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Original Article

Functional outcome after arthroscopic management of traumatic recurrent dislocation shoulder using Bankart repair and Remplissage techniques

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ARTICLE INFO

Article history:
Received 30 September 2016
Accepted 10 May 2017
Available online xxx

Keywords:
Recurrent shoulder dislocation
Bankart lesion
Hill–Sach lesion
Remplissage

ABSTRACT

Background: Recurrent dislocation shoulder is one of the common shoulder injuries encountered by the orthopedic surgeon in clinical practice. Bankart repair using the arthroscopic method has become one of the standard techniques in the management of recurrent dislocation shoulder. Remplissage technique can be used as adjunct to Bankart repair in certain conditions.

Method: In this case series, we have assessed the functional outcome and return to activity at midterm follow-up after arthroscopic management.

Results: 51 patients with traumatic shoulder dislocation were operated using the shoulder arthroscopic technique. Rowe score improved significantly at the latest follow-up. No major complication was noticed in our case series.

Conclusion: The shoulder arthroscopy procedure requires special instrumentation and expertise. We believe that this is a less invasive and safe procedure and provides an additional tool in the management of instabilities including in cases of complex recurrent dislocation of the shoulder.

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Introduction

Recurrent dislocation of the shoulder is common in the general population and is more so among athletes and military personnel due to their young age, training, and high demand of activity that is dependent on their shoulder.[1] Most of the time, Bankart lesion (avulsion of the labrum from the glenoid rim) is the underlying pathology, and in some cases, ALPSA (anterior labroligamentous periosteal sleeve avulsion) lesion, Hill–Sachs lesion, capsular laxity, and SLAP lesion can also be seen. Best treatment option available for recurrent dislocation

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http://dx.doi.org/10.1016/j.mjafi.2017.05.004
0377-1237/© 2017 Published by Elsevier B.V. on behalf of Director General, Armed Forces Medical Services.

of the shoulder is repair of the underlying pathology. There are many surgical techniques that have been described for the management of this condition, which include open as well as arthroscopic repair of pathology depending upon the nature of lesions.[1–6] These techniques have used several different implants for fixation, which include staples, screws, absorbable tacks, absorbable sutures drilled transglenoid, and various types of other suture anchors.

Arthroscopic treatment of the shoulder's instability is considered to have advantages compared to the open procedure. The advantages are the following: shorter surgical time, lesser morbidity, lesser postoperative pain, lesser hospitalization time, and a reduced risk of complications. Also, few studies have reported a lesser loss of range of motion (ROM) in patients treated arthroscopically compared with those treated using an open procedure.[7–8] However, some studies have reported higher failure rate, with the arthroscopic procedure ranging from 7.5% to 23%[9–10] as compared to open surgical procedures ranging from 0% to 11%.[11,12]

Shoulder arthroscopy was introduced in India and in the armed forces only in the past decade. Ours is one of the main centers in the armed forces where these kinds of surgeries have been performed for more than the past five years on a regular basis. We have evaluated the midterm results of arthroscopic management at our center in terms of the functional outcome and return to preinjury level of activity after the surgical outcome in this study.

Material and methods

All the patients operated for recurrent dislocation of the shoulder at our center between 2013 and 2015 were recruited on the basis of inclusion criteria. Records of all the patients were retrieved from the operation theater and details were obtained from the orthopedics department or hospital admission discharge summary. All the patients were evaluated at the final follow-up (Fig. 1). In this study, we have evaluated the results of arthroscopic management of recurrent dislocation of the shoulder using Bankart repair and Remplissage at midterm follow-up (minimum follow-up one year). Patients were assessed functionally using Rowe Score[13] and Tegner's activity level.[21]

Inclusion criteria

A) Patients diagnosed clinically with traumatic recurrent (anterior) dislocation of the shoulder and operated at our center
B) Age: 20–45 years
C) Both genders
D) Patients who are willing to participate

Exclusion criteria

A) All the patients with associated Rotator cuff tears
B) Patients with associated SLAP lesions
C) Large bony defects of the glenoid requiring bone grafting procedure
D) Atraumatic multidirectional instabilities
E) Revision surgery
F) Patients operated earlier for any shoulder problem

Surgical technique

All the patients were taken up for surgery under general anesthesia and placed in the lateral position. A padded traction was applied to the arm for distracting the shoulder joint. Standard posterior portal was used as viewing portal while two standard anterior portals were made. The surgery in

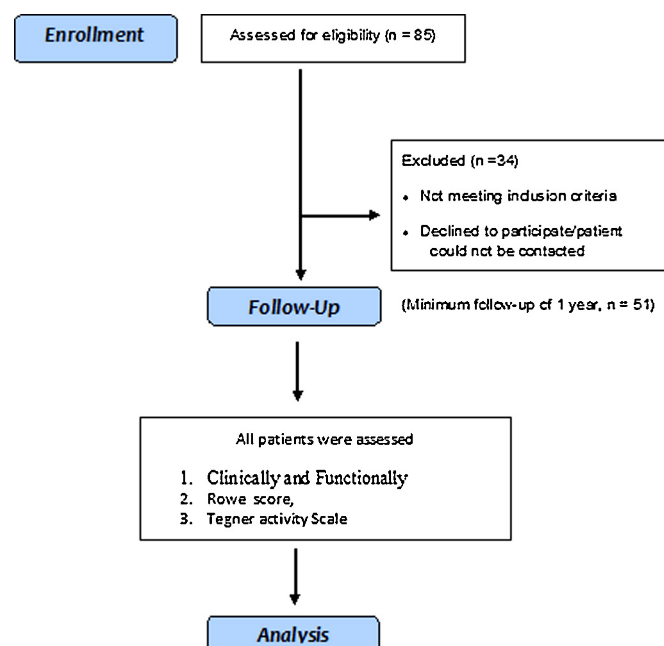

Fig. 1 – Flow chart showing details of the study.

Please cite this article in press as: Sood M, Ghai A. Functional outcome after arthroscopic management of traumatic recurrent dislocation shoulder using Bankart repair and Remplissage techniques, *Med J Armed Forces India*. (2017), http://dx.doi.org/10.1016/j.mjafi.2017.05.004

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