《심포지움 II 16:24~16:36》

OPEN RECONSTRUCTION FOR SHOULDER INSTABILITY

전 재 명

울산의대

Shoulder Instability
  Multiple mechanisms
  Anatomic variations
Shoulder Instability
  Host factors
  Magnitude of force
  Traumatic force; the most frequent cause
Diagnosis
  Most cases; History & Physical examination
  Radiographic imaging; X-ray, CT, MRI
  Others
  Examination under anesthesia
  diagnostic arthroscopy
History
  Injury mechanism
  Magnitude of forces
  Direction of forces
  Number and frequency of previous dislocations
  Reduction method
  Duration of pain after reduction
Classification & Description
  Cause
  Traumatic, Repeated microtrauma, Atraumatic
  Direction
  Anterior, Anteroinferior, Posterior, Multidirectional
  Degree
  Occult, Subluxation, Dislocation

Chronology

Acute, Chronic, Recurrent (Rarely vs Frequent)

Physical examination

Systemic approach

Inspection

Palpation

ROM

Strength

Neurologic examination

Stability tests

Stability tests

Unaffected side; First

Generalized Ligament Laxity

Amount of passive translation of the humeral head and glenoid foss

Attempts to reproduce the symptoms of subluxation and apprehension

Authors preferred technique of stability test

Anterior; Apprehension test

Inferior; Sulcus test

Posterior; Jerk test

Authors preferred method of imaging studies

True AP, Axillary Lat.

Instability series

West point view; Anterior glenoid lesion

Stryker notch view; Hill-Sachs lesion

Apical oblique view; Anterior glenoid lesion

Weight-bearing view; Inferior instability

Authors indication of Surgery

Cause; Traumatic (Rarely repeated microtrauma)

Direction; anterior or anteroinferior

Degree; subluxation or dislocation

Chronology; frequent recurrency (More than three times)

Consider functional limitations

Contraindication

Voluntary instability with psychiatric problem

Advanced GH arthritis

Paralysis

Triple Protection Procedure

Anatomical restoration of labral detachment; Bankart repair

Reinforcement of deficient capsule; Capsular imbrication

Further protection; Augmentation

Prior to TPP

Bankart repair & Capsular Imbrication

From March, 1995

84 cases

Recurrency; 4 cases

All cases; recurrent after trauma

Reoperation; 2 cases

Recurrency

Hematoma

Short-term results

From February 1999

23 cases

ROM; Normal ~ -10º (F/E & or E/R)

No limitation of ADL

Complication of TPP

No; Infection or Hematoma

No; Nerve injury

No; Detachment of Subscapularis

Reoperation; One case

Resistant pain after direct injury postop. 2 m.

Disruption of RI Closure

Well healed Bankart lesion

Repeated Capsular imbrication and Suture augmentation

Authors experience of revision cases

Transferred cases (4 cases)

Putti-Platt (2) → Capsular imbrication

Open repair with suture anchors (1) → Capsular imbrication

Arthroscopic repair (Caspari) (1) → Capsular imbrication

Authors own cases (2 cases)

Capsular imbrication (1) → TPP

TPP (1) → TPP

No recurrency