

# SHOULDER ARTHROSCOPY IN FIRST TIME GLENOHUMERAL DISLOCATION

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Treatment options in first episode of glenohumeral instability remain controversial. The glenohumeral joint is the most unstable joint leading to a high frequency of this pathology. The study of natural history of first time dislocation has been made in many articles but in mainly looking at redislocation recurrence and not at apprehension or subluxation. Most of recurrences occur within two years. Glenohumeral instability is a lot more complex problem and using only redislocation as a critical factor is not enough. This is why quality of life index dedicated to shoulder instability has been developed. Only few prospective and randomized studies have compared arthroscopic and conservative treatment of the first episode of shoulder instability and showed a highly significant difference for patients under thirty year old. This difference

was in favor of the arthroscopic treatment. The French Orthopedic Society has conducted a symposium on shoulder anterior instability long term results comparing various open and arthroscopic treatments. Results were comparable in term of glenohumeral arthritis. It was more the gravity of the initial instability (bony lesions, number of dislocations) that influences the functional prognosis both clinical and radiological. Several arthroscopic studies have been made in first episode of instability looking at intraarticular lesions. Major injuries were found not only on the anterior labrum (Fig 1) and the Inferior Glenohumeral Ligament but also on the superior labrum (SLAP Lesions) and major osteochondral fractures. Chronic shoulder instability will lead to a progressive plastic deformation on the capsulolabral structures. This is why the surgical treatment has to deal with this problem using capsuloplasty or bone block procedures. Conservative treatments of the first dislocation are not precisely defined in terms of length of immobilization, type of immobilization, and rehabilitation. Recurrence rates for patients under thirty is 40%. We do not have a large experience on the immobilization in external rotation. We have tried this treatment but patients have complained of pain if the external rotation was greater than 10 degrees, and the logical position would be external position and abduction. The arthroscopic treatment can be made under local regional anesthesia in an outpatient setting. Fixation of good quality tissue is easy without any need for capsuloplasty (Fig2). Results of arthroscopic

treatment have shown a recurrence rate between 10 and 13%. The arthroscopic treatment in the first episode of traumatic shoulder instability is an option that has to be proposed to our patients. In high level athletes in high risk sports associating overhead activity and contact (rugby, judo...) arthroscopic treatment of a truly posttraumatic injury is the treatment of choice. These athletes expect to be off of the field for a 4 month period but they want to be sure that their shoulder is stable when they go back to sport. For other patients younger than 30 the arthroscopic treatment should remain as an option that has to be proposed to the patient. All around the world conservative treatment is induced with a failure risk higher than 50% without proper patient information and without giving the patient the other option. If the first option has been a conservative treatment our attitude is to treat arthroscopically any recurrence of instability (apprehension, subluxation, dislocation) within two years after the first episode.

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## FIGURES

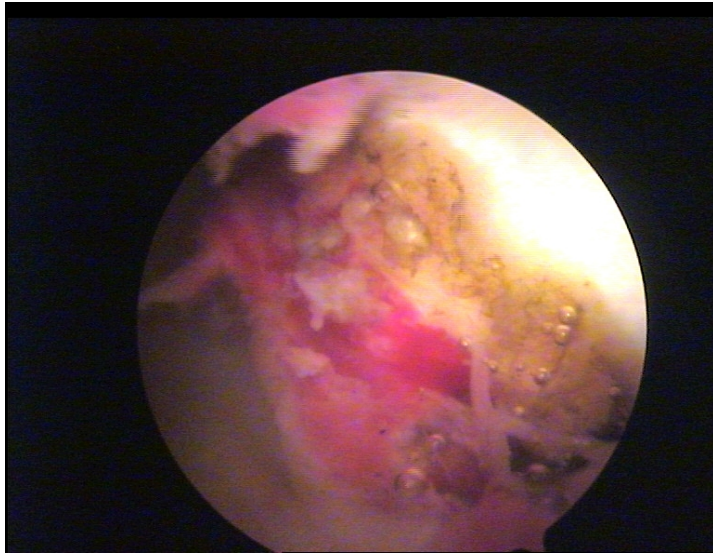


Fig 1: Acute APLSA lesion (Anterior view left shoulder)



Fig2: Anterior fixation of the labrum with anchors (right shoulder posterior view)