SIMULTANEOUS POSTERIOR DISLOCATION OF BOTH SHOULDERS

Report of a Case

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Seven undoubted cases of simultaneous posterior dislocation of both shoulders have been reported (Coover 1932, Wilson and McKeever 1949, Dorgan 1955 (2 cases), Arden 1956, O'Connor and Jacknow 1956, Goodfellow and Boldero 1959). Of these, five were caused by an epileptiform fit, and one by a road accident. In one, the cause was unknown. Manipulation was tried in five cases, but it was successful only in two. In both of these, treatment was undertaken at once (Dorgan 1955, Goodfellow and Boldero 1959).

A further case is here reported, in which manipulative reduction was possible after five days.

CASE REPORT

A muscular man aged fifty-six had been stooping while working with concrete in his garden. He felt unwell, came into the house and sat down. His wife then observed a fit, in which he

FIG. 1

FIG. 2

Vertical view of right (Fig. 1) and left shoulders showing bilateral posterior dislocation, the posterior glenoid rims engaging in notches in the humeral heads.

FIG. 3

FIG. 4

Vertical view after reduction shows that the indentations in the humeral heads correspond to the shape of the posterior glenoid rims, and it is concluded that these are impacted fractures. Figure 3—Right shoulder. Figure 4—Left shoulder.

kicked out his legs, flexed his elbows and contorted his face. Blood came from his mouth, and he was unconscious for five minutes. He did not pass urine during the attack.

On admission to the medical ward, he complained of severe pain in both shoulders. The left side of the tongue had been bitten, the left upper canine tooth was loose, and the gum was bleeding. There was a petechial rash over the shoulders and base of the neck. No abnormal neurological signs were found.

Four days after admission, orthopaedic advice was obtained. The arms were by the sides and the shoulders fixed in 60 degrees of medial rotation. The humeral heads were displaced backwards, leaving the acromion and coracoid processes prominent in front. An antero-posterior radiograph of the right shoulder, taken on the day after admission, suggested incongruity. Vertical views confirmed posterior dislocation of both shoulders, the posterior glenoid rims engaging in notches in the humeral heads (Figs. 1 and 2). Under anaesthesia, the dislocations were reduced easily, and collar and cuff slings were applied. Radiographs after reduction showed that the indentations in the humeral heads corresponded to the shape of the posterior glenoid rims (Figs. 3 and 4). It is concluded that these were impacted fractures; Goodfellow and Boldero so explained similar indentations in their case.

The shoulders were freed after four weeks. Twelve weeks after injury the shoulders were stable, and movement and function were full.

COMMENT

Simultaneous posterior dislocation of both shoulders is almost always due to an epileptiform fit. It is noteworthy that four patients, men of seventy years (Coover), forty-one years (Arden), forty-six years (Goodfellow and Boldero), and fifty-six years (the present case), had never had a fit before. Arden's patient and the present one had each been stooping at work in the garden just before the fit, no organic cause for which was found in our patient and none reported in the other three. Our patient has had no further fit in the subsequent eight months, nor were any more reported in the others. These unusual features suggest a possibility that the fits may be of a special nature. Their severity is indicated by the dislocation and also, in our case, by the petechial rash over shoulders and base of neck.

SUMMARY

A case of simultaneous posterior dislocation of both shoulders, occurring in an epileptiform fit, is described. Manipulative reduction succeeded after five days, and full function was gained.

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