ANTERIOR DISLOCATION OF THE GLENOHUMERAL JOINT LEADING TO GLENOID FRACTURE AND REVERSE BANKART LEASION
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Background: A 21 year old offensive guard (306lbs. and 6'3") complained of sharp pain in his left shoulder while blocking another player. He described felling his shoulder “pop” out and then immediately “popping” back in. The athlete at the time had no history of instability in the involved extremity, however had been previously treated for an anterior dislocation of the right shoulder. Initially, X-rays and an MRI showed a posterior tear in his left labrum. The athlete, after reviewing his options, decided to forgo surgery and rehabilitate his injury. The athlete, following a successful rehabilitation program, was able to return to play the following season. During a game, the subsequent season following the initial injury, the athlete after making a tackle said he felt his arm “pop” out again. Upon inspection his left shoulder appeared to be slightly abducted. He was immediately removed from the playing field and reduced by the team physician.

Differential Diagnosis: Humeral head fracture, Clavicle fracture, AC joint separation.

Treatment: Athlete was prescribed medication for pain and placed in a sling. Diagnostic imaging revealed a glenoid fracture, the previously diagnosed posterior labral tear, and a newly formed anterior labral tear. A follow up CT scan confirmed the glenoid fracture and labral tear. Surgical intervention was then recommended. Surgery was then scheduled 10d. post-injury to repair the glenoid fracture and labral tears. Prior to surgery, the athlete’s treatments focused on pain management and range of motion exercises. The athlete went through all glenohumeral motions with minimal resistance. After each treatment, the athlete was placed on a compression/cryotherapy machine with no pressure with either high volt or inferential electrical stimulation, and then in a sling. During surgery, an extremely large reverse Bankart lesion was noted and repaired, along with the glenoid fracture. Immediately after surgery, the athlete was placed in an abduction sling for 2 weeks, and then a regular sling for 2 weeks. The day after surgery, the athlete started ROM exercises at the elbow and wrist, and isometric exercises at the shoulder. Rehab exercises include elbow flexion and extension, Codman’s, and shoulder isometrics that included abduction, adduction, flexion, extension, internal rotation and external rotation. The athlete continued ROM exercises and started rhythmic stabilization exercises 7 days post surgery. After each treatment, the athlete was placed on a compression/cryotherapy machine with no pressure. At this time the athlete is progressing with treatment and may hope to return to full competition in the spring season. Uniqueness: Anterior dislocations are a common injury seen among football players, however glenoid fractures are rarely seen as a complication. Additionally, glenoid fractures resulting from a dislocation are more commonly seen with a posterior dislocation rather than an anterior dislocation. Although this athlete, as a preventative measure, was in a harness during the game, still suffered a dislocation.

Conclusion: Athletic trainers, following an anterior dislocation, should refer for diagnostic imaging in order to determine the extent of the injury. Although rare, glenoid fractures, can occur following a dislocation and are often difficult to recognize. In this particular case, due to diagnostic imaging, the glenoid fracture and labral lesion, were recognized early which allowed for the development of an appropriate treatment plan.

Word Count: 530