News Letter ■ Issue # 3

Glenelg Orthopaedics

Providing Quality Orthopaedic Care

Phone 8376 9988

Consulting Glenelg, Mawson Lakes, Torrens Park and Middleton

Treatment of Trauma

Upper Limb Trauma

As September draws nearer, so does the time when the state holds its breath whilst trauma is moved from east end of North Terrace to the west end, I felt it would be worthwhile making our 3rd edition of the newsletter dedicated to trauma.

Whilst compound fractures, dislocations and distorted limbs (with neurology at risk) are an emergency, there are still a lot of Upper Limb and Hand trauma that can be treated cold. Whilst we are always available to give advice, unfortunately it is difficult (and unsafe) to be on call all the time. That being the case, we welcome any contact with general practitioners dealing with a traumatic injury and will do our best to offer assistance. There are many cases that warrant delay for both workup/ staging of the injury to determine the best treatment option as well as ordering the appropiate equipment if surgery is recommended. In these cases, the following algorithms are offered so as to assist you in the initial phase of management, with the aim of stabilising the scenario and then passing it on to a team such as ours.

Dr Nimon is on the on-call roster at The Queen Elizabeth Hospital as part of his Public Service commitment

TEAM WORK

The Philosophy and Mantra at Glenelg Orthopaedics is about engagement. Involvement of the patient , their family and the General Practitioner in the treatment algorithm is vital. We believe that the greater the understanding of the treatment options and their involvement in the treatment plan, the better the treatment journey will be.

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FRACS Fellow of the Royal Australasian College of Surgeons

Management of Shoulder Dislocations

"What is the current thought on the treatment of a shoulder dislocation."

Acute Shoulder Dislocation

Unstable shoulders are common events brought to the limelight by sporting injuries particularly in Australian Rules Football.

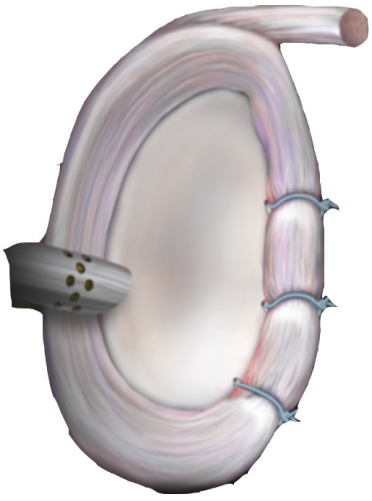
Question: What is the pathology of the condition and how is it treated?
Instability of the shoulder is really an event where the shoulder (humeral head or ball of shoulder) dislocates out of the joint (glenoid cavity or socket). The shoulder is made up of the glenoid which is a socket in which the ball of the shoulder (humeral head) sits. Because of the range of motion required for the shoulder, the humeral head is approximately four times larger than the socket.

To make the shoulder more stable, the body develops a tissue around the socket called the labrum. The combination of the socket itself (glenoid) and the labrum, produces a total socket which is much closer to the size of the humeral head and along with the capsule which joins to the labrum, provides for increased stability. Usually it is this tissue that tears in a shoulder dislocation.

Question: How is an episode of shoulder instability treated?

In the past, patients were treated with a sling for comfort and then rehabilitation, however following a first time dislocation, the shoulder has a much higher chance of re-dislocation. As such the re-dislocation rate in a patient < 35 years of age is associated with an 85% re-dislocation rate and in these patients, surgical repair is warranted. Those patients who decline it and then go on to a second dislocation have close to a 100% re-dislocation rate. Surgery can reverse these odds and bring it down to approximately 10% re-dislocation rate. In someone who has had previous dislocations, a sling is used for comfort alone and then rehabilitation is recommended.

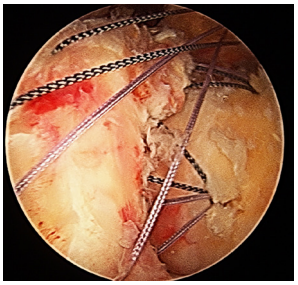
In a patient over 35 years, the chance of re-dislocation is a lot less but what can occur in the older patient is a tear of the rotator cuff tendons. This should always be checked, particularly in a patient who does not recover the strength following an initial dislocation in the older age group.



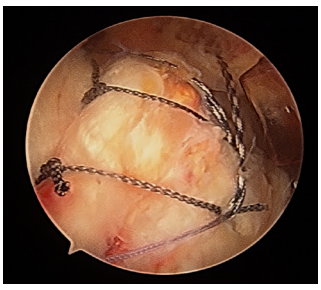
Depiction of labral repair

Consequently, in the acute traumatic instability episodes, there are 3 main groups:-
1)There is a young person with a first time dislocation in which surgical intervention is warranted.
2)There is a middle age person, who may opt for a physiotherapy regime and non-operative approach.
3)The older patients who have a higher risk of tendon tear and this should always be investigated because if there is a tendon tear, then surgery may warranted.

Therefore a shoulder dislocation is an indication for further investigation and may require surgical treatment.



cuff tear being repaired after acute injury



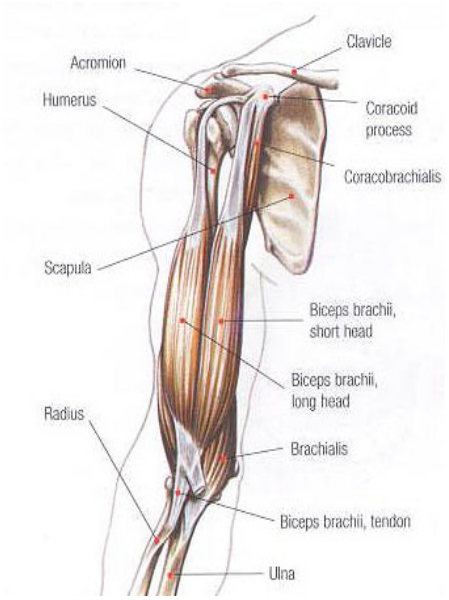
Long Head of Biceps Tendon Injuries

This is a very common injury especially with ageing. It will often present with several months of increasing pain around the shoulder , leading to a sudden increase in pain and bruising. Often there is development of a more prominent lump which appears distally (further down the arm) leading to concern that it is something sinister.

A few weeks after the tendon tears, the pain often improves.

There is little evidence of this leading to weakness and surgery is usually only indicated in a younger patient or if rotator cuff surgery is contemplated.

In these cases, what is undertaken is to tenodese (retensioning) the long head of biceps. What one does is to tension the biceps tendon and re-attach it either to soft tissue or bone below the shoulder joint, thus bypassing the shoulder joint.



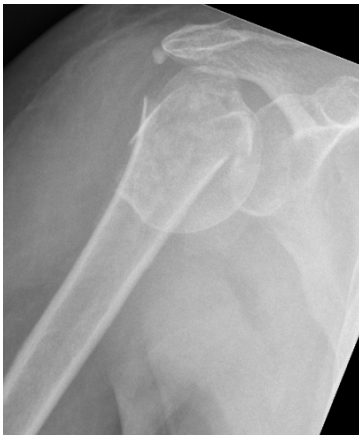
Distal Biceps Tendon Injuries

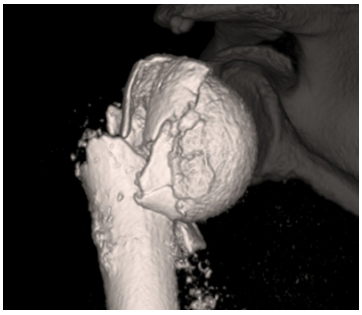
Distal bicep tendons are different to the proximal biceps tendons in that the bulk of the muscle attaches distally through one tendon at the radial bicipital tuberosity.

Tears occur after excessive force is placed through the elbow. Because the tear is quite deep, the amount of bruising or deformity can be minimal, just discomfort ensues.

The diagnosis is easily confirmed with ultrasound. If the tendon tear is significant, a muscle can contract further up the arm so that they also have a "Popeye Sign" but the Popeye Sign is more proximal ie. closer to the shoulder.

The issues that arise from the distal biceps tendon tearing are both cosmetic and also functional with weakness. Thus these tears justify surgery, which is undertaken through an "L" or "S" shaped incision with the tendon being sutured back into bone passing it through a hole drilled in the bone and secured with a small metal button and a plastic screw holding the tendon tight against the bone in a tunnel. A sling is required for 6 weeks after surgery avoiding heavy lifting for upto 6 months.





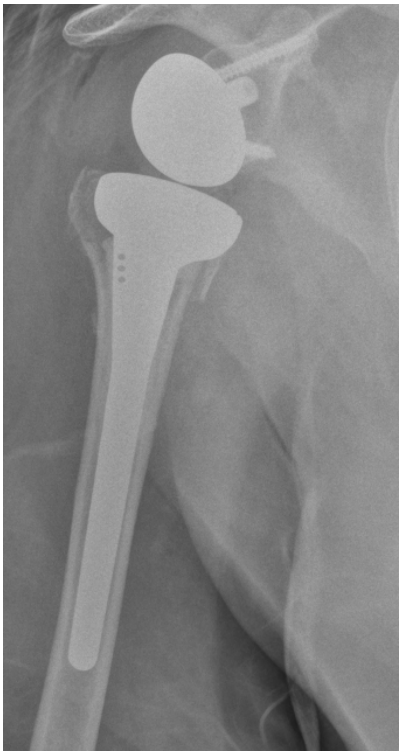
Reverse Total Shoulder Replacement

-a solution for a difficult problem-

Fractures like the one on the left have in the past been a vexing issue. Left alone, and the results are poor. Yes it heals , but the patient is left with poor function and pain.

Attempt of fixation resuts in the tuberosities failing to heal and therefore the tendons pull off the bone with the tuberosity.

The Reverse shoulder allows us to attempt fixation, (and repair the cuff) with the reassurance that if the tendons pull away, the shoulder replacement will still function. The end results are remarkable.



GLENELG ORTHOPAEDICS

GP Advice Line
8376 9988

" We believe it's important to be available to help. It does not matter if it's a patient of mine or not, I am always available to offer advice or recommend a treatment plan. Do not hesitate to call me should the need arise."

Medical treatment is a team effort, that's why there is always a friend available to give advice.

We have provided a large amount of information in "Plain English Style" to help explain things to patients and their families. Please feel free to refer to them and suggest topics you may also wish to see covered, by emailing us at admin@glenelgorthopaedics.com.au.

THE UNIVERSITY of ADELAIDE

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