

Technique and Results in Voluntary dislocators

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Since Rowe Original article (1) there was a general belief that Voluntary dislocators have psychiatric issues that make surgery impossible. However, this is seldom the case, even in Rowe article just a minority of patients got this issue.

Voluntary dislocators are classified just for the ability of dislocate - relocate his shoulder

Gerber(2) gave 3 groups voluntary a) dislocators without apprehension, b) symptomatic voluntary dislocators or subluxators and), Psychiatric patients. However, this classification is not enough for a variety of different directions and ways to dislocate or subluxate the shoulder.

Shoulder can be dislocated inferior, posterior or anterior, it could be held statically dislocated, or in a point of a dynamic movement, or just subluxate.

This is important to state, because pathology and so correction of it varies, and each patient needs a different way to be managed in surgery.

Of course, physiopathology is complex; could be capsular redundancy, capsular tissue failure, rarely glenoid bone dysplasia, neuromuscular coordination, or of course psychiatric issues

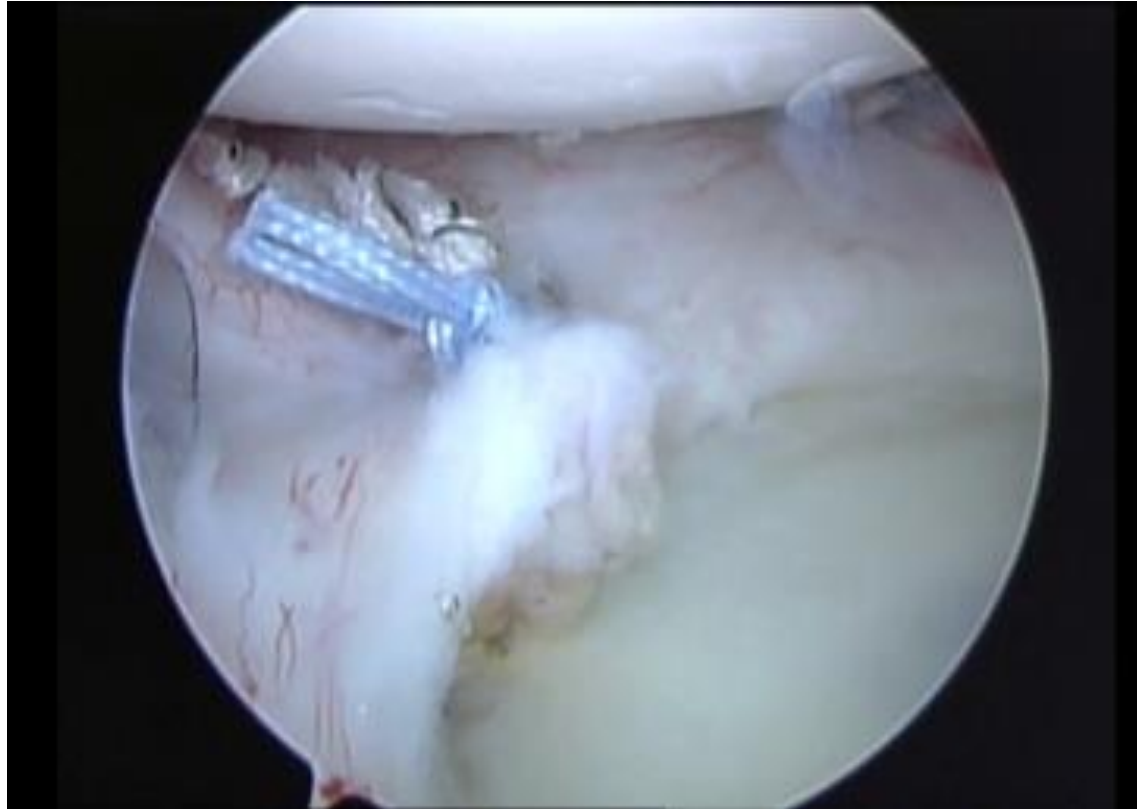
To select the correct technical approach, we should first examine what is main direction of instability and quantify it, also if there is a general laxity issue. We should always be aware that

Even if there is a main direction of instability Voluntary dislocators are multidirectional in nature and sometimes, you have to correct in 360 degrees.

We try to use to different techniques in general:

- 1) what we call capsular shortening, by aggressively cutting and plicating anterior, posterior or inferior capsule to the Glena with double loaded anchors, we do this when we think that instability is pure capsular

redundancy



- 2) what we call capsular folding by taking, if it is anterior capsular instability, the anteroinferior part and fold it with multiple stiches to the anterosuperior one. If it is inferior, the anteroinferior capsule to the posteroinferior one



- 3) if the posterior capsule is involved we usually after shortened it we use an allograft to improve thickness because it is normally thin

Results

There are few reports on results after surgical stabilization, Gerber(3) report on voluntary subluxators and Ahmad (4)on voluntary dislocators so we divided

Our population in this way

We operated on 14 voluntary dislocators 2 lost to follow up. Mean Age 23 10 women 2 men. Mean Fu 81 months. No sports involvement.

3 mainly Anterior dislocators 7 inferior 2 posterior. No significant bone deficiencies were found

At final Follow up no redislocations. of course, this was a population not involved in Sports, with a mean internal rotation deficit of 15 % to the other side, and 20 % ext. rotation deficit

Rowe Scores 9 excellent 2 good 1 regular

On voluntary subluxators all posterior. 11 patients 1 lost to follow up. Mean Age 20 .5 women 5 men, 3 contact sports athletes. In this group

6 patients received a posterior allograft. Internal Rotation deficit averages 25 % external rotation deficit mean 15%. 1 patient dislocates 1 subluxates Rowe Score 6 excellent 2 good 2 regular

This result is in line with literature although as already stated lacks of A comparable control group. Also, all surgeries are highly variable due to the dominant direction of instability and degree of capsular laxity.

However voluntary dislocators must be taken as candidates for surgeries because results are good in spite of a general idea that they are not.

References

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- 3)Fuchs B Jost B Gerber C Posterior-Inferior Capsular Shift for the treatment of Recurrent,voluntary Subluxation of the Shoulder.JBone Joint Surgery 82 A 16-25
- 4)Greiwe M Galano G Grantham J Ahmad C.S Arthroscopic Stabilization for Voluntary Shoulder Instability J Pediatric Orthop 2012 32 781-786