Kalyani's Knee & Shoulder Clinic

कल्याणी घुटना एवम कंधा क्लिनिक

Recurrent Dislocation of Shoulder

Patient Awareness | Shoulder Instability & Sports Injury Care

Appointments: 9554066663 | 9554066664 | 9219200378

Address: Umaraha Market, Varanasi

What is recurrent shoulder dislocation? Recurrent shoulder dislocation means the ball of the shoulder joint repeatedly comes out of the socket, or feels as if it is slipping out. It commonly follows a first traumatic anterior shoulder dislocation and can cause pain, apprehension, weakness and loss of confidence during overhead or sports activity.

Shoulder preservation focus: Each instability episode can damage the labrum, cartilage and bone. Early assessment of Bankart lesion, Hill-Sachs lesion and glenoid bone loss helps choose the correct treatment, restore stability and preserve long-term shoulder function.

Mode of injury

- Fall on an outstretched hand or directly on the shoulder.
- Sports tackle, collision or forced abduction and external rotation.
- Seizure or electric shock can cause posterior or complex dislocation patterns.
- Recurrent episodes may occur with throwing, overhead activity or even during sleep in severe instability.
- Risk is higher in young active patients, contact sports, hyperlaxity and untreated structural lesions.

Common symptoms

- Repeated episodes of shoulder coming out, slipping or subluxing.
- Fear or apprehension in the throwing position or with the arm overhead.
- Pain, weakness and loss of confidence in sport or gym activity.
- Clicking, catching or dead-arm feeling during movement.
- Difficulty with dressing, lifting, sleeping or manual work.
- Numbness or tingling after a dislocation needs urgent assessment.

When to seek early consultation

- Any recurrent dislocation or repeated feeling of slipping.
- First-time dislocation in a young athlete or contact-sport player.
- Persistent pain, weakness or inability to raise the arm after reduction.
- Numbness, vascular symptoms, fracture suspicion or failed reduction.

Examination and diagnosis

History: injury direction, number of dislocations, self-reduction, sports/work needs, seizure history and previous treatment are reviewed.

Inspection: posture, muscle wasting, scapular control, bruising and guarding are assessed.

Range and strength: active/passive movement, rotator cuff strength and pain inhibition are checked.

Instability tests: apprehension-relocation test, anterior/posterior load-and-shift, sulcus sign and generalised laxity assessment may be used.

Imaging: X-rays check reduction, fracture and bone loss. MRI/MR arthrogram assesses labrum, capsule, Bankart lesion and rotator cuff. CT may be useful for glenoid bone loss or Hill-Sachs assessment.

Contributing pathology

Bankart lesion: tear/detachment of the anterior-inferior labrum and capsule from the glenoid socket. This is a key cause of recurrent anterior instability.

Hill-Sachs lesion: compression defect on the posterolateral humeral head caused when it impacts the front edge of the glenoid during dislocation.

Bone loss concept: treatment planning considers glenoid bone loss and whether the Hill-Sachs lesion is engaging/off-track. This helps decide Bankart repair alone, Bankart plus remplissage, or a bony procedure such as Latarjet in selected cases.

Recurrent Shoulder Dislocation - Treatment and Surgical Details

Non-surgical / rehabilitation-based care

- Usually considered after selected first-time dislocation, low-demand patients or those without major structural bone loss.
- Short period of sling support followed by guided physiotherapy as pain settles.
- Physiotherapy focuses on rotator cuff strength, scapular control, posture, proprioception and safe return to activity.
- Activity modification avoids high-risk abduction-external rotation positions early.
- Regular review is needed; recurrent episodes often need surgical stabilisation.

Surgical treatment

- Considered for recurrent dislocation, young active patients, contact sports, failed rehabilitation or significant Bankart/Hill-Sachs pathology.
- Arthroscopic Bankart repair restores the labrum and capsule to the glenoid rim using suture anchors.
- Remplissage may be added when the Hill-Sachs defect is engaging or at risk of engagement.
- Large glenoid bone loss, failed previous repair or very high-risk instability may require bony procedures such as Latarjet in selected cases.
- Associated rotator cuff, SLAP, biceps or cartilage problems are addressed when clinically appropriate.

Bankart repair with remplissage: technical details

Arthroscopic assessment: keyhole portals are used to inspect labrum, capsule, glenoid bone loss, Hill-Sachs lesion, rotator cuff and cartilage.

Bankart repair: the labrum/capsule is mobilised and repaired back to the anterior-inferior glenoid using suture anchors to recreate the bumper effect and capsulolabral tension.

Remplissage: the Hill-Sachs defect is filled by anchoring the posterior capsule and infraspinatus tendon into the defect. This converts the defect into an extra-articular area and reduces engagement with the glenoid rim.

Goal: restore stability, reduce recurrence, protect cartilage/labrum and allow safe return to work or sport after rehabilitation.

Useful classification for patient understanding

Pattern	Meaning	Typical approach
First-time traumatic dislocation	First episode after injury; recurrence risk varies.	Reduction, imaging, sling briefly, physiotherapy; early specialist review in young athletes.
Recurrent instability	Repeated dislocation/subluxation or apprehension.	MRI/CT planning; stabilisation often considered.
Bankart lesion	Labrum/capsule detached from glenoid.	Arthroscopic Bankart repair if symptomatic/unstable.
Hill-Sachs lesion	Humeral head compression defect after dislocation.	Observe if small/non-engaging; remplissage if engaging/off-track risk.
Bone loss / failed repair	Glenoid deficiency or high-risk instability.	May need Latarjet or other bony stabilisation in selected cases.

Rehabilitation and return to activity

Recovery is stepwise: early sling/protection and pain control, controlled motion to avoid stiffness, progressive rotator cuff and scapular strengthening, then sport/work-specific drills. Return to contact sport or overhead activity depends on healing, strength, confidence and surgeon/physio clearance.

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Note: Patient education only. Final diagnosis and treatment should be individualised after shoulder specialist consultation, clinical examination and imaging. Sources reviewed: AAOS OrthoInfo, NHS patient guidance and orthopaedic literature on Bankart repair and remplissage.