

Clinical case

Locked posterior dislocation of the shoulder: A report of three cases

Les luxations postérieures invétérées de l'épaule. À propos de trois cas

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Abstract

Posterior shoulder dislocations account for 4% of all shoulder dislocations. In two-thirds of the cases, the diagnosis is made only once the shoulder is locked, which radically changes the treatment and prognosis. We report three clinical cases of locked posterior shoulder dislocation. Closed reduction was attempted in one case but failed. All patients underwent open reduction and subscapularis transfer according to either Neer's (2 cases) or McLaughlin's technique (1 case). The functional outcome was satisfactory in two cases despite recurrent dislocation on the third day after surgery. The third patient eventually developed post-traumatic shoulder osteoarthritis. The best treatment consists of detecting posterior dislocations immediately when they occur under suggestive circumstances (electrocution, epileptic seizure, severe trauma shoulder).

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Keywords: Chronic; Missed; Locked; Dislocation shoulder

Résumé

Les luxations postérieures de l'épaule représentent 4 % de toutes les luxations de l'épaule. Leur diagnostic est fait dans deux tiers des cas au stade de luxation invétérée, ce qui change radicalement le type de la prise en charge et le pronostic. Nous rapportons 3 cas cliniques de patients présentant une luxation postérieure de l'épaule passée inaperçue à la phase aiguë. La réduction orthopédique a été tentée dans un seul cas sans succès. Tous les patients ont subi une réduction sanglante avec transfert du subscapulaire selon la technique de Neer dans 2 cas et selon la technique de McLaughlin dans un cas. Le résultat fonctionnel au dernier recul était satisfaisant dans 2 cas. La troisième patiente a présenté une omarthrose post-traumatique. Le meilleur traitement reste le dépistage des luxations postérieures dans les circonstances évocatrices (électrocution, crise d'épilepsie, traumatisme violent antéro-postérieur de l'épaule).

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Mots clés : Luxation épaule ; Chronique ; Ancienne ; Invétérée

1. Introduction

Locked shoulder dislocations, either anterior or posterior, are very rare. They are always the source of classification, diagnosis and treatment challenges. The diagnosis can be missed, even for anterior dislocations, despite notable clinical and radiographic evidence. This is even more likely for locked

posterior dislocations, where the initial dislocation is missed in 60% of cases, despite injury circumstances that are often highly suggestive.

This article reports three clinical cases of patients with posterior shoulder dislocations that were missed in the acute phase. For each case, the surgical technique used and the functional outcome at the last follow-up will be described. A review of literature provides supporting evidence for our surgical plan and helped to determine the prognosis for these shoulders and to propose a practical course of action when faced with a locked posterior shoulder dislocation.

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2. Case reports

2.1. Case 1

A 26-year-old, right-handed, female patient came to us 26 days after having been electrocuted; she complained of chronic right shoulder pain and in particular, shoulder stiffness during internal rotation. Physical examination of the right shoulder found limited external rotation, but normal neurological function.

Standard radiological assessment and CT scan (Fig. 1) revealed a posterior dislocation of the humeral head with a defect involving 20% of the anterior part of the humeral head (reverse Hill-Sachs lesion).

When closed reduction under anesthesia failed, an open reduction was performed and the lesser tuberosity was transferred according to Neer's technique; the shoulder was immobilized after the surgery in neutral rotation (Fig. 2).

After 3 years, the right shoulder had a Constant score of 80 (contralateral shoulder at 100) with a pain score of 10/15, slight handicap during daily living and recreational activities, anterior elevation and abduction of 150°, internal rotation allowing the thumb to reach the 12th thoracic vertebra and strength deficit evaluated at 18/25.

2.2. Case 2

A 59-year-old epileptic patient came to us because of pain and stiffness in her left shoulder, 45 days after an epileptic seizure that required 3 days of hospitalization in intensive care.



Fig. 1. X-rays of a posterior shoulder dislocation.

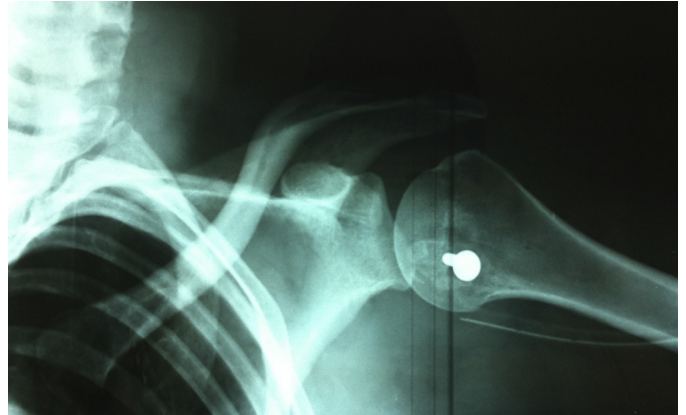


Fig. 2. Preoperative x-rays showing a defect involving 20% of the anterior part of the humeral head.

Standard X-rays supported the diagnosis of a posterior shoulder dislocation and a CT scan examination (Fig. 3) revealed a defect involving 30% of the humeral head's articular surface.

The patient underwent open reduction with lesser tuberosity transfer into the defect, followed by immobilization in neutral rotation. On the 3rd postoperative day, the patient's left shoulder dislocated again. The shoulder joint was reduced under anesthesia and then immobilized in 20° external rotation.

After 1 year, her epilepsy had stabilized and there were no further shoulder dislocations. Her Constant score was 60, pain at 5/15, activity level score of 14/20, anterior elevation and abduction of 120°, internal rotation allowing the thumb to reach the 3rd thoracic vertebra and strength deficit evaluated at 15/25.

2.3. Case 3

A 36-year-old female patient who was involved in a motor vehicle accident suffered a mid-shaft fracture of the right humerus, which was fixed with an intramedullary nail. After the



Fig. 3. The lesser tuberosity is transferred into the defect and secured with a screw.

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