ORTHOPAEDICS WA

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SHOULDER INSTABILITY

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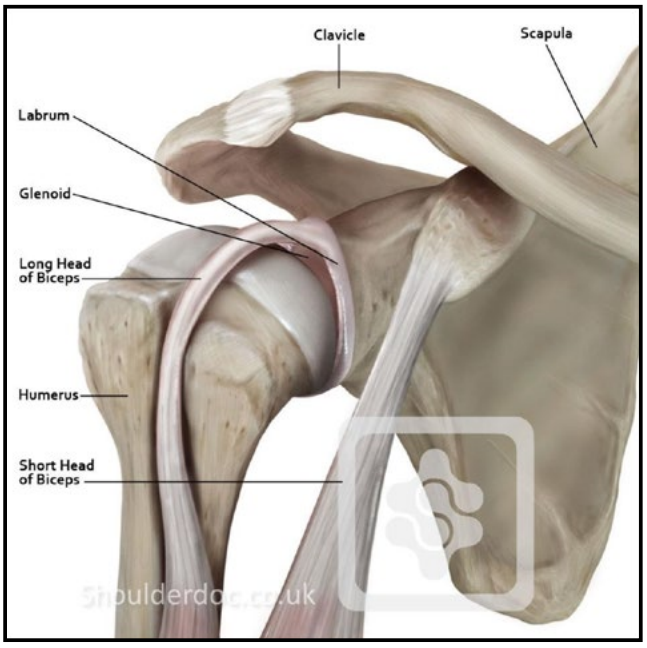
The shoulder is the most mobile joint in the body. This makes the shoulder joint the most vulnerable to dislocation. This ball-and-socket joint has a very shallow socket called the glenoid and this is deepened by a soft tissue ring which surrounds it called the labrum. Ligaments around the joint further stabilise it.



Shoulderdoc.co.uk

In a dislocation, these structures can be torn or stretched making the shoulder prone to re-dislocation. In addition, the bone of the socket and/or ball can also be fractured adding to the risk of instability (imagine a golf ball balancing on a shallow tee made more unstable by a large chip in it).

The most common dislocation is in the forward direction and this commonly causes a tear of the front labrum and joint capsule. There can be associated nerve injury which can cause muscle weakness and a loss of sensation over the shoulder or further down the limb.

DIAGNOSIS

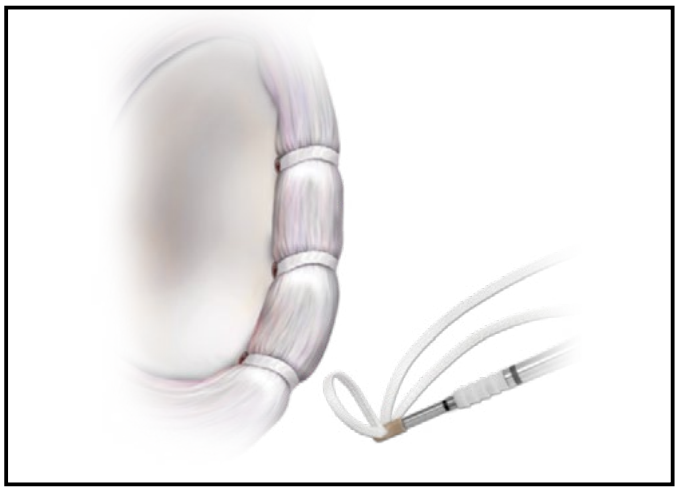
Your surgeon will take a history and examine you and it is common to have imaging of the joint with x-rays and oftentimes a CT scan or MRI. This is to assess the bone and soft tissues to help with determining the likelihood of further instability and to aid surgical planning.

X-ray image of glenohumeral (GH) dislocation

MANAGEMENT

Younger patients who dislocate are more likely to have repeated instability while older patients may sustain a tear of the muscle tendons (rotator cuff tears). Factors such as loose ligaments, fractures and participation in contact sport increase the risk of re-dislocation.

Patients assessed to have a low risk of re-dislocation can be managed with physiotherapy and rehabilitation.

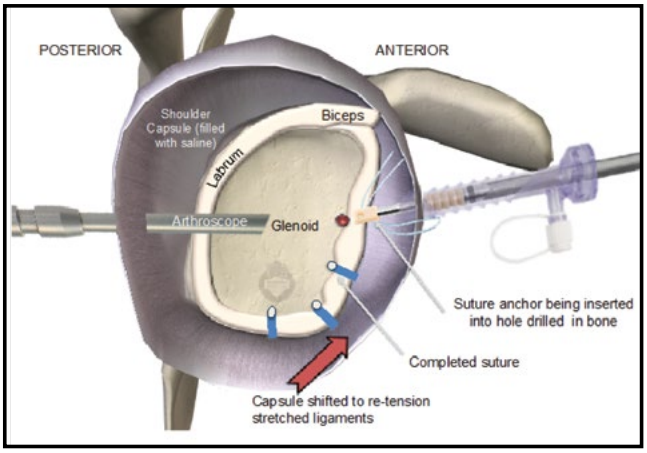


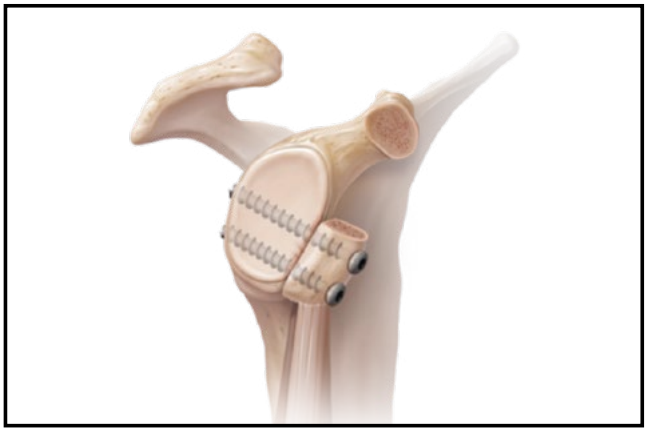
Sutures to repair torn labrum

If the risk of re-dislocation is higher, surgery is considered. Depending on individual factors, this may be in the form of arthroscopic or 'key-hole' surgery where the labrum and capsule is repaired. The other common stabilising procedure is to perform a transfer of a bone block from the knuckle of bone near the shoulder joint with its attached tendon (Latarjet procedure). Your surgeon will discuss with you which procedure is most suitable depending on your risk profile.

RECOVERY FROM SURGERY

Surgery can be a day-case procedure or involve an overnight stay in hospital. A sling is required for 6 weeks after surgery. Physiotherapy starts immediately with very gentle exercises only whilst in the sling and progresses to more active ones as recovery is gained. Driving is often possible after around 8 weeks. Return to sport often takes around 6 months and also depends on passing rehabilitation milestones and is not solely time-based.





Latarjet or bone block transfer

POTENTIAL RISKS AND COMPLICATIONS OF SURGERY

- Wound infection, pain, blood in the joint (haematoma)
- Stiffness/frozen shoulder
- Nerve injury which can result in weakness and loss of sensation
- Clotting (deep vein thrombosis)
- Recurrent dislocation, mechanical failure of fixation or repair

The risk of complications is managed by a thorough medical assessment by your surgeon and anaesthetist, meticulous surgical technique and good rehabilitation.

The information provided here is of a general nature and is intended to supplement a comprehensive consultation with your surgeon. References :

- Hospital for special surgery
- Arthrex website
- 3rd Edition, Australian Orthopaedic Association patient information.