Correspondence

We welcome letters to the Editor concerning articles which have recently been published. Such letters will be subject to the usual stages of selection and editing; where appropriate the authors of the original article will be offered the opportunity to reply.

Letters should normally be under 300 words in length, double-spaced throughout, signed by all authors and fully referenced. The edited version will be returned for approval before publication.

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The floating shoulder

Sir,

We read with interest the paper by Owens and Goss¹ in the November 2006 issue entitled 'The floating shoulder' and we wish to comment on the indications for surgical fixation of the glenoid fracture.

The authors advise open reduction and stabilisation of the glenoid neck fracture when there is translational displacement by 1 cm or more and/or angulatory displacement of 40° or more in the coronal or sagittal plane. We wish to draw attention to the particular relevance of caudal dislocation of the glenoid fracture. Van Noort et al² published one of the largest studies reviewing floating shoulder injuries. In this multicentre study, caudal dislocation of the glenoid resulted in a significantly adverse outcome with an average Constant score of 42 compared to 76 overall for the conservatively managed group. Van Noort et al² replied to correspondence from Gerber³ in the July 2002 issue to define the glenoid as 'caudally dislocated' if the inferior angulation was 20° or more. This definition was based on an anatomical study by Churchill et al,⁴ investigating variation of the glenoid including angle inclination.

We feel that attention should be brought to the importance of caudal dislocation of the glenoid fracture when determining which cases should undergo operative fixation, and that surgeons should accept a lower degree of angulation of the glenoid neck fracture than that advocated by the authors.

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Author's reply:

Sir,

We would like to thank Mr Corner and Mr Emery for their interest in our paper and for their thoughtful comments. We have noted the work of Van Noort and colleagues and their subsequent response to Professor Gerber's letter. They reported on 35 patients with floating shoulder injuries. Of the 28 who were managed conservatively, six displayed 'caudal dislocation' of the glenoid. The mean Constant score of these six was 42, while that of the remaining 22 was 85. Of the seven patients managed operatively, five had persistent 'caudal dislocation' resulting in a mean Constant score of 62 while the other two patients with anatomical reduction of the glenoid fragment had a Constant score of 85. The authors concluded that patients with significant caudal displacement of the glenoid fragment had more inferior results than those without such displacement. They also noted that open reduction and internal fixation of the clavicular fracture alone may not adequately reduce the glenoid fragment and this appears to be critical to the final functional outcome. The authors, however, do not provide data on the amount of angular displacement present, either at initial injury or final follow-up. When questioned by Professor Gerber in this regard, they stated that inferior angulation of the glenoid fragment of 20° or more was 'arbitrarily' defined as being unacceptable.

The recommendations in our article for surgical treatment of glenoid fractures with greater than 40° of angular displacement are based on a thorough review of the available literature. Although this number remains controversial and Van Noort et al believe that 20° or more of inferior angulation of the glenoid fragment is unacceptable, we feel there is insufficient data to support this stricter indication for surgical intervention.

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