

Madigan Army Medical Center Referral Guidelines

Shoulder Dislocation

Diagnosis/Definition

Complete displacement of the humeral head from the glenoid fossa often caused by direct trauma. First time dislocations will often require external force for reduction. Severe dislocations can be associated with brachial plexopathies, peripheral nerve injuries, rotator cuff tears, and vascular compromise.

Initial Diagnosis and Management

- History and physical exam.
 - Individuals under the age of 30-35 are more likely to have a recurrent dislocation
 - Individuals over the age of 30-35 are more likely to tear a rotator cuff muscle with the dislocation
 - 95% of dislocations are anterior
 - As high as 90% of anterior dislocations are associated with a Bankart lesion
 - A full neurovascular examination should be conducted – especially sensation of the lateral shoulder/deltoid region (axillary nerve dermatome)
 - Timeliness of reduction may be associated with decrease risk for nerve damage
- Plain radiographs (AP and lateral axillary, internal and external rotations) – however if it has already been reduced and the imaging has taken in the ER, there is no need for additional imaging.
- MRI/CT not indicated.
- Reduction should only be performed by a medical specialist trained in this procedure (usually happens in the ER)
- Immobilize the shoulder for a minimum of 2 weeks and up to 6 weeks or until seen by therapist (they will reinforce the immobilization for this time period at the time they see patient). This includes sleeping with it at night, as dislocations can recur. There is controversy regarding the best position for immobilization. One controversial RCT challenged the standard internal rotation position showing a significant decrease in recurrent dislocations for those immobilized in 10 degrees of external rotation (0 recurrences) compared to in internal rotation (30-45% recurrence. Another recent study tried to replicate this and found no difference between the two. Some argue that the time of immobilization is more important and should be at least 4 weeks. Patients under the age of 40 are at a much lower risk of getting adhesive capsulitis and so a longer period immobilization may be better to ensure proper healing.
- Ice as needed for pain and swelling.
- NSAIDs.
- Appropriate activity limitations (include profile for no running, sit-ups, push-ups, pull-ups, or other activities requiring significant use of UE)

Ongoing Management and Objectives

In cases not requiring surgical intervention, early mobilization and progressive rehabilitation usually results in the ability to return to full activity within 10 weeks.

Indications for Specialty Care Referral

- Contact/consult orthopedics for fractures, suspected fractures, radiographic evidence of Bankart or Hill-Sachs lesion, neurologic or vascular compromise.
- Physical Therapy should be consulted within 72 hours for acute dislocations for patients without fracture or neurologic or vascular compromise.
- Consult Orthopedic Surgery if there is no or slower than expected resolution after 6-8 weeks.

Criteria for Return to Primary Care

- Resolution of the acute or chronic symptoms.
- Patient meets discharge criteria/goals.

References:

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- Quillen, DM, Wuchner, M, Hatch, RL: Acute Shoulder Injuries. *Am Fam Physician*. 2004 Nov 15;70(10):1947-1954.
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Referral Guidelines require review every three years.

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Clinical Practice and Referral Guidelines Administrator