BACKGROUND: A 21 year old male NCAA Division II golfer presented with severe multidirectional instability of the right shoulder. The instability began two years ago, following a traumatic anterior dislocation when he landed on an outstretched hand while playing recreational football which resulted in a posterior dislocation. Upon initial dislocation, an x-ray was performed and revealed full relocation of glenohumeral joint. No MRI was performed at this time. Physical findings included bilateral laxity of the shoulders, elbows, digits and knees, positive apprehension and relocation tests, Grade II+ load and shift test, positive sulcus sign, and positive for active compression for labral involvement. Over a two year period the athlete reported at least 20 dislocations from activities other than golf. All dislocations were self reduced. Examples as to the significance of his instability include instances such as when the athlete dislocated his shoulder while throwing a Frisbee throw and again while picking up a backpack. He also reported dislocation while in the SwimEx during physical therapy for an ACL reconstruction. He also dislocated while actively stretching in bed. DIFFERENTIAL DIAGNOSIS: Because of repeated dislocations, a Bankart lesion, Hill-Sachs lesion, tendon rupture, and ligament rupture were suspected. An X-ray and MRI arthrogram revealed a Bankart lesion, Hill-Sachs lesion and ligament rupture had occurred. Physical therapy was recommended and surgical intervention to be considered if symptoms persisted. TREATMENT: Because repeated attempts at physical therapy were unsuccessful and the patient reported additional dislocations, surgery was performed revealing the following: a complete anterior surface tear of the glenoid labrum with the remaining labrum frayed and irregular, the adjacent capsule was stripped and the middle was torn, the infraspinatus tendon was torn on the articular surface, and a Hill-Sachs lesion presented on the posterolateral aspect of the humeral head with adjacent subchondral cysts. Currently patient is four weeks post surgery for anterior capsular repair and stabilization. Rehabilitation includes manual therapy, passive range of motion, scapular stabilization exercises, and shoulder strengthening activities to protect the anterior capsule. UNIQUENESS: This case is unique because of the severity of instability while continuing to participate in intercollegiate golf without dislocating. The athlete’s sport specific functional patterns do not place him at a greater risk for shoulder instability and yet, upon surgery, it was shown how truly unstable he was. CONCLUSION: The athlete demonstrated severe multidirectional instability in his shoulder which is inconsistent with the movement patterns associated with his sport. The athlete’s shoulder was unstable to the extent that he was unable to perform normal activities of daily living without subluxation. Despite the shoulder instability, the athlete completed his golf season with out incident.

KEYWORDS: dislocation, multidirectional instability, anterior stabilization