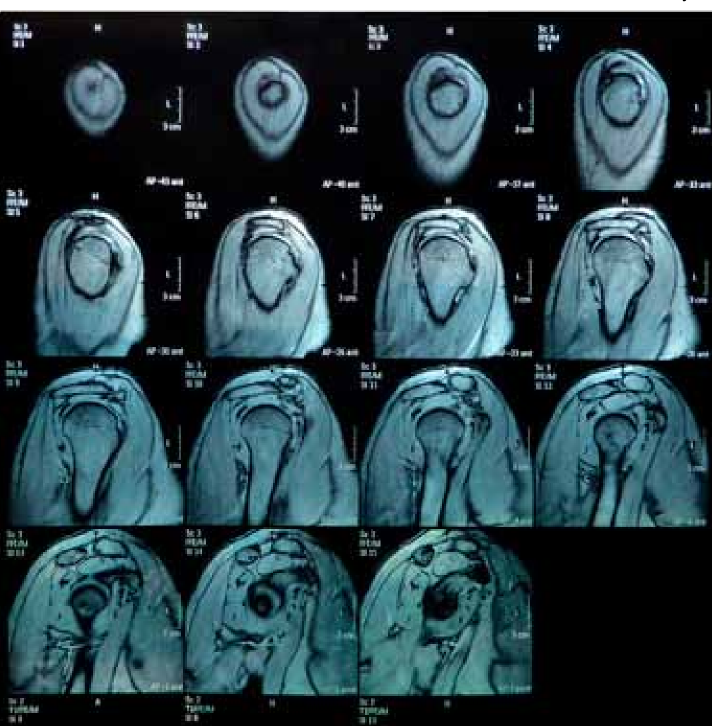
MEDICAL INSIGHT: THE SHOULDER

Mr Omar Haddo takes a look at problems caused by shoulder instability and the treatments on offer at The Wellington Hospital

The summer of 2010 will be remembered for many things, but perhaps mostly for the run of great sporting events (including the World Cup, Wimbledon and the Australian Rugby Tour) happening in the next few months. However, it is precisely at this time that we ask you to spare a thought for your shoulder. Whilst these sporting events provide great entertainment to all, the demand on the shoulder occasionally exceeds its capabilities, whether through the constant overhead activity or the regular trauma it sustains with falls and direct impact.

Despite its great design, which offers us diversity of movement unequalled by any other joint, we still seem to find ways of pushing it to the limit – and sometimes beyond.

MRI scan of a shoulder joint



The shoulder is a ball and socket joint, with various components working together to offer stability in all directions. But before we digress, it is important to set out the distinction between instability and laxity. In simple terms, instability is symptomatic laxity. A joint can be lax without any complaints from the patient; and in this case, this can be considered as a variation of normal.

Shoulder instability most commonly develops after a significant trauma, causing the humeral head (the upper extremity of the humerus) to dislocate. This is anterior in 95 per cent of cases, with forced abduction and external rotation. Posterior dislocations are rare.

Once traumatic dislocation occurs in the young, the risk of recurrent dislocations is high with some papers quoting 90 per cent. This is due to the loss of the stabiliser with the detachment of the labrum (cartilage which may include a bony fragment), the stretching of the capsule and the tearing of the ligaments, leaving a capacious space. However, traumatic dislocations in the elderly have lower risk of recurrent dislocations.

The introduction of the Stanmore triangle classification has provided us with clearer understanding of the pathological process and the treatment plan for shoulder instability. This describes three 'polar' groups – the traumatic structural, atraumatic structural and the muscle patterning group. It also describes the fluidity of this condition with patients falling between groups.

The immediate treatment of shoulder dislocations is to reduce the joints urgently and safely. Following a short period of rest in a sling, physiotherapy offers great benefit. This is certainly the treatment of choice in the muscle patterning group.

Research from Japan has shown that immobilising the first time traumatic dislocators in external rotation for six weeks, reduces the risk of recurrence. Unfortunately, compliance with this regime has proved a challenge in the Western world and the debate on early versus delayed and open versus arthroscopic surgery continues.

Surgery for traumatic dislocations includes labral repair and capsular shift. Capsular shrinkage or placation can be carried out for the lax, capacious capsule. The Bristow-Latarjet procedure is reserved for cases with bone deficiency.

In our practice, the choice of timing and the type of surgery is tailored to the patient's pathology, lifestyle and demand. Patients should try conservative management before undergoing surgery. However, we understand that in certain groups of patients, their professional demands may not allow the time required for conservative management. Here, at The Wellington Hospital, we are all experienced in arthroscopic and open shoulder surgery for instability. We also have a highly qualified team of shoulder physiotherapists to offer the support required to the patients, both pre- and post-operatively.

For more information or to arrange an appointment with Mr Omar Haddo contact the Wellington Enquiry Helpline on 020 7483 5148, www.thewellingtonhospital.com