Case Report

An Unusual Disengagement of the Humeral Head Component after Hemiarthroplasty: A Case Report Presentation

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Abstract

Introduction: Proximal humeral fractures account for 4% to 5% of all fractures. Complex proximal humeral fractures with displaced three- and four- part fragments, humeral head splits and fracture-dislocations are more difficult to treat. In older patients, because of poor bone quality, hemiarthroplasty is often the indicated treatment.

Case Report: One such case of a 73-year-old woman is presented here. The patient presented with a four-part fracture of the proximal humerus, with displacement of the humeral head. Hemiarthroplasty was done in the right shoulder. At postoperative 20 days, during physical therapy, the humeral head component of the prosthesis disengaged and a second operation was necessary. A deltopectoral approach was repeated using the previous incision. The humeral stem was seen to be well-fixed into the bone so the humeral head was changed for a new one of the same size. At two years, the dominant right side had active, painless ROM.

Conclusion: The management and two-year follow-up of this case is reported here, which was the first to occur at our institution.

Keywords: Complications; fracture; proximal humerus; shoulder hemiarthroplasty; surgical treatment.

Introduction

Proximal humerus fractures account for approximately 5% of all extremity fractures which represent nearly 50% of all shoulder girdle injuries, and the incidence is higher in the elderly population [1]. Although performed with less frequency than hip and knee arthroplasties, the prevalence of shoulder arthroplasty has doubled in the last two decades as ageing populations increase. Patients older than 70 years with severe fractures are candidates for arthroplasty [2]. Osteoporotic fractures in elderly patients are commonly associated with minor trauma such as ground-level falls. The indications for hemiarthroplasty (HA) include comminuted three- and four-part fractures with dislocation of the head, and fractures which split the head with involvement of more than 40% of the articular surface [3]. Primary humeral head replacement is a well accepted...
treatment option for a variety of fractures of the proximal humerus and provides consistent pain relief [4]. Specific complications of shoulder arthroplasty include dislocation, fracture, joint stiffness, nerve injury, and detachment of the deltoid muscle. In the case presented here, an unusual disengagement of the humeral head component occurred three weeks after the index surgery. The presentation and management is reported here of this uncommon complication in a 73-year-old female. To the best of our knowledge there are no published reports of disengagement of the humeral head component after hemiarthroplasty of shoulder and its subsequent management.

Case Report
A 73-year-old right hand-dominant female patient was admitted to the emergency department of our hospital with severe pain in the right upper extremity following a fall at her home. Clinical examination determined painful and restricted range of motion of the shoulder, crepitus from the fracture fragments and extensive ecchymosis to the elbow on her right shoulder. No neurovascular impairment was found. From her history, we learned that she had only hypertension which is under control. Anteroposterior, lateral radiographs and computed tomography (CT) scanning of the right shoulder revealed a four-part fracture-dislocation of the proximal humerus [Fig 1]. The fracture type was graded using Neer’s original classification [4]. Her arm was stabilized in arm slings, and surgical intervention was planned. Three days after admission, she underwent HA surgery. After proper induction of general anesthesia, the patient was placed in the beach chair position. A standard deltopectoral approach was used to access the proximal humerus. Bone cement was used to fix the nine mm humeral stem and then an artificial 44/17 mm humeral head prosthesis (Bio-modular® Shoulder System; Biomet Inc, USA) was positioned in approximately 20° of retroversion. The head was impacted and after it was checked with full manual effort for the security. The artificial head of the humerus was fitted into the glenoid cavity of the scapula, secured by the tendon of the long head of the biceps brachii. The rotator cuff was realigned using 1.0 vicryl sutures. A hemovac drain was used and the wound was closed in anatomic layers. The operation was successfully performed, without any intraoperative complications [Fig 2]. The affected limb was suspended in a shoulder sling for six weeks. In first 3 weeks, only passive shoulder-joint activities (eg: pendulum exercises) were carried out, and active functional exercises of the ipsilateral hand, wrist, and elbow were initiated concurrently. After 3 weeks from the operation, under physiotherapist control, slightly active ROM exercises were started. Upper extremity lifting was avoided during the first six weeks [5]. Also these are our routine physiotherapy program after HA in our institution.

The patient was discharged from hospital one week postoperatively. After 20 days, she was re-admitted to our hospital suffering pain and deformity in the right shoulder. From the history, we learned that during physical therapy, she had experienced pain, discontinued the daily program and returned to hospital. On radiographic examination an unusual disengagement of the humeral head component of the prosthesis was detected [Fig 3]. We know that this complication has occurred in the first 20 days. This means, the patient was under passive ROM program. We could not learn from the physiotherapist that what maneuver is caused to this unusual disengagement. But we think that, during physiotherapy maybe a forceful activity was done and this unusual complication has occurred. The patient underwent a second surgical operation. A deltopectoral approach was repeated using the previous incision. During the operation, in addition to the disengagement of the component, hypertrophic biceps tendon was determined. We do not have any idea because of hypertrophic tendon, only we have seen it. The humeral stem was seen to be well-fixed into the bone.
are known to be superior and posterior migration of the greater tuberosity, nonunion between the tuberosities and the diaphysis, bone resorption of the greater tuberosity, rotator cuff failure, periprosthetic fracture, nerve lesions, luxation of the prosthesis, heterotopic ossification and deep infection [2,12]. However, the disengagement of the humeral head component of the prosthesis is uncommon and has not been previously reported.

Postoperative rehabilitation remains a matter of debate. A sling is generally recommended for four weeks to six weeks, with early passive rehabilitation to avoid stiffness. The purpose of slings is to provide support, decrease dependent edema, and increase comfort for the patient. The resting position in internal surgery. When the patient was discharged, resistance rotation exercises were not allowed during the first postoperative six weeks. The patient was followed-up at one, three, six and ten weeks postoperatively and at three-month intervals thereafter. After the second surgery, the patient used a shoulder immobilizer for a period of four to six weeks with the arm kept in a neutral position. Passive motion was started four weeks later with active motion commencing after six weeks. At two years, the dominant right side had active, painless ROM of 120° of forward flexion, 90° of internal rotation, 90° of abduction, and 60° of external rotation in abduction. This was equivalent to the contralateral side, which had also undergone HA five years previously in our institution. The shoulder prosthesis had not failed [Fig 4].

Discussion

Shoulder arthroplasty remains a valuable solution for the treatment of non-reconstructable proximal humeral fractures in elderly patients [6]. Over 75% of all proximal humeral fractures occur in patients over 60 years of age and over 75% of all proximal humeral fractures occur in women [7,8]. However, the treatment of three- or four-part fractures and split head humeral fractures is an unresolved problem [9,10]. With continued advancements in the production of artificial joints and surgical techniques, hemiarthroplasty has become increasingly popular for treating comminuted fractures of the proximal humerus and has become the routine therapeutic approach for this type of fracture in many centers [11].

In literature, complications of shoulder hemiarthroplasty provide support, decrease dependent edema, and increase comfort for the patient. The resting position in internal surgery. When the patient was discharged, resistance rotation exercises were not allowed during the first postoperative six weeks. The patient was followed-up at one, three, six and ten weeks postoperatively and at three-month intervals thereafter. After the second surgery, the patient used a shoulder immobilizer for a period of four to six weeks with the arm kept in a neutral position. Passive motion was started four weeks later with active motion commencing after six weeks. At two years, the dominant right side had active, painless ROM of 120° of forward flexion, 90° of internal rotation, 90° of abduction, and 60° of external rotation in abduction. This was equivalent to the contralateral side, which had also undergone HA five years previously in our institution. The shoulder prosthesis had not failed [Fig 4].

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In literature, complications of shoulder hemiarthroplasty are known to be superior and posterior migration of the greater tuberosity, nonunion between the tuberosities and the diaphysis, bone resorption of the greater tuberosity, rotator cuff failure, periprosthetic fracture, nerve lesions, luxation of the prosthesis, heterotopic ossification and deep infection [2,12]. However, the disengagement of the humeral head component of the prosthesis is uncommon and has not been previously reported.

Postoperative rehabilitation remains a matter of debate. A sling is generally recommended for four weeks to six weeks, with early passive rehabilitation to avoid stiffness. The purpose of slings is to
shoulder function. Postoperative functional exercise should be carried out in an ordered manner. Active exercise should occur after passive exercise, the angle should be increased gradually, and the exercise should be performed for each individual attentively [5,17]. It is necessary to ensure that the patient understands the non-weight-bearing activity limitations: no active internal and external rotation, and no shoulder extension beyond neutral. The patient must avoid putting weight on the affected arm and using the arm to push up from a sitting position. The operated arm must not be used actively or to lift objects until instructed by the surgeon.

Clinical Message
The disengagement of the humeral head component of the prosthesis is uncommon and has not been previously reported. Systematic and correct rehabilitation exercises are highly important for optimal recovery of shoulder function. Postoperative functional exercise should be carried out in an ordered manner. Also the motivation of the patient is especially important for the treatment success.

Conclusion
Dislocation of an artificial joint and also only disengagement of the humeral component from the stem may occur. There is an increased risk of dislocation after surgery and during the healing process, which is why activity is restricted and a shoulder immobilizer is used. The motivation of the patient is especially important for the treatment success. It should be noted that no active muscular activity was started until a complete range of passive movement had been achieved.

References

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