



Tips From the Training Room

For more information contact the athletic training staff at
Towson Sports Medicine, 410-828-4TSM (4876).

Acute Traumatic Shoulder Dislocation:

The shoulder is the most commonly dislocated joint. The glenohumeral joint is made up of the humeral head and the glenoid fossa. In a dislocation, all articular contact is lost between the humeral head and the glenoid. A shoulder subluxation occurs when the shoulder does not completely dislocate, and the humeral head spontaneously returns to its normal position. Anterior dislocations are more common than posterior dislocations and occur about 95% of the time. It is estimated that roughly 80% of first time dislocaters under the age of 20 will experience a recurrent event. This injury occurs most commonly in football, wrestling, and rugby,

Mechanism of Injury:

Anterior shoulder dislocations occur when the elbow is away from the body and the shoulder is externally rotated. This commonly occurs when a person falls on an outstretched arm. Posterior shoulder dislocations occur when the humeral head is driven out the back of the socket with the arm in front of the body. Structures that could be damaged during a dislocation include the rotator cuff tendons or muscles, the biceps tendon, the deltoid muscle, the nerves (most commonly the axillary), and the cartilage or bone on the surfaces of the humeral head and glenoid fossa.

Signs and Symptoms of an Anterior Shoulder Dislocation:

When a shoulder dislocation occurs symptoms may include sudden intense pain, swelling, deformity with a "step off" at the shoulder edge (loss of normal shoulder contour), inability to elevate or internally rotate the arm and shoulder, and numbness or tingling in the shoulder, arm, and hand.

Treatment:

The goal is to relocate the shoulder to its normal position without causing further damage. When the dislocation is noticed right away it is possible for the person to "pull" the humeral head back into socket. However, after a few minutes pain and muscle spasms typically prevent a person from easily reducing the humeral head back into its socket. In many cases the shoulder will need to be reduced by a medical professional. X-rays will be obtained to rule out a fracture dislocation, and then a closed reduction will be

performed. Pain medicine and sedation may be needed to help with the reduction. It is very rare for an open surgical reduction to be required. Following reduction, the patient is placed in a sling or immobilization device. The sling is worn for a period of 4-6 weeks. Physical therapy is recommended after immobilization to regain full range of motion and strength.

Prevention:

Prevention techniques include strengthening the rotator cuff muscles with exercises using resistance weights, rubber bands, and cables. It is important to incorporate rotational exercises with the arm down at the side and in neutral. It is also important to avoid contact sports and other activities early on to prevent re-injury. In addition on return to contact or collision sports the use of braces that limit abduction and external rotation of the shoulder may be implemented. An example of a brace is the Sully Brace by Don Joy. See picture below.



When Surgery May be Necessary:

Patients who have recurrent shoulder dislocations despite adequate rest and rehabilitation are potential candidates for surgery. The need for surgery depends on the functional demands of the patient and the severity of the instability. Research has shown surgery to be nearly 95% successful in returning patients with unstable shoulders to full activity without limitations.

Helpful Websites:

AOSSM: Sports Tips on Shoulder Dislocation

<http://www.sportsmed.org/secure/reveal/admin/uploads/documents/ST%20Traumatic%20Shoulder%2008.pdf>

Elite Sports Medicine and Rehabilitation:

<http://www.elite-sports-med.com/recovering.htm>