AN OPERATIVE METHOD OF TREATMENT OF RECIDIVANS AND HABITUAL HUMERAL JOINT LUXATIONS

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Key-words: humeral joint — habitual luxation — operative method — favourable results

There are numerous operative methods of treatment of recidivans and habitual humeral joint luxation. Each of them is meant to prevent the dislocation of the humeral head out of the glenoidal fossa. Some methods form a bone arthro-

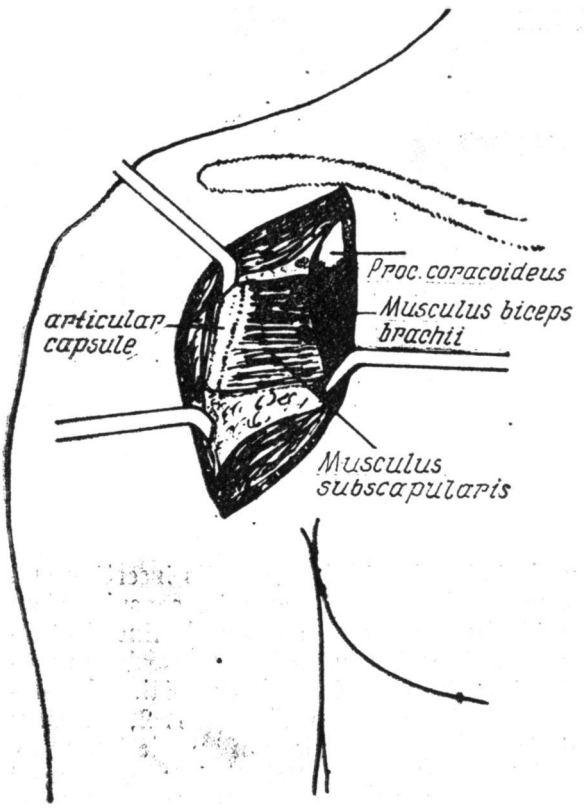

Fig. 1.

lysis on the front wall of the articular fossa of coracoid process (6), other ones stitch up or stabilize the anterior capsular wall (4). Most methods aim the strengthening of the soft-tissue part in front of the synovial capsule by means of tendon and muscle transpositions (1—3, 5, 7).

Since 1971 we perform a homoosteoplastics of the anterior capsular wall of the humeral joint. Any anterior recidivans and habitual humeral luxations are indicated for this operation.

The operation is done under general anaesthesia. The patient lies on back with slightly lifted shoulder. A cutaneous cut is done along the deltoideopectoral sulcus but the cephalic vein is removed aside. In depth along the anterior part of the deltoid muscle one reaches the insertion of the subscapular muscle to the

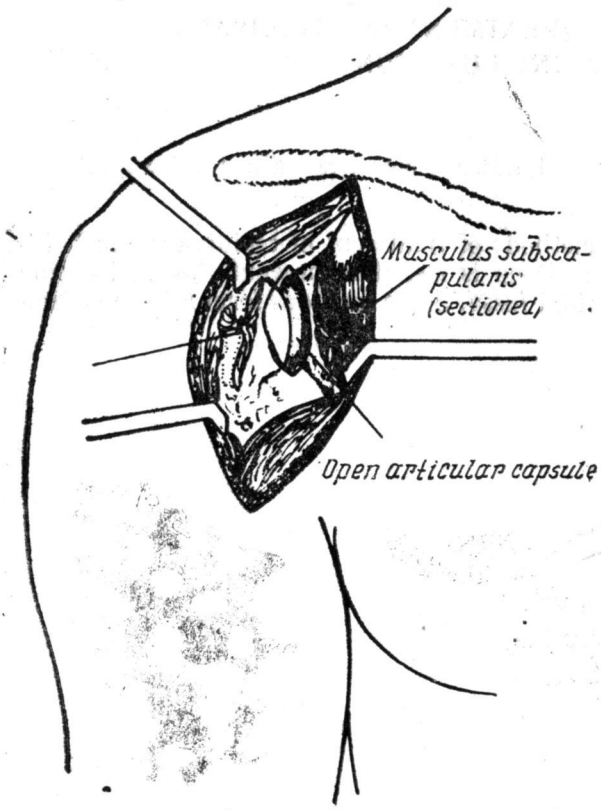

Fig. 2.

humeral bone. The tendon of this muscle is tenotomized near to its insertion and then lifted forward thus revealing the external side of the anterior capsule. Then homospongious bone grafts (3—4 cm wide and 3—4 mm thick) preliminarily prepared are placed on the anterior capsular wall and suturated to it in order to prevent its displacement. The graft is not fixed into the frontal edge of the glenoidal fossa but left freely placeuoıdu e whole anterior capsule (fig. 1, 2, 3). Then the tendon is reinserted. If the capsule is opened at the place of muscle tenotomy it is also repaired. Both subcutis and cutis are suturated. Velpo's bandage is used for upper limb fixation for 3—4 weeks. The rehabilitation of the humeral joint operated begins after sling removal. The homospongious graft with the size required can be prepared in the Centre for bone transplants and provided to the Clinic ready. If, however, ready grafts are not available, smaller in size ones can be used. In this case 3—4 grafts are placed to cover the capsular surface. We apply autobone grafts or even purely cortical ones in single cases only but the results were the same. That is why we recommend only homospongious grafts.

What about the evolution of the bone graft?

As we have not performed any reoperation in our patients we could not carry out any histological examination. However, we suppose that spongious or com

pact bone undergoes a constant absorption with involvement of the capsular wall, too. This leads to thickening and congestion of the anterior capsular wall thus preventing humeral joint luxation. Spongious bone grafts remain invisible on roentgenograms but cortical bone demonstrates evolution of bone absorption on serial roentgenograms.

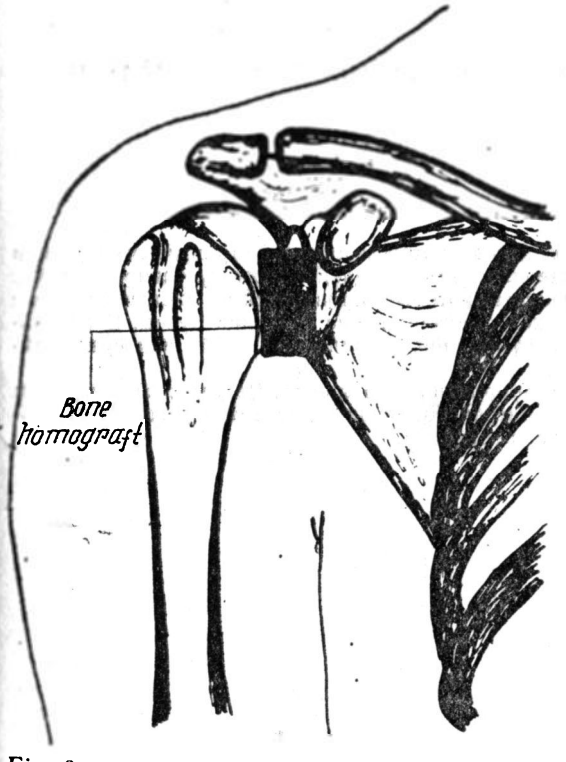

Fig. 3.

A total of 53 patients are operated by this method. There are 44 males and 9 females. Right humeral joint is operated in 30 cases and the left one in the rest 23 patients. Most patients are aged between 20 and 30 years. Habitual luxations have been common in most patients. These patients are physical workers, sportsmen, university students. At the average, every year between 3 and 7 patients with recidivans and habitual humeral joint luxations undergo operations. Some of them were permanently afraid even of loading of the corresponding upper limb prior to operation. In the early period after the operation humeral rotation was limited in 18 patients but then it was improved by the rehabilitation procedures.

Patients are followed-up for 2—14 years after operation. There are no recidives. All of them have started a normal production process. In one case there was a suppuration due to catgut and after extraction of the stitches rehabilitation procedures continued.

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ОПЕРАТИВНЫЙ МЕТОД ЛЕЧЕНИЯ ПОВТОРЯЮЩИХСЯ И ПРИВЫЧНЫХ ВЫВИХОВ ПЛЕЧЕВОГО СУСТАВА

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РЕЗЮМЕ

Представлена оперативная техника лечения повторяющихся и привычных вывихов плечевого сустава. Операция состоит в остеопластике передней стенки суставной сумки с использованием гомоспонгиозного трансплантата, который вставляется по внешней стороне передней стенки суставной сумки без глубокого вложения в ее передний рубец. В результате этого получается утолщение суставной сумки, представляющее собой непосредственное препятствие вывиху плечевого сустава.

С использованием этого метода было оперировано 53 больных. Результаты операции прослеживались в течение 2—14 лет после оперативного вмешательства. Ни у одного из прооперированных не установлено появление рецидивов.