

Posterior Shoulder Instability
Scott D. Mair, MD
University of Kentucky Sports Medicine



1

Disclosure


- Smith and Nephew Endoscopy –
– Fellowship support




2

Definition

- Excessive posterior glenohumeral translation that produces symptoms

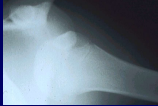


3



Differences from Anterior

- Less common
- Can be a more difficult diagnosis
- Usually not a true dislocation



4



Common in 2 Types of Athletes

- Those subjected to posteriorly directed forces
 - Offensive linemen, weight lifters
- Those with multidirectional instability
 - Frequently have a significant posterior component



5



Symptoms


- Often vague with diffuse pain
- May describe “slipping” posteriorly
- Arm position can be important clue



6

Physical Exam


- Complete exam
- Patients better able to relax than anterior
- Comparison to opposite shoulder essential
- Most important – translation



7

Posterior apprehension

- Flexion and internal rotation of the adducted arm
- Posteriorly directed force



8

Jerk Test


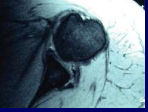
- Shoulder relocates with abduction



9

Imaging UK

- Xrays – generally normal, may see small fleck off glenoid (reverse bony Bankart)
- MRI – may show posterior labral detachment (especially in traumatic setting)

10

Posterior Instability Treatment Options UK


- Initial treatment generally non-op
- Relative rest
- Avoid provocative activities and arm position
- NSAIDs
- Early surgery
 - Clear MRI findings
 - Off season athlete



11

Physical Therapy UK

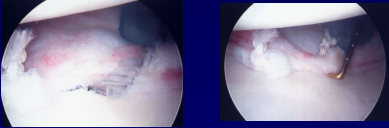
- Periscapular muscles – stable platform
- Rotator cuff –
 - Fine tunes stability
 - Compressive effect



12

Response to PT

- Generally better than with anterior instability
- Patients with history of significant trauma less likely to respond



13

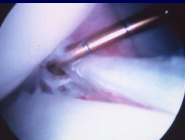
Factors Influencing Decision for Surgery

- Degree of symptoms and disability
- Appropriate PT, still unsatisfied
- Exam / MRI findings
- Timing regarding season

14

Surgical Treatment

- Tighten posterior capsule
- Repair labrum if torn
- Open or arthroscopic

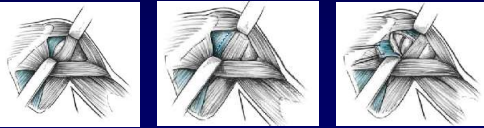


15

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Open Posterior Stabilization

- Technically difficult
 - Hard to see, deep hole
 - Posterior capsule thin
- Can add infraspinatus tenodesis - Hawkins




16

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Arthroscopic Stabilization

- Exam under anesthesia
- Lateral position
- Start with standard posterior portal
- 2 anterior rotator interval portals



17

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Arthroscopic Stabilization Portals


- Scope in AS portal
- Lower anterior portal used for shuttling sutures
- Make new angle of entry posterior portal



18

Posterior Portal

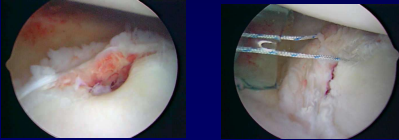
- Need angle for placing anchors
- Amazing how lateral starting point needs to be
- Localize with spinal needle
 - Around corner of posterolateral acromion
- Avoid 2 posterior portals (too crowded)
- Use same capsular hole, new angle



19

Labral Repair

- Place anchor
- Spectrum with PDS suture through capsule / labrum
- Shuttle through anterior portal
- Arthroscopic knot tied from posterior portal



20

Arthroscopic Labral Repair

- 3-4 capsulolabral sutures



21



22

Reverse HAGL Lesion

- Capsule torn from humeral side
- Repair posterior Bankart if present
- Repair capsule back to humerus




23

Reverse HAGL Lesion



24



Post-op Rehab

- Immobilize 4-6 weeks with ER at least neutral
- Gun-slinger brace?
- No stretching of posterior capsule
- Strengthening held until 8-12 weeks

25




Return to Sports

- Normal ROM and strength
- Minimum 4 months, often 6




26



Results of Surgery

- Open techniques – failure rates of 20- 50 % common
- Arthroscopic techniques – success of 90% in recent reports



27



Conclusions

- Posterior instability less common
- Unless preceded by significant trauma, rehab often successful
- Surgery heading toward arthroscopic techniques



28



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THANK YOU

29
