



Bilateral Anterior Shoulder Dislocations due to Seizure

Joseph R Shiber*, Jesus A Diaz and Kamal I Bohsali

College of Medicine, University of Florida, USA

A 33 year-old man presented to the emergency department (ED) after intentional overdose of prescription drugs with concomitant cocaine and alcohol abuse. During assessment, he had a witnessed generalized tonic-clonic seizure that terminated after intravenous lorazepam administration. He was admitted to the Intermediate Care Unit for ongoing close monitoring due to persistently altered mental status. When more alert the following day he complained of bilateral shoulder pain with markedly restricted range of movement. An initial screening chest radiograph demonstrated bilateral anterior shoulder dislocations with an associated fracture of the left greater tuberosity (Figure 1). On further discussion a history of multiple bilateral shoulder dislocations with minimal force was elicited. He was reviewed by the orthopedic service that elected to perform closed reduction under general anesthesia and he was placed in bilateral shoulder immobilizers for 2 weeks. Operative repair was recommended.

Due to its inherent mobility the shoulder is the most commonly dislocated joint encountered in clinical practice accounting for 85% of all dislocations [1]. The vast majorities (95%) of these are anterior dislocations (1.5-4.3% posterior and 0.5% inferior) and in 15% are associated with a fracture of the greater tuberosity [1-3]. Bilateral shoulder dislocations due to seizure activity or electric shock are classically posterior while traumatic mechanisms are more associated with bilateral anterior shoulder dislocations [4-6]. Though similar presentations to that noted in our case above have been documented elsewhere [1,6]. It appears there may be a significant delay in recognizing bilateral shoulder dislocations when due to trauma or seizures that is compounded by the difficulty communicating with the obtunded patient and the loss of asymmetry that clinically heralds

unilateral dislocations [1,5]. This case highlights these difficulties and the value of simple portable radiological imaging as a screening tool to diagnose dislocations in a high level care setting.

References

1. Lasanianos N, Mouzopoulos G (2008) An undiagnosed bilateral anterior shoulder dislocation after a seizure. *Cases J* 1: 342-345.
2. Gosens T, Poels PJ, Rondhuis JJ (2000) Posterior dislocation fractures of the shoulder in seizure disorders—two case reports and a review of literature. *Seizure* 9: 446-448.
3. Betz ME, Traub SJ (2007) Bilateral posterior shoulder dislocations following seizure. *Intern Emerg Med* 2: 63-65.
4. Kumar Y, Nalini KB, Maini L, Nagaraj P (2013) Bilateral traumatic anterior dislocation of the shoulder—a rare entity. *JOCR* 3: 23-25.
5. O'Connor-Read L, Bloch B, Brownlow H (2007) A missed orthopedic injury following a seizure: a case report. *J Med Case Reports* 1: 20-21.
6. Dinopoulos HT, Giannoudis PV, Smith RM, Matthews SJ (1999) Bilateral anterior shoulder fracture-dislocation. A case report and review of the literature. *Int Orthop* 23: 128-130.



Figure 1: Chest radiograph demonstrated bilateral anterior shoulder dislocations with an associated fracture of the left greater tuberosity.

*Corresponding author: Joseph R Shiber, College of Medicine, University of Florida, Jacksonville, FL 32209, USA, Tel: 904-551-4646; E-mail: shiberj@bellsouth.net

Received November 29, 2013; Accepted January 24, 2014; Published January 26, 2014

Citation: Shiber JR, Diaz JA, Bohsali KI (2014) Bilateral Anterior Shoulder Dislocations due to Seizure. *Trop Med Surg* 2: 160. doi:10.4172/2329-9088.1000160

Copyright: © 2014 Shiber JR, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.