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Case report

Simultaneous bilateral shoulder and bilateral central acetabular fracture dislocation: What to do?

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ABSTRACT

Musculoskeletal injuries following seizures have a high morbidity and mortality. These injuries are often missed and the diagnosis is delayed due to a lack of clinical suspicion and appropriate investigations. We report a case of 72 years old male with simultaneous bilateral central acetabular fracture dislocation and bilateral posterior shoulder fracture dislocation secondary to an epileptic seizure. Present study highlights the significance of clinical suspicion and clinico-radiological evaluation for diagnosis of a rare injury following episode of seizures. Simultaneous fracture dislocation of all four limbs treated with a holistic approach can lead to a good functional recovery. Surgical management with open reduction and internal fixation is preferred and replacement arthroplasty should be reserved for cases with implant failure and elderly patients.

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Introduction

Injuries around the shoulder, hip joint and vertebral compression fractures following epilepsy episode are described in medical literature.^{1–4} The possible mechanism of musculoskeletal injury following seizures is due to severe muscle contraction.^{5–12} Without direct trauma, simultaneous acetabular fracture and shoulder fracture dislocation are extremely rare. Central acetabular fracture is a complicated and life-threatening injury because of hypovolume shock from severe blood loss.^{11–17} Musculoskeletal injuries following seizures have a high morbidity and mortality.^{4–7,12–17} These injuries are often missed and the diagnosis is delayed due to a lack of clinical suspicion and appropriate investigations.^{1–6,15–17}

We report a case of 72 years old male with simultaneous bilateral central acetabular fracture dislocation and bilateral posterior shoulder fracture dislocation secondary to an epileptic seizure.

Case report

A 72 years old male patient presented in our emergency services department following two episodes of generalized tonic clonic seizures. He had no trauma and past epilepsy episodes. On clinical examination, his pulse rate was 100 per minute and systolic blood pressure was 90 mmHg and diastolic pressure was 50 mmHg. The respiratory and abdomen system examination were unremarkable. Patient presented with hypo-volume shock and was treated with hypertonic solution and plasma expanders. Once patient was hemodynamically stable, computed tomography of the brain was performed and found within normal limit. Magnetic resonance imaging of the brain revealed multiple ischemic foci, suggesting small vessels disease. After postictal period, patient had severe pain, deformity and reduced movements of both shoulder and hip joints. The neurological examination was within normal limits. Clinical examination showed swelling and deformity around both shoulder joints. On examination of the hip joint, bilateral hip deformity and painful movements were found. The distal pulsations and neurological examination in both upper and lower limbs were normal. Plain radiograph of the pelvis showed bilateral central dislocation of the acetabulum (Fig. 1). Computed tomography of the pelvis was performed and showed comminuted fracture of the anterior, posterior, and medial walls of the right acetabulum

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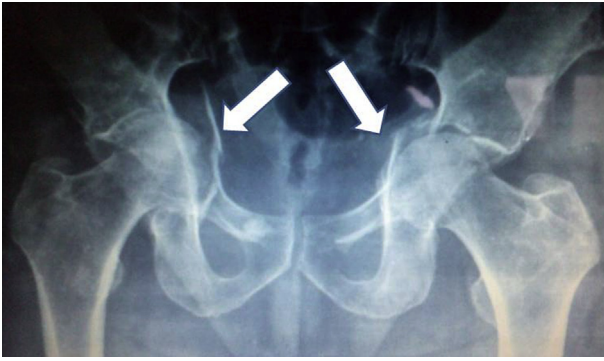


Fig. 1. Anteroposterior radiograph of the pelvis showing bilateral central acetabular fracture dislocation.

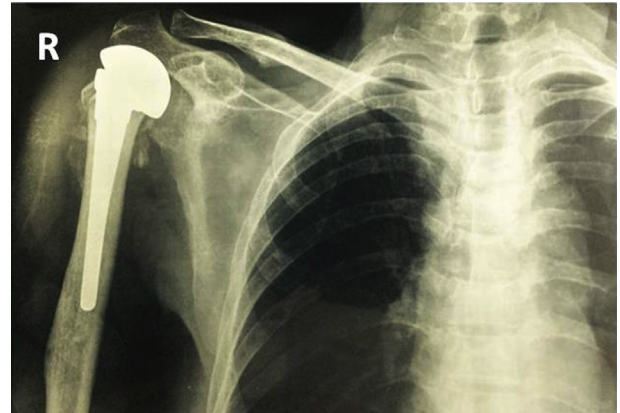


Fig. 3. Anteroposterior radiograph of the left shoulder showing fracture dislocation.

with superior and inward displacement of the right femoral head. Also comminuted fracture of anterior-posterior column as well as superior and inward displacement of the left acetabulum was observed.

Plain radiographs of both shoulders were performed and showed both shoulder fracture dislocation (Figs. 2 and 3). Computed tomography of the right shoulder showed comminuted and posteriorly displaced fracture of the surgical neck of humerus and the humeral head was displaced posterior–inferiorly. Computed tomography of the left shoulder showed fracture of the spine of scapula with comminuted and posteriorly displaced fracture of the surgical neck of humerus and the humeral head was displaced posterior–inferiorly.

Patient was initially treated with a shoulder arm pouch. Hemiarthroplasty was performed for right shoulder fracture dislocation (Figs. 4 and 6). Left humeral fracture dislocation was treated with open reduction and internal fixation with plating (Figs. 5 and 6). Bilateral central hip dislocation was treated conservatively initially with slower femoral skeletal traction. During postoperative period, passive shoulder mobilization started for right shoulder while left shoulder was immobilized in internal rotation for 6 weeks in the shoulder arm pouch. The patient was asked to non-weight bearing for 3 months. During skeletal traction, passive



Fig. 4. Anteroposterior radiograph of the right shoulder showing fracture dislocation treated with Neer's hemiarthroplasty.

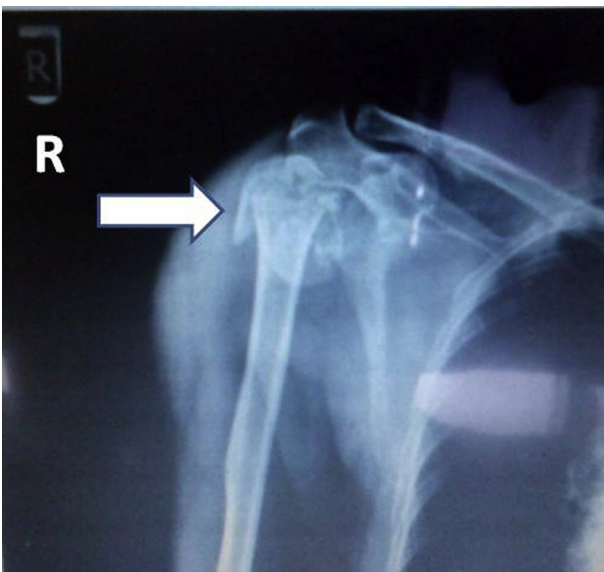


Fig. 2. Anteroposterior radiograph of the right shoulder showing fracture dislocation.

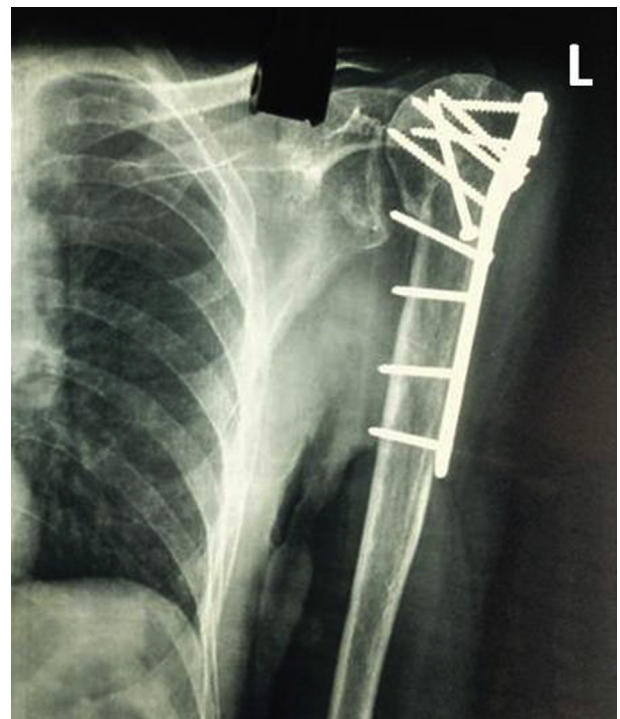


Fig. 5. Anteroposterior radiograph of the left shoulder showing fracture dislocation treated with open reduction and internal fixation with plating.

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