

SUSSEX SHOULDER & ELBOW

Shoulder Instability

What is shoulder instability

The shoulder joint is the most mobile large joint in the body. It is mobile because it consists of a round 'ball' resting on a relatively flat 'dish'.

The problem with being so mobile is that it is also the most unstable of the large joints. Stability is provided mainly by the labrum (a rim of tissue which deepens the dish), the ligaments within the capsule and by the overlying rotator cuff muscles. When you dislocate your shoulder the labrum is typically pulled off the rim of the dish and the capsule and ligaments are stretched. The head of the humerus (the 'ball') becomes lodged on the front of the dish and this may squash the bone on the back of the head creating an indentation (a so called Hill Sachs lesion).

What causes shoulder instability?

Shoulder instability is usually caused by an injury but some people are born with lax ligaments and develop instability 'spontaneously'. 95% of dislocations occur anteriorly (the ball rides off the front of the dish) and are typically caused by a fall forcing the arm upwards and outwards such as during rugby. Sometimes a dislocation is associated with a bony injury to the joint or a tear of the rotator cuff. This is more common in older patients. A complete dislocation is usually fairly obvious and is very painful. The joint often has to be put back under sedation in A&E after an x-ray to exclude a fracture. Sometimes a 'partial' dislocation or 'subluxation' occurs.

After the injury the patient may experience an ongoing sensation that the joint is unstable and may come out of socket again, usually with the arm raised and rotated outwards. Sometimes the symptom is of pain with the arm in certain positions.

Posterior dislocations (where the ball rides off the back of the socket) are much less common and characteristically occur during an epileptic seizure or an electric shock. They may occur, however, when the arm is forced directly backwards. Posterior instability is also quite common in people with lax ligaments who feel their shoulder pop out backwards as they lift their arm forwards.

How is shoulder instability diagnosed?

The first step is to make the correct diagnosis. A history of a frank dislocation is usually quite obvious but subluxation can be confused with impingement, SLAP tears and acromioclavicular joint problems.

The diagnosis is made by taking a careful history, particularly around the onset of the symptoms and the sorts of activities which cause the pain.

A thorough examination is very important assessing the range of movement of the joint, strength of the individual tendons and the manoeuvres that cause pain. Specific tests for shoulder instability are performed and other joints assessed for signs of underlying ligamentous laxity.

An x-ray is helpful to see whether there has been any significant bony damage to the joint. We usually arrange more specialist tests such as an MRI arthrogram (dye is injected into the joint before the MRI is performed which improves the accuracy of the scan) or, after multiple dislocations, a CT scan to help confirm the diagnosis and plan further treatment.

Cameron Hatrick

MA (Cantab), MB, BChir, FRCS (Tr&Orth)
Consultant Orthopaedic Surgeon

Joideep Phadnis

FRCS (Tr&Orth), Dip Sports Med, MRCS, MBChB
Consultant Orthopaedic Surgeon

These notes are intended as a guide and some of the details may vary depending on your individual circumstance and at the discretion of your surgeon.
© Sussex Shoulder

Shoulder Instability

What are the treatment options?

If you are under 20 years old when you first dislocate your shoulder, as a result of injury rather than due to underlying ligamentous laxity, then there is a high chance (about 80%) of further or 'recurrent' dislocations.

The risk of recurrent dislocation gradually reduces with age but the risk of stiffness or injury to other structures, such as the rotator cuff or nerves around the shoulder, increases. Generally speaking, providing you haven't torn a tendon or fractured the bone, we would recommend physiotherapy after your first dislocation to help recover movement and strengthen your shoulder.

If you recover good movement and function in your joint and it feels stable then no further intervention is needed. If you have ongoing pain or re-dislocate your shoulder (fully or partially) then we would arrange a scan and discuss surgical stabilisation of your shoulder. Patients with instability as a result of underlying ligamentous laxity are usually best managed with specialist physiotherapy and surgery is only very occasionally helpful.

What does surgery involve?

The operation for shoulder instability is usually Arthroscopic Stabilisation. The surgery is 'key hole' and involves reattaching the labrum to the rim of the dish and tightening of the capsule and ligaments.

The operation is typically performed as a day case under a general anaesthetic with a nerve block (which helps the pain for the first 12-16 hours) and takes about 60 minutes. Occasionally, if the damage is bad or you have had previous key hole stabilisation then an open approach is required. This usually involves transfer

of a piece of bone in the front of your shoulder (the coracoid) which is fixed to the front of your dish to deepen the socket. This procedure, known as the Bristow-Latarjet technique, is also performed under general anaesthetic with a nerve block and takes about 90 minutes. You will usually be admitted to the hospital early in the morning and be home by mid afternoon.

What can I expect after surgery?

You will wake up from surgery with your arm in a sling. Your arm will feel numb and 'heavy' whilst the nerve block is working during the first night.

The shoulder will become a bit sore after that but you will be provided with painkillers which you should take regularly for the first few days. It is important to rest your arm in the sling, day and night, for the first 6 weeks.

You should only remove the sling to perform your exercises and carefully when in the shower. You will be provided with a 'rehabilitation' sheet showing you the appropriate exercises or you can download the instructions from the Exercises and Rehabilitation section of this website. Your physiotherapist will closely monitor your exercises and progress.

During the first 6 weeks you will be performing elbow and careful shoulder exercises only. From 6 weeks you will wean yourself out of your sling but you should avoid lifting your arm upwards and outwards for the first 3 months to protect the repair.

You should be able to return to driving at around 8 weeks post surgery, to swimming (breaststroke) at around 3 months, to light duties around 8 weeks and to heavier duties around 3 months. You should avoid contact sports for the first 6 months after surgery.

Cameron Hatrick

NHS Patients

Brighton NHS
Tel: 01273 696955 ext 4258, Tara Kirk
Lewes NHS
Tel: 01273 474153 ask for Glynis Mockett

Private Patients

Direct Tel: 01273 828095 Angela Crosskey
Montefiore Hospital Hove
Tel: 01273 828120

Joideep Phadnis

NHS Patients

Brighton NHS
Tel: 01273 696955 ext 8258, Shirley Boyack

Private Patients

Direct Tel: 01273 828099, Allison Litynski
Montefiore Hospital Hove
Tel: 01273 828120

We value your feedback

myclinicaloutcomes.co.uk

Don't forget to register on myclinicaloutcomes.co.uk before your surgery so that you can track the progress of your shoulder.

iwantgreatcare.org

You are also welcome to provide feedback on iwantgreatcare.org so that we can continue to improve the service we provide.