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**Figure 1.** Anteroposterior radiograph of the shoulder demonstrating slightly increased overlap of the humeral head of the glenoid fossa.



**Figure 2.** Computed tomography of the shoulder indicating a posterior dislocation with associated impaction of the humeral head and a resulting groove fracture defect. Used with permission of Barry Hahn, MD, Department of Emergency Medicine, Staten Island University Hospital, Staten Island, NY.

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A 60-year-old woman presented with left shoulder pain that woke her from sleep. On examination, the patient maintained her shoulder in adduction and internal rotation, with limited range of motion and no obvious asymmetries.

Radiographs were interpreted as inconclusive (Figure 1). Attempts at manual reduction were unsuccessful. The patient was unable to tolerate axillary views. What would be the next step in the treatment of this patient?

*For the diagnosis and teaching points, see page 633.  
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- All patient transfers, including those involving MCO members, should be consistent with ACEP's published guidelines.
- Emergency physicians should be fairly reimbursed for all services provided, including the provision of mandated EMTALA-related care. Claims should be processed expeditiously and on the basis of established billing and coding procedures. Claims should be adjudicated on the basis of the patient's presenting complaint and symptoms. An equitable and timely appeal process should exist for disputes involving reimbursement.
- Payers are expected to cover on-call specialty services when emergency physicians access hospital on-call panels to meet MSE and stabilization expectations as required by EMTALA.
- Emergency physicians should assume an active, positive role in any contract negotiations involving provider institutions

and payers, especially where emergency services are included as part of a comprehensive program of services.

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#### REFERENCES

1. The Emergency Medical Treatment and Active Labor Act (EMTALA), as established under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 USC 1395 dd), Section 9121, as amended by the Omnibus Budget Reconciliation Acts (OBRA) of 1987, 1989, and 1990. Rules and regulations published. Federal Register June 22, 1994; 59:32086-32127. Amended September 9, 2003; 68:53221-53264.
2. Third-party payers include: Medicare, Medicaid, managed care organizations, indemnity insurers, and businesses that contract for services.

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### IMAGES IN EMERGENCY MEDICINE

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#### DIAGNOSIS:

*Posterior shoulder dislocation with reverse Hill-Sachs deformity.* Signs of a posterior dislocation are an arm maintained in adduction and internal rotation and inability to supinate the forearm. The normal contour of the anterior shoulder may be lost. The dislocated humeral head may create a posterior fullness. Posterior dislocations are rare and easily overlooked. They are commonly misdiagnosed as adhesive capsulitis. When the diagnosis cannot be confirmed by radiographs, a computed tomographic (CT) scan is indicated. This patient's CT scan revealed a posterior dislocation and reverse Hill-Sachs deformity (Figure 2). The humeral head was locked on the glenoid at the site of fracture deformity, which is characteristic of most posterior dislocations. In retrospect, our patient's plain radiograph exhibited overlapping of the humeral head and glenoid, one of several subtle findings on radiograph that are indicative of posterior instability.

Reduction is performed by traction on an internally rotated and adducted arm, combined with posterior pressure on the humeral head. Countertraction may be applied. Closed reduction is recommended if the dislocation occurred within 6 weeks and the articular defect involves less than 20% of the articular surface on axillary radiograph. Fractures greater than 40% require surgery.