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Figure 1. Left upper extremity position on presentation.

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An 18-year-old white man presented with the chief complaint of left shoulder pain and inability to move the left upper extremity from an overhead position. The patient stated he awoke from his sleep after rolling over and developing pain and immobility. Patient's medical history was unremarkable, and he denied any medications or illicit drug use. Initial vital sign results were normal. Physical examination revealed a horizontally abducted and locked left upper extremity at the shoulder. Sensation was intact over the deltoid, and patient was otherwise neurovascularly intact. The initial position of the left upper extremity on presentation to our emergency department (Figure 1) and the corresponding shoulder radiograph (Figure 2) are shown.

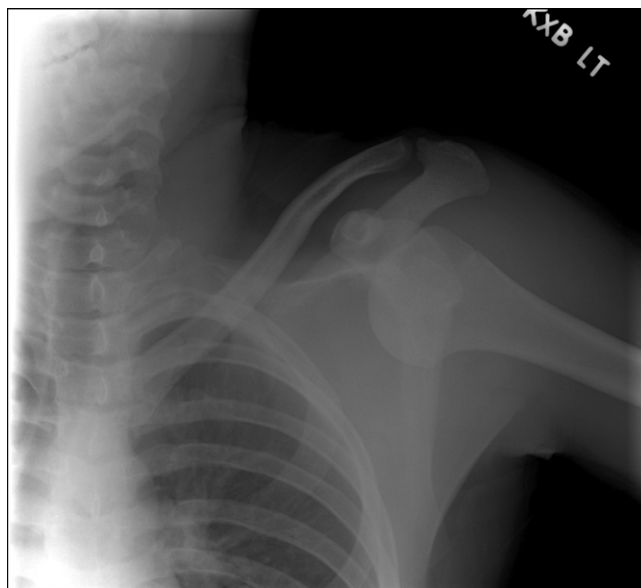


Figure 2. Left shoulder radiograph. Used with permission of Michael M. Mohseni, MD, Department of Emergency Medicine, Mayo Clinic, Jacksonville, FL.

For the diagnosis and teaching points, see page 231.

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- Insofar as hospital disaster preparedness, perhaps we still must say, as with Justice Potter Stewart in his comments on *Miller v California*, “I know it when I see it.”⁵

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DIAGNOSIS:

Luxatio erecta (inferior shoulder dislocation). The figures demonstrate an inferior shoulder dislocation, also termed luxatio erecta. The shoulder radiograph reveals the humeral head locked beneath the glenoid fossa. The patient underwent procedural sedation with etomidate, and traction-countertraction was used to reduce the dislocation. Postreduction, the patient remained neurovascularly intact, and his pain was much improved. The patient was placed in a shoulder immobilizer and instructed to follow up with orthopedics.

Magnetic resonance imaging in the outpatient setting revealed tearing and fraying of the inferior and superior labrum. A moderate joint effusion was present, but the rotator cuff was intact. Approximately 2 weeks after his initial presentation, the patient had returned to work as a landscaper, with appropriate precautions about shoulder range of motion.

Luxatio erecta was described by Middeldorpf and Scharm¹ in 1859. It is a rare presentation of a common problem, with some estimates as low as 0.5% of all shoulder dislocations. This injury can occur as a result of a hyperabduction force or axial loading on the abducted arm. In our patient the mechanism was unclear but was likely related to hyperabduction during sleep. The presentation is typically with the arm in the overhead position, with the humerus locked in various degrees of abduction.

In comparison with other dislocation types, luxatio erecta is associated with a high degree of concomitant injuries.² Axillary nerve involvement is observed in up to 60% of these patients, and axillary artery injury occurs in greater than 3%.³ Soft tissue injuries are also common, such as labral lesions and rotator cuff tears.⁴ Reduction can generally be performed with appropriate sedation and traction-countertraction. Occasionally, general anesthesia may be necessary. Appropriate outpatient follow-up is necessary to evaluate for possible long-term complications of this infrequent dislocation.

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