MUSCULOSKELETAL CASE 2: DIAGNOSIS

INFERIOR DISLOCATION OF THE GLENOHUMERAL JOINT (LUXATIO ERECTA)

The anteroposterior projection demonstrates displacement of the humeral head inferiorly to the glenoid fossa with the humeral shaft abducted superiorly (Fig. 1, arrow). An irregular contour to the glenoid fossa can be seen on close inspection.

Dislocations of the glenohumeral joint are very common. However, unlike this case, most are anteroinferior dislocations (Fig. 2), which cause significant damage to the anterior capsular structures, therefore predisposing to repeated dislocation. Fractures may be associated with the dislocation, affecting either the posterolateral humeral head or the rim of the glenoid fossa, or both. Less than 5% of dislocations occur in different directions, luxatio erecta being a distinctly unusual variety. As with anterior dislocation, fractures may be present. In luxatio erecta, fractures of the greater tuberosity are more common than those of the glenoid rim (which is present in this case [Fig. 1, arrow]). Luxatio erecta can usually be treated by
closed reduction, and, unlike antero-inferior dislocation, patients are not usually predisposed to repeated episodes.

Posterior dislocation is the second most common type of glenohumeral joint dislocation (Fig. 3). Classically, posterior dislocation is associated with seizures or direct anterior trauma. Those dislocations that are not associated with recognized seizures are notorious for being difficult to appreciate clinically and may become chronic.1,3

Pure superior dislocations are exceedingly rare. On radiographs (Fig. 4), the humeral head is displaced above the glenoid, and these dislocations may be associated with fractures of the acromion or clavicle or with disruption of the acromioclavicular joint, or both.1,3

References