

Emergency dislocations, Quick reference



All open injuries and/or injuries with neurovascular compromise need discussion with appropriate team (orthopaedics or plastics)

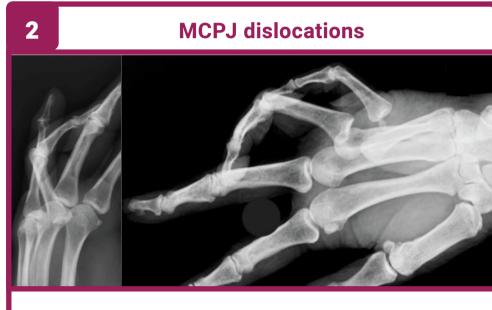
Finger / Hand Elbow



Dorsal dislocations more common. usually sports ball injuries. If no fractures post reduction treat as volar plate injuries. Volar dislocations less common, post reduction treat as central slip injurycheck with modified elson's test. Note DIPJ has no central slip but has a volar

Immobilisation: Volar plate injuries 30° flexion thermoplastic splint. Central slip injuries extension thermoplastic splint. DIPJ dislocations (volar-rare) mallet/ protective thermoplastic splint in slight flexion.

Follow up: Plastics OPD & hand therapy. **Red flags:** if not sure if there is a volar plate versus central slip, central slip takes priority in splinting-apply extension thermoplastic splint and refer to plastics OPD for further follow up.



Dorsal dislocations more common. Volar dislocations rare. If dorsal dislocation has no fractures post reduction treat as volar plate injuries. To reduce dorsal dislocation, flex the wrist to take tension off the intrinsic+extrinsic flexors before applying direct pressure over dorsal aspect of proximal phalanx

Immobilisation: Radial or ulnar gutter backslab according to affected fingers. For thumb, zimmer splint at 30° flexion. Follow up: Plastics consults for volar dislocations. Plastics OPD & hand therapy.

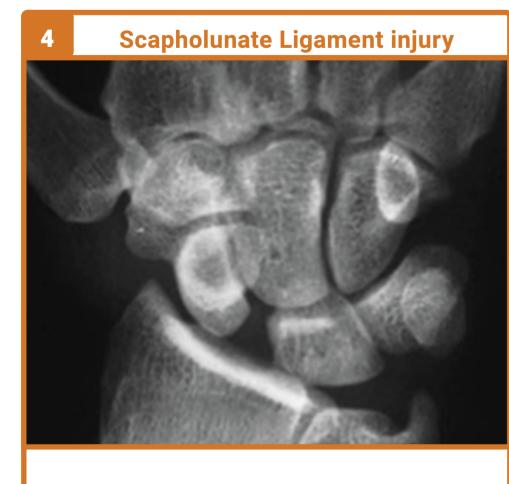
Red flags: if unable to reduce volar dislocations, may need open reduction. Discuss with plastics.

Wrist



- Loss of collinearity of radius, lunate and capitate on lateral view xray (usually volar)
- Scapholunate angle >70°
- Spilled teacup sign Closed reduction in EDDiscuss with
- orthos about further management
- · Immobilisation: Sugar tong backslab. Follow up: Orthopaedics OPD.

Red flags: High risk of median nerve injury/acute carpal tunnel syndrome.



- Scapholunate gap >3mm in AP xray view (Terry Thomas sign)
- Scapholunate angle >70°
- Pain increase with extreme wrist

extension and radial deviation. Discuss with orthos about management. Immobilisation: Dorsal backslab. Follow up: Orthopaedics OPD.





Posterolateral dislocation is the most

- No associated fractures
- No instability. • Reduce in ED.

Discuss with orthopaedics about management. Immobilisation: Broad arm sling.

Follow up: Orthopaedics OPD. **Red flags:** Risk of brachial artery and ulnar nerve injuries.

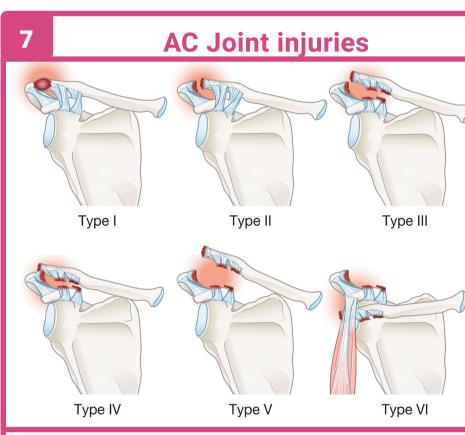


Terrible Triad Injury:

- Posterolateral dislocation most
- Associated radial head/neck fracture and coronoid fracture
- Elbow instability
- •LCL and possible MCL disruption. Reduce in ED and discuss with orthos for further management +- ORIF, risk of brachial artery and ulnar nerve injury. **Immobilisation:** Above elbow backslab at 90° Flexion and forearm pronation.

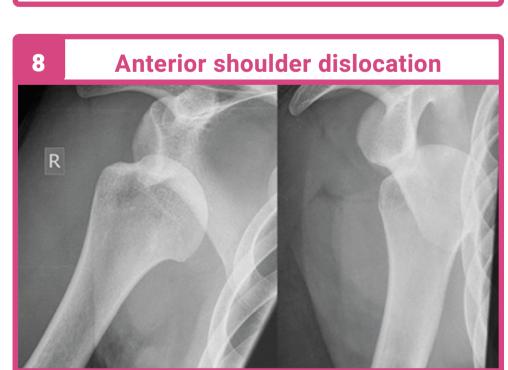
Follow up: Orthopaedics OPD. **Red flags:** If reduction cannot be performed closed is often due to entrapped soft tissue or osteochondral fragments, resting slab and discuss with orthos.

Shoulder



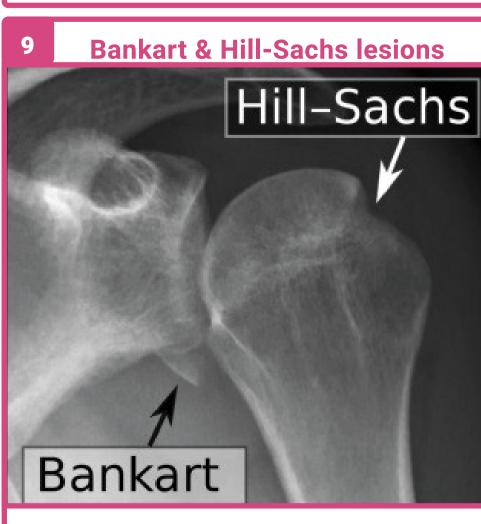
- Uncomplicated: Type I-III <2cm displacement
- Complicated: Type III > 2cm displacement, IV-VI discuss with Orthos about potential ORIF.

Immobilisation: Broad arm sling. **Follow up:** Uncomplicated-physio rehab. Complicated Orthopaedics OPD.



- Uncomplicated: 1st dislocation without
- lesions/fractures · Complicated: Multiple dislocations, fractures or associated lesions (Bankart/Hill-Sachs).

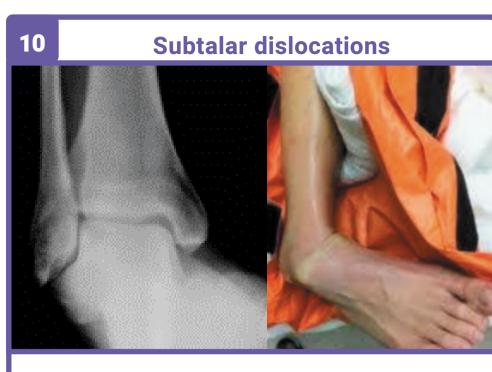
Discuss with orthos about management. Immobilisation: Shoulder immobiliser sling for a week post-reduction in ED. Follow up: Uncomplicated-physio rehab. Complicated Orthopaedics OPD.



- Dislocated shoulder associated lesions · Bankart: fracture/fragment of the
- anterior inferior glenoid labrum • Hill-Sachs: Dent in the back of the humeral head.

Discuss with orthos about management. Immobilisation: Shoulder immobiliser sling for a week post-reduction in ED. Follow up: Ortho OPD.

Foot



- Hindfoot dislocation that result from high energy trauma
- Medial dislocation more common (acquired clubfoot), talar head will be superior to navicular on lateral view
- · Lateral dislocation more likely to be open (acquired flatfoot), talar head will be collinear or inferior to navicular on lateral view

Reduce in FD. Discuss always with orthos about management.

Immobilisation: Below knee backslab, non-weight bearing. Follow up: Orthopaedics OPD.



• Reduce in ED. **Immobilisation:** Buddly splinting for a Follow up: GP follow up.

Ankle dislocation

Discuss with orthos about management.

Knee dislocation

Immobilisation: Below knee backslab,

Follow up: Orthopaedics OPD.

Ankle

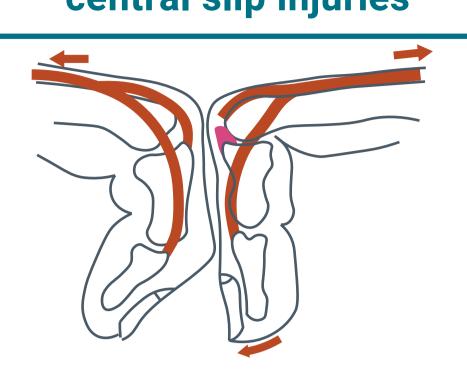
· Reduce in ED.

non-weight bearing.

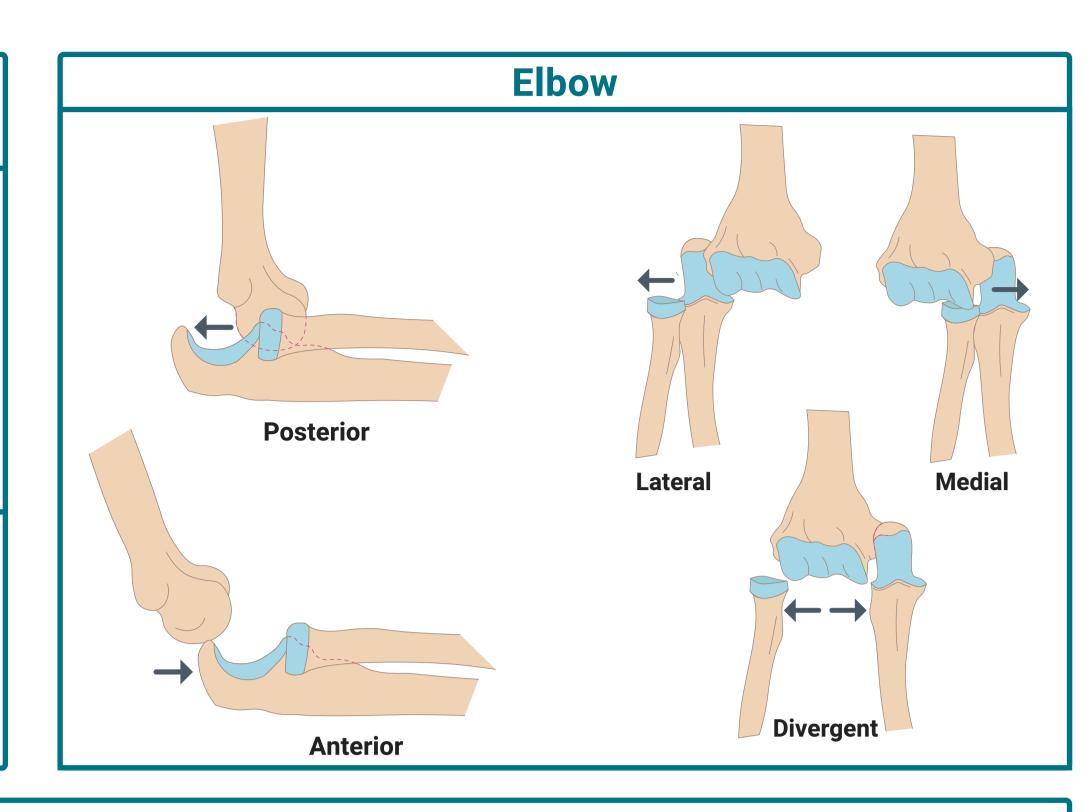
Knee

Education

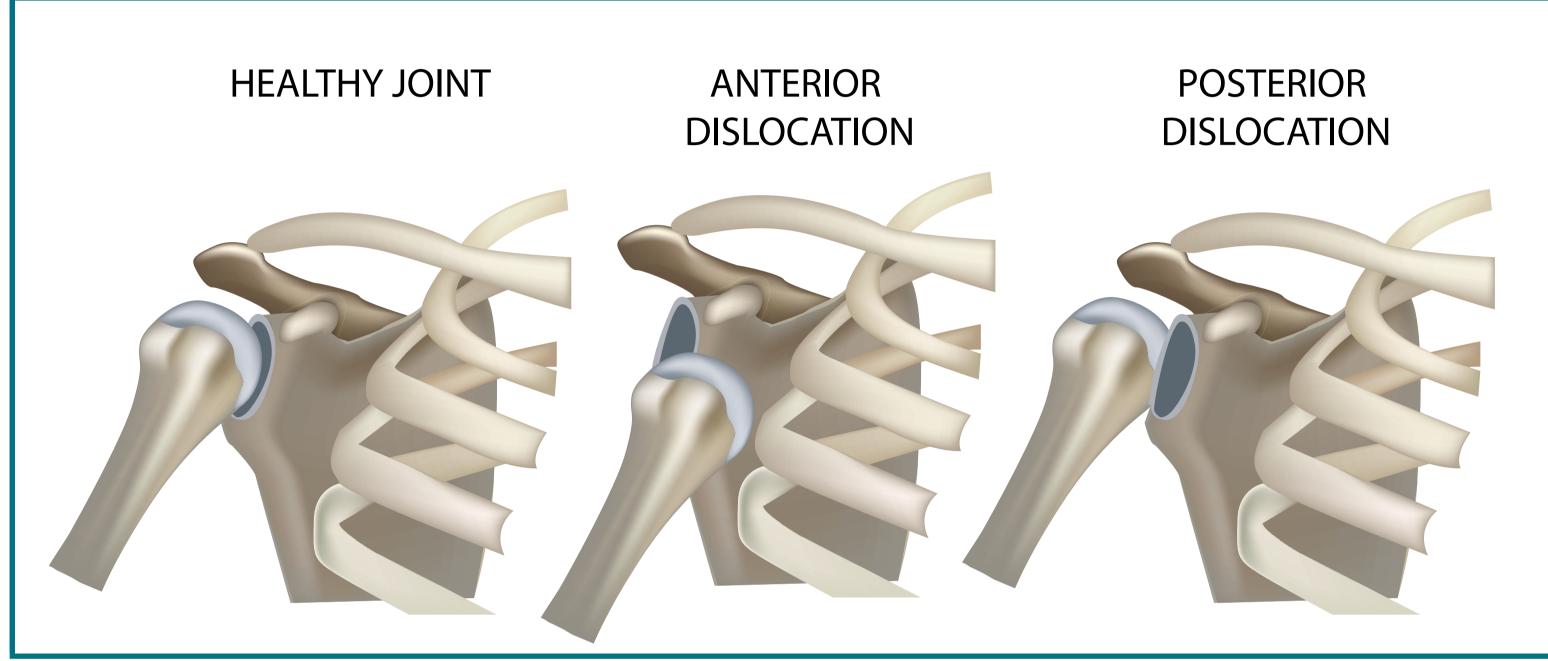
Modified Elson's test for central slip injuries



- Injured & contralateral figners knuckle to knuckle in 90° PIP flexion, pr extends
- Normal:
- DIPs symmetrically flexed
- Central slip injury:
- Injured DIP extends more



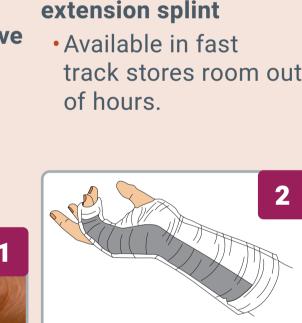
Shoulder dislocation





mallet splint/protective splint Contact CCT OT to

apply splint within working hours.



Stax tuft/mallet splint/

protective splint Available from fast track store room

- Secure with Elastoplast Give directions
- to patient in how to remove splint correctly, keeping DIPJ straight at all times, supported by firm straight surface

underneath (i.e. table).



Thermoplastic middle

contacting ED CCT

OT within hours.

phalanx extension

finger splint

Dorsal 30°

flexion zimmer

plate injuries

finger splint for volar

Available in fast

out of hours.

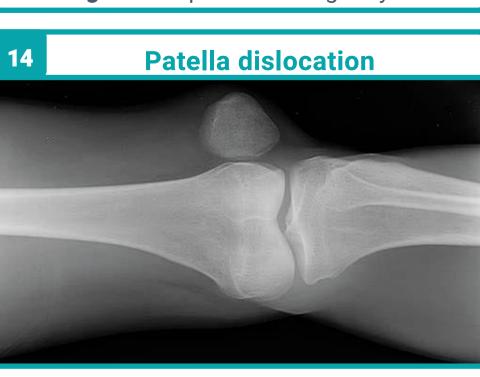
track stores room

Available by

 Available by contacting ED CCT OT within hours. Rule out vascular injury before and after

reduction in ED. **Discuss with orthos** immediately, may require vascular consult too. **Immobilisation:** Above knee resting backslab at 20-30° flexion. Follow up: Orthopaedics OPD. Red flags: Orthopaedic emergency.

High energy traumatic injuries



· Reduce in ED. Immobilisation: Richards splint, weight bear as tolerated for 3-5 days. **Follow up:** Physiotherapist. If multiple dislocations have occurred or ongoing

instability refer to ortho OPD.

Treatment and intervention



Shoulder immobiliser

near triage door

Kept in store

Above elbow backslab on forearm pronation •90° elbow flexion Hand on pronation.



Radial and ulnar gutter backslab

•30° wrist extension •70° metacarpal flexion.

 Only use the back strap when applied for shoulder dislocations.



Sugar tong backslab •30° wrist extension •90° elbow flexion.



Dorsal Backslab

 Slight wrist palmar flexion · Ulnar deviation.





cupboard in corridor **Above knee backslab** •20-30° knee flexion •90° ankle dorsiflexion.

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Below knee • Make sure ankle position is at 90° flexion.

Richards splint



• Two options: short and long-need to be fitted to your patient to start with (one size fits all -need to be altered with the Velcro straps to the patella cut out sections for your patient measurements)

· Lie patient with the affected knee flat

 Open the brace out flat and remove patella cut out sections Position main part behind knee with widest part of the brace at the thigh and position each side section in line with the patella cut-out section before your secure it to the main

- splint with the Velcro straps
- Wrap the brace around the leg Secure by pulling the Velcro bands around, thread through the buckles and press down to fasten comfortably.



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