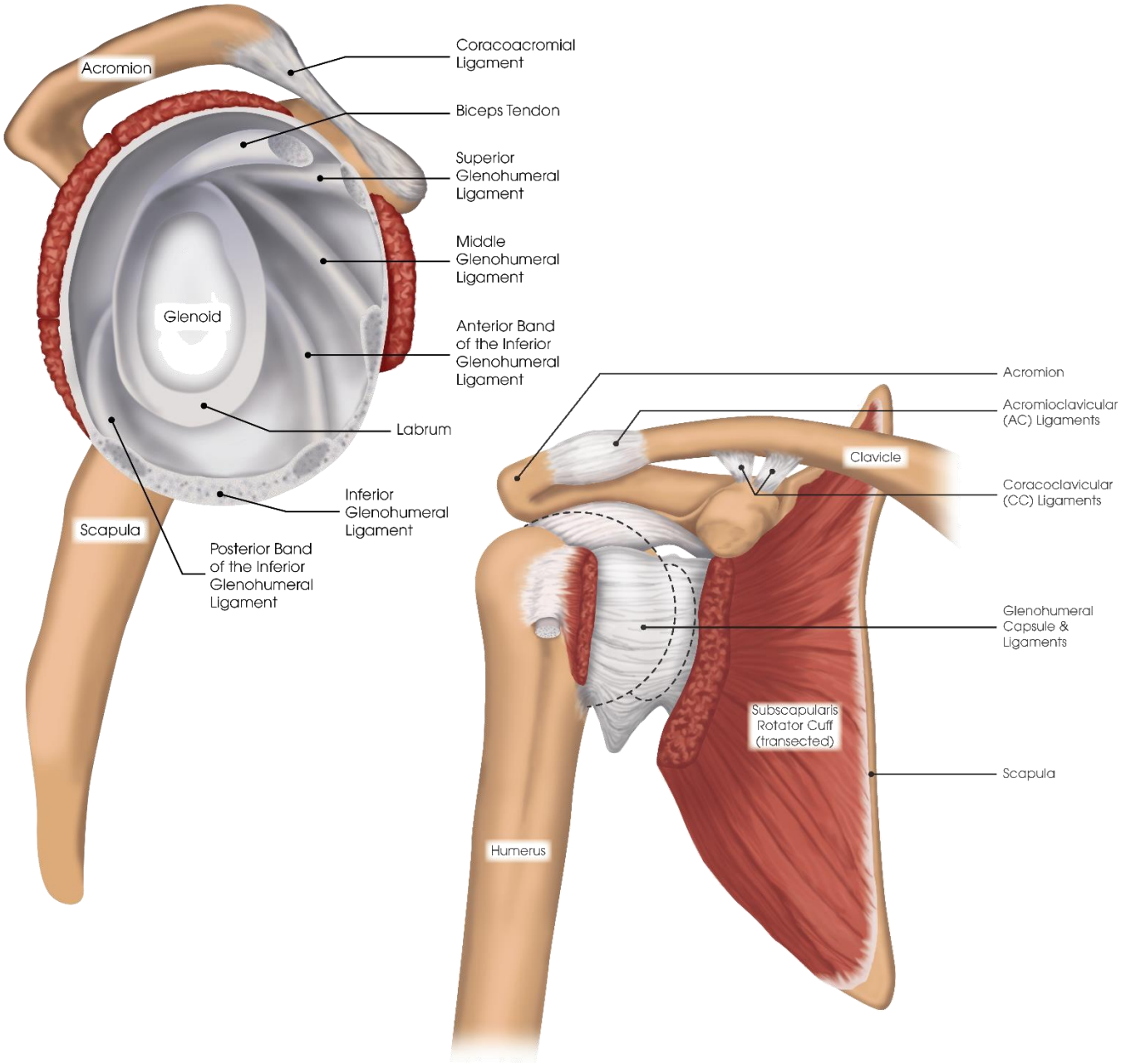
Capsular and Ligamentous Anatomy of the Shoulder



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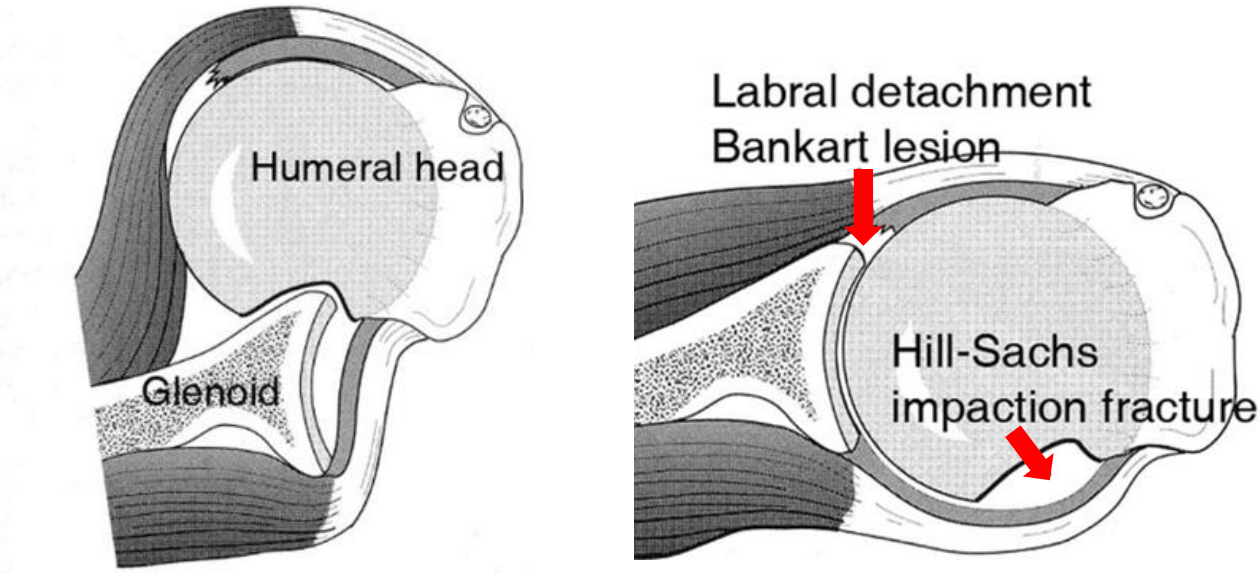
Anterior Dislocation **Reduced Dislocation**



Pictured on the left is an anterior dislocation where the humeral head is dislocated anteriorly out the front. On the right, the dislocation is reduced revealing a bankart lesion (tear) and Hill-Sachs impaction fracture (dent).

Etiology (Causes)

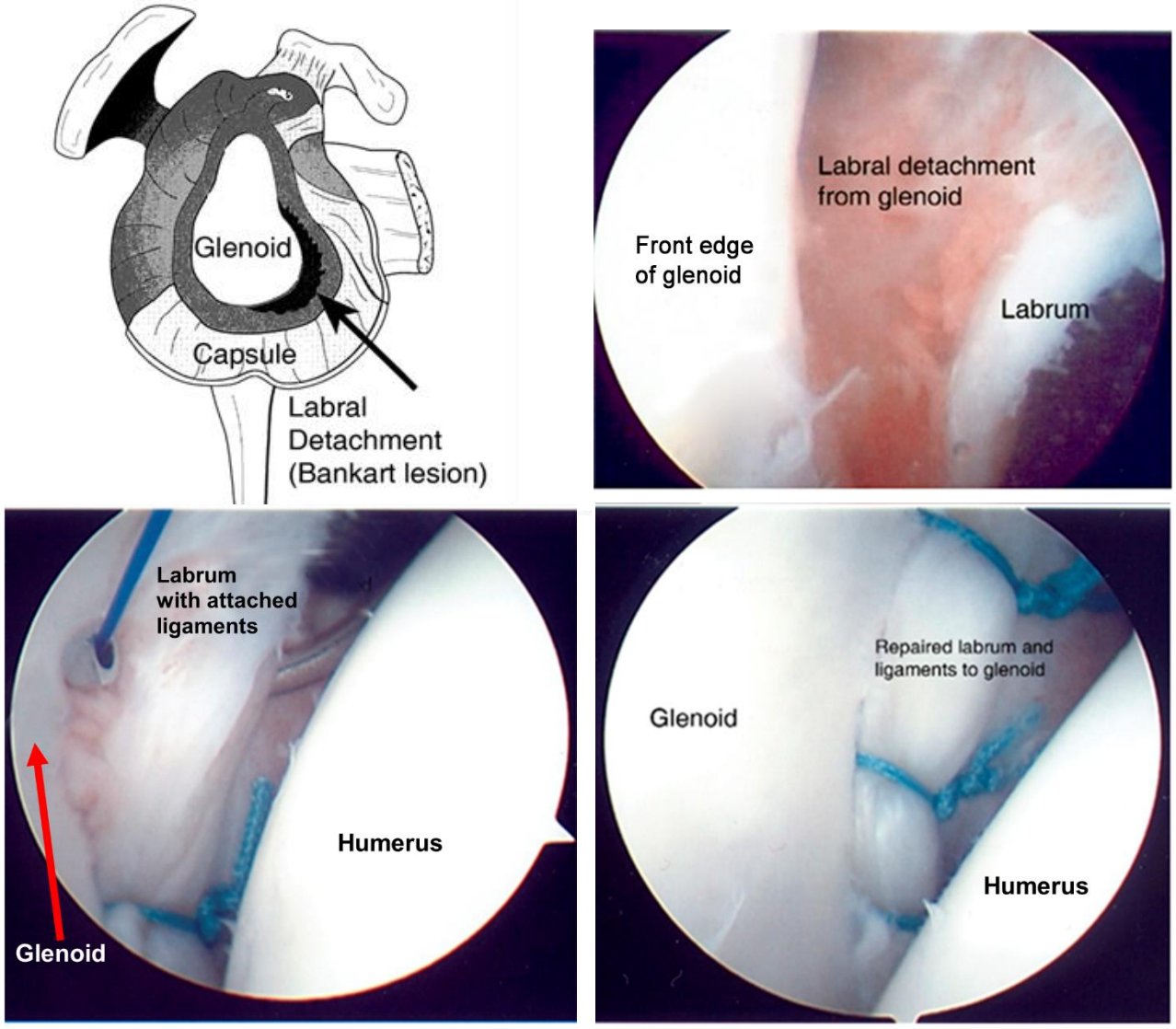
- Direct blow to the shoulder
- Traumatic force on an extended or outstretched arm overhead
- Tackling with an outstretched arm
- Falling and attempting to “catch yourself” with a single arm
- Fall forward on an outstretched arm (posterior dislocation)
- Blocking or hitting with your arm extended out in front of your body

Risk Factors

- Loose joints
- Female gender
- Contact sports such as football, rugby, and wrestling
- Sports that involve repetitive overhead activity such as baseball, volleyball, and swimming (less common)
- Previous shoulder dislocations or injuries
- Poor physical conditioning (strength and flexibility)
- Congenital abnormality (you are born with it), such as a shallow or malformed joint surface or a ligament disorder

Prevention

- Appropriately warm up and stretch before practice or competition
- Maintain appropriate conditioning:
  - Shoulder strength, flexibility, and endurance
  - Cardiovascular fitness
- For participation in contact sports, proper tackling technique



The top pictures demonstrate a Bankart lesion or tear of the labrum and capsular ligament away from the glenoid (shoulder socket). The bottom pictures show arthroscopic surgical repair.

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Treatment Considerations and Outcomes

Following a shoulder dislocation, the shoulder must be reduced (put back in place) as quickly and safely as possible. Initial physical therapy is important to reduce swelling, pain, and regain range of motion and strength. Outcomes following traumatic shoulder dislocations depend on the age of the patient and the extent of the pathology. Patients who sustain a shoulder dislocation at age 40 or older are less likely to have a repeat dislocation and rarely need surgery to prevent future dislocations. However, patients over age 40 often suffer a fracture or tear of the rotator cuff with a shoulder dislocation and may require surgery to repair the fracture or rotator cuff. For younger patients, the rate of repeat dislocation and further damage to the shoulder is so high that arthroscopic surgery to repair the torn labrum, ligaments, and other structures is often required and recommended after the first dislocation. Careful attention must be taken to repair all of the involved structures including the bone of the humeral head and glenoid, the glenoid labrum (a thickening of soft tissue surrounding the glenoid socket), the capsule, and ligaments which connect the humerus to the glenoid, and the tendons of the rotator cuff muscles.

Potential Complications

- Prolonged recovery, repeat dislocations and instability
- Stiffness and decreased shoulder range of motion
- Nerve injury from the dislocations
- Further damage to the cartilage, bone, labrum and rotator cuff of the shoulder with each dislocation
- Early arthritis of the shoulder following multiple dislocations

Modalities (Cold Therapy)

Cold is used to relieve pain and reduce inflammation. Cold should be applied for 15 to 20 minutes every two to three hours for inflammation and pain and immediately after any activity that aggravates your symptoms. Use ice packs or an ice massage with a cloth between the ice and your skin to prevent burning /freezing your skin.

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