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CONDITION
ACJ Dislocation

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What is Acromioclavicular Joint (ACJ) Dislocation?

The ACJ connects your collar bone to your shoulder blade and forms part of the shoulder joint. The ligaments holding this joint together can tear causing the collar bone to 'dislocate.'

What is Acromioclavicular joint (ACJ) dislocation?

The ACJ is the small fibrous joint between the end of your clavicle (collar bone) and the acromion (a protruberance of your shoulder blade). You can usually feel your ACJ as the small bump on the top of your shoulder. If you fall heavily on the side of your shoulder, such as when falling off your bike or during contact sports, the impact can compress the acromion beneath the end of the clavicle forcing it upwards. Depending on the force of the impact the joint will either be sprained or will actually dislocate. The injury is typically graded into a Type I injury (simple compression of the joint), Type II where the acromio-clavicular ligament is damaged and there is slight widening of the joint and Type III where all the ligaments stabilising the joint are damaged and the end of the clavicle displaces 100%. There are also other less common types of injury.

How is ACJ dislocation diagnosed?

The injury is diagnosed from the history of injury and examination of the shoulder. A thorough examination is very important to exclude other injuries to the shoulder. There is often an obvious bump on the top of the shoulder which is very tender. Movement of the shoulder is limited by pain. An x-ray will demonstrate, in most cases, the injury to the joint and will exclude a fracture of the end of the clavicle. An MRI scan is seldom indicated.

What are the treatment options?

For most Type I and II injuries the shoulder is rested in a sling for two to three weeks whilst the joint is slowly mobilised as pain allows. Ice and painkillers are helpful. You will then be able to start physiotherapy to help restore movement and strengthen the muscles around the shoulder. It can take several months to recover good function in your shoulder. Occasionally a steroid injection into the injured joint is required to settle persistent discomfort. About 5-10% of patients will have ongoing problems such as painful clicking a year after injury and, in those patients, we usually recommend key hole excision of the end of the clavicle and clearance of the damaged cartilage.

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Most type III injuries can also be managed without surgery initially. In our experience if you have not made quite good progress by three or four months following your injury then we would recommend surgical reconstruction of the ACJ. For more severe grades of injury we recommend early reconstruction.

What does surgery involve?

For persistent pain after a Type I or Type II injury we usually recommend key- hole surgery to excise 5mm off the end of the collar bone and clear the scar tissue. You will be able to move your arm straight after surgery but it can take up to three months for the pain to settle. For reconstruction of Type III or more severe injuries we use a ligament graft which may be synthetic or tissue based. This graft loops around the coracoid (a protuberance of your wing-blade), passes behind your collar bone and is fixed in place on the top of your collar bone with a screw once the collar bone has been pulled down into place.

What can I expect after surgery?

You will wake up from surgery with your arm in a sling which you should wear for the next three weeks. Your arm will feel numb and 'heavy' whilst the nerve block is working during the first night. The shoulder will become a bit sore after that but you will be provided with painkillers which you should take regularly for the first few days. For the first three weeks you will exercise your elbow and shoulder carefully, taking care not to lift it above the horizontal. You should avoid lifting with your arm for the first 6 weeks. You will be provided with a 'rehabilitation' sheet showing you the appropriate exercises or you can download the instructions from this website.

Most patients will have recovered quite good movement by 6 weeks post surgery, will be able to return to driving by 4-6 weeks, will be able to return to light manual work by 6 weeks and heavier duties, including sports, by 12 weeks. By 3 months 80% patients can expect to have had a good or excellent outcome.

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If you have any problems or concerns, do not hesitate to contact the office or myself. I can generally be reached on one of the numbers listed below and if I am not immediately available, I will try to get back to you as soon as possible. If for some reason I am unable to be reached, then you may be able to seek advice from the hospital ward or from your General Practitioner.

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