

## Post Traumatique Shoulder Dislocation Type Erecta : About Three Case Reports

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### **Summary :**

Shoulder dislocation in its erecta form is a rare variety. We report 03 observations of shoulder dislocation type erecta collected between 2019 and 2022. Three men were involved, with an average age of 40 years. The pathognomonic attitude was found in all three cases, with the upper limb in irreducible hyperabduction with the arm in the air. In one case, axillary nerve damage was found, with an associated fracture of the greater tuberosity. A frontal x-ray of the shoulder showed inferior dislocation of the humeral head. Inferior shoulder dislocation of the erecta type is rare, its mechanism being a fall onto the upper limb in extreme abduction and external rotation. Diagnosis is clinical, confirmed by an antero-posterior x-ray of the shoulder. Treatment consisted of reduction under anaesthesia, followed by immobilization for three weeks.

**Mots clés :** luxation erecta ; épaule ; réduction

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### **I-Introduction:**

The aim of this article is to review the bibliography concerning this rare pathology and to show its clinical and radiological aspects as well as its therapeutic management.

### **Ii-Material And Method :**

- We report three observations of erect dislocations of the shoulder.
- The first patient (fig1.2.3.4) was 37 years old and had fallen from a height of two metres. Clinical and radiological examination revealed an erectal dislocation of the left shoulder with axillary nerve damage and associated fracture of the greater tuberosity.
- The second patient (fig 5.6), aged 56, suffered a direct impact to the right shoulder following a road traffic accident. Clinical and radiological examination revealed an erect dislocation with no associated vascular or nerve damage.
- The third patient (fig 7.8.9) was a 25-year-old victim of a road traffic accident causing polytrauma with erecta dislocation of the right shoulder.
- In all three cases, treatment consisted of emergency reduction under general anaesthesia, followed by immobilization and early rehabilitation.

### **III- Results:**

Mean follow-up is 9 months. Evaluation is based on the UCLA grading scale, which includes an assessment of pain, function, range of motion, strength and patient satisfaction (1,4). Outcome was excellent in two cases and fair in one case with associated axillary nerve and greater tuberosity injury (7).

There was no recurrence of dislocation in any of the three cases.

All patients returned to work.

### **IV-Discussion:**

Dislocation erecta is rare, accounting for 0.5% of all shoulder dislocations (1,3,8).

It was first described in 1859 by Middeldorpf and Scharm (5).

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The usual mechanism is sudden upward pressure on an abducted, externally rotated shoulder with bent elbow. It may occur as a result of violent abduction of the shoulder. Road traffic accidents are the main etiology (2,3). In one case, this etiology was the cause of a polytrauma requiring multidisciplinary management. Clinically, the affected arm is hyperabducted and the humeral head is palpable below the humeral glenoid.

The diagnosis is clinically confirmed by radiography. The dislocation erecta must be reduced as a matter of urgency under general anaesthetic, traction of the arm in the axis of the limb while the helper applies counter-pressure to the thorax. The arm is then returned to adduction and immobilized at the elbow for 3 weeks (3,6).

X-rays of the shoulder after reduction are systematically performed.

Reduction is surgical in cases of associated labrum or rotator cuff lesions, or fracture of the greater tuberosity (2,3).

We found peripheral nerve damage to the axillary nerve associated with a non-displaced fracture of the greater tuberosity, which was treated orthopedically. The nerve damage regressed within 5 months(2). No vascular damage was found (7).

### **V-Conclusion:**

Shoulder dislocation of the erecta type is rare. Diagnosis is clinical and confirmed by standard radiography. Vascular and nerve complications are frequent. Treatment is based on emergency reduction of the dislocation, followed by immobilization and early rehabilitation.

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**Fig 01**



**Fig 02**



**Fig 03**



**Fig 04**



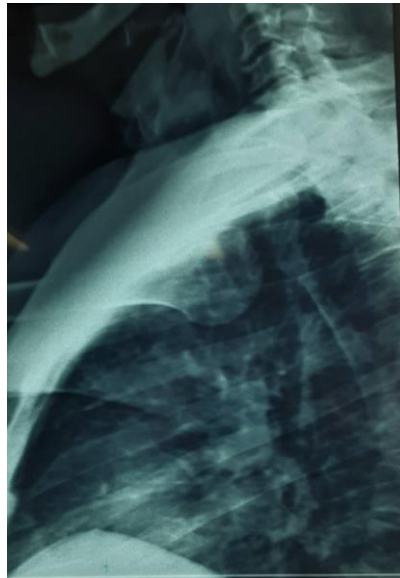
**Fig 05**



**Fig 06**



**Fig 07**



**Fig 08**



**Fig 09**