The Physio Movement

ANTERIOR SHOULDER DISLOCATION

ANATOMY:

The shoulder joint is a ball and socket joint. The ball, at the top of the humerus (upper arm), fits into the shallow socket called the glenoid fossa which is part of the scapula (shoulder blade). The ball doesn't fit into the socket but is rather held against it (visualise a golf ball sitting on a tee) and is held in place with tissues and reinforced by muscles and ligaments.

INJURY DESCRIPTION:

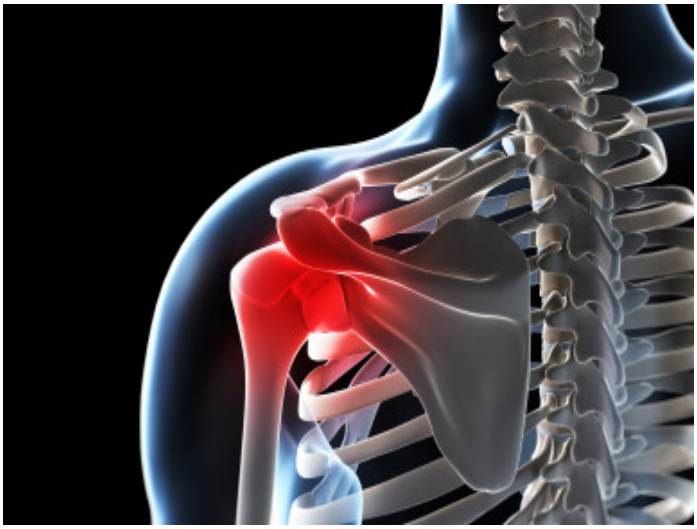
The shoulder can dislocate in many directions including backwards, downwards and in 95% of cases, forwards. When the ball comes out of the socket it is known as a dislocation.

MECHANISM OF INJURY:

A shoulder dislocation will usually occur when excessive forces are placed on the shoulder. Usually it involves falling onto an outstretched hand (FOOSH) that applies large external rotation forces or a sudden blow to the shoulder, which results in the shoulder coming out of it's resting socket.

INJURY FACTS:

The shoulder is the most frequently dislocated joint in the body. The shoulder sacrifices stability for mobility in its design and is therefore more prone to dislocation injury.



COMMON PATIENT COMPLAINTS:

- Dead arm symptoms
- Shoulder stiffness associated with painful movements
- Shoulder weakness
- Pain when reaching above head or backwards
- Apprehension when sleeping with the arm above head in abduction and external rotation
- Shoulder joint pain, often non specific
- Burning, tingling and/or numbness into the shoulder or arm

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PHYSIOTHERAPY TREATMENT OPTIONS:

- Taping
- Dry Needling
- Strengthening programs
- PilateS
- Massage
- Healing foods education
- Postural assessments
- Pain management strategies
- Electrotherapy
- Fascia scrapping
- Mobilisation techniques
- Biomechanical analysis
- Education
- Return to sport screenings
- Proprioception training

PROGNOSIS/TIMELINES:

Phase 1 (0-6 weeks) – immobilization for initial period, followed by elbow, wrist mobility exercise and isometric shoulder strengthening

Phase 2 (6-12 weeks) – Active range of motion followed by increased strengthening once range is restored

Phase 3 (12-24 weeks) – Function strengthening, proprioception and return to activity/sport goal.

POST INJURY:

It vital that the shoulder is 'relocated' in a safe manner, which should occur by a qualified professional preferably in the hospital setting. X-ray will be taken to check the relocation position and for any fractures. Usual the arm will be placed in a sling, although evidence is now showing this should be minimised and in some cases completely avoided. The RICER principle should be followed for the first 72 hours, with wrist and elbow movements encouraged frequently to avoid other risks such as frozen shoulder.

COMPLICATIONS:

Up to 90% of anterior shoulder dislocations will be accompanied by a Hill-Sach's (small fracture) defect or Bankart lesion (labral disruption)

Once you have dislocated your shoulder you are more likely to dislocate it again.

The younger you are, the more likely you will dislocate it again.