

Dr. Myeroff's Proximal Humerus Fracture Information Sheet

Non-Operative Treatment

What is a proximal humerus fracture?

- The shoulder joint includes the top portion of the arm bone (proximal humerus; the “ball”) and the shoulder blade (glenoid - part of the scapula bone; the “socket”) (figure 1).
- The rotator cuff consists of 4 relatively small, highly synchronized muscle-tendon units that come from the socket and attach on the proximal humerus. They have a significant role in shoulder motion and strength. They make small coordinated changes that allow your big muscles (deltoid and latissimus) to provide efficient strength (Figure 2).
 - 4 Tendons: Supraspinatus, Infraspinatus, Teres Minor, Subscapularis.
- When the bone breaks near the rotator cuff and there is shifting of the bones, the shoulder function can severely affected.
- How do these fractures occur?
 - An Injury (trauma):
 - High energy injuries: Car crash, fall from ladders, sporting injuries
 - Low energy: Ground level falls
 - These injuries are concerning for osteoporosis and warrant evaluation and treatment of your bones to prevent another fracture!
- Types: There are multiple varieties of proximal humerus fractures
 - Parts: I will give your fracture a grade, 1-4, based on the number of pieces (figure 3).
 - 1 – part: There is a fracture line that is barely displaced.
 - almost normal alignment
 - 4 – part: There are 4 distinct displaced pieces, the highest grade
 - Head Split: This means the ball joint portion itself is cracked
 - Fracture-Dislocation: The bone is both broken, and dislocated.

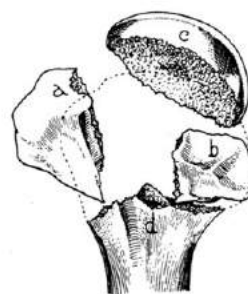
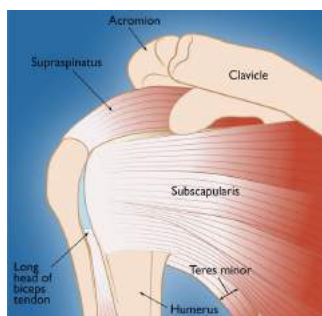
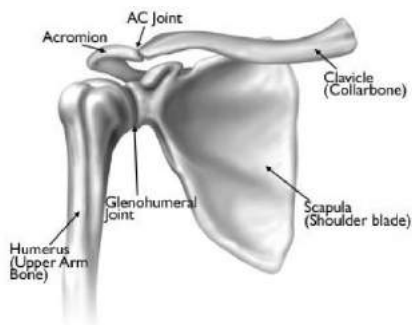


Figure 1 Normal Shoulder Bony Anatomy.
<https://orthoinfo.aaos.org/en/diseases--conditions/arthritis-of-the-shoulder>

Figure 2
<https://orthoinfo.aaos.org/en/diseases--conditions/rotator-cuff-tears/>

Figure 3 The parts of a proximal humerus fracture. Codman 1934

**How
are**

proximal humerus fractures diagnosed?

- The first thing I do is listen to your story, which usually includes an injury.
- Exam: I will examine your shoulder carefully. I will mostly be checking your nerves and ruling out additional injuries (especially elbow, wrist and skin issues).
- Imaging: If you haven't already had them recently, I will obtain X-rays.
 - In proximal humerus fractures, I will look for the number of pieces (fragments) that are broken and how much they have moved (displacement) (Figure 3).
 - For some severe fractures, I may order a CT scan. This provides me a 3D image of your fracture and helps with planning your treatment.

How will we get you back to function?

- Treatment decision is a shared process between you, myself, and your loved ones. It is based on your level of activity, your health, your fracture type. Most importantly it is based on your decision after we have a thorough discussion on the risks and benefits of each option – a process called informed consent.
- Treatment of these fractures is a battle between perfect fracture healing (best done by **NOT MOVING** the shoulder) and maximizing your motion (best done by **MOVING** the shoulder. Hence, our **dilemma!**
- Goal: Regardless of treatment chosen, our goal is to maximize your function with the following steps:
 - Restore or maintain your anatomy
 - Restore: Surgery, or rarely, gravity alone can restore your anatomy
 - Maintain: A period of protection in a sling can minimize further bone movement while your body heals the fracture.
 - Treat your arm like a limp noodle to avoid the rotator cuff muscles from pulling the bones apart.
 - Maintain your elbow, wrist and finger function (Figures 4-6)
 - You must come out of your sling 2-3 times per day to work on elbow wrist and finger motion. We don't want to cause stiffness elsewhere just because you are in a sling!
 - Safely regain shoulder motion while the fracture is unstable

What are your treatment options?

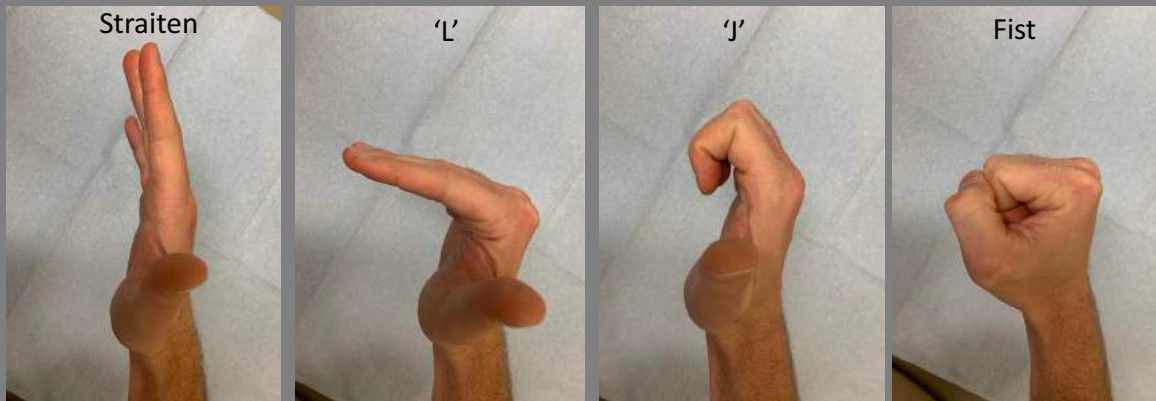
- Treatment is always shared decision making between you, me, and your loved ones.
 - I present all of the information we know and you decide what fits your goals.
 - Factors include your level of activity, your health, your fracture type.
 - Treatment plans often evolve based on your fracture, your recovery, and your preferences.
 - In rare instances I will make a strong recommendation.

- Most importantly it is based on your decision after we have a thorough discussion on the risks and benefits of each alternative – a process called informed consent.
- **Non-operative (conservative) treatment:**
 - I treat over 80% of proximal humerus fractures without surgery.
 - I recommend this in patients where a surgery would add little to no benefit in your outcome.
 - Minimally displaced and simple fracture patterns
 - Where the rotator cuff (and bones they attach to) are in good position
 - Regardless of age or activity
 - Lower demand patients
 - Medically unwell
 - When surgery is ill-advised
 - Non-operative treatment involves a period of restrictions, followed by physical therapy once your fracture is stable enough to work on motion.
 - The speed of rehab and final outcome are variable and dependent on many factors (fracture pattern, speed of healing, your comfort).
 - In general, for simple fractures we aim to get your shoulder to 60-90% of your pre-injury function depending on how severe the fracture is.
 - Benefits
 - Little to no medical risk associated with surgery like infection, blood vessel or nerve injury
 - Risks
 - Non-union: There is a chance the bones don't heal
 - Malunion: There is a chance the fractures heal in the wrong position
 - Poor position can result in pain, stiffness and weakness
 - Anatomy – Some degree of malunion is predictable since we have little ability to improve the bony alignment, sometimes it can worsen with time and muscle forces.
 - Stiffness (scar)
 - We can't start shoulder motion (breaking up the scar) until your fracture shows signs of healing
 - From that point we do all we can to regain motion with therapy.
 - There is always the chance we need to perform surgery later.
 - Delayed surgery is slightly more complex and more costly as far as time.
 - Avascular Necrosis (Dead Bone)
 - Regardless the treatment we choose, the blood supply to your bone has been injured by this fracture and may result in the bone dissolving.
 - Occurs in about 10% of overall fractures

- Close diabetes control
- Avoid NSAIDs (ie ibuprofen, advil, alieve) for 6 weeks
- Bone health
 - I recommend:
 - Initiating over the counter suppliments
 - 1500mg Calcium daily
 - 2000 IU Vitamin D daily
 - If your fracture occurred from a low energy mechanism (ground level fall), it is likely you have osteoporosis (thinning of the bones) and I highly recommend (and will facilitate) bone health workup with labs and a DEXA scan.
 - You will have a consult with our bone health specialist to forge a plan to optimize your bone strength.
 - You should work with therapy on avoiding future falls:
 - Home safety evaluation
 - Cane / walker / wheelchair
 - Balance / strength training
- Abide by your restrictions with 2 main early goals
 - **Avoid fracture displacement:** You must avoid active motion (using your own muscles) of the shoulder. This includes no reaching, lifting, pulling with the shoulder to prevent loss of alignment of the bones before they heal. Early in I will ask that you treat the shoulder like a wet noodle.
 - This will help prevent your rotator cuff from pulling on the bone pieces.
 - **Avoid stiffness:** You should move your fingers (Figure 4), wrist and elbow (Figure 5)
Once safe, you will work with therapy and at home on passive shoulder motion (without using your own shoulder muscles) (Figure 6).
- 0-6 weeks: You will wear your sling full time except for basic therapy. You can return to desk work.
 - Work on early passive range of motion
 - Having an assistant, your other arm, or something else (pulleys) move your shoulder for you while relaxing the muscles in your injured shoulder.
 - This allows you to prevent and break up scar tissue but minimizes the risk of further displacement of your fracture (pulling on your fragments by the rotator cuff).
 - This is initiated once there is adequate but not complete healing
 - Usually 2-4 weeks after injury

- Sooner after surgery.
 - In general, surgery does allow us to begin earlier range of motion because the bones are more secure, but surgery also adds additional scar tissue we need to break up.
 - 6-12 weeks: Your sling is removed, therapy increases, you can drive if it I feel it is safe. You can return to 'light duty'.
 - Shoulder strengthening, and more aggressive motion exercises are initiated once the fracture is healed
 - Usually starts around 6-12 weeks after injury or surgery
 - Can take up to 6 months!
 - 3 months: You will begin strengthening, you will begin full duty work when you are cleared by your therapist as being safe
 - You should plan on working on shoulder range or motion for up to 6 months as this is usually the limiting factor in your recovery.
- **Expectations**
 - In my experience, your outcome is based on obtaining as normal anatomy as possible and as much motion as possible.
 - While these injuries are a spectrum, you can expect to regain 60-90% of your pre-injury function depending on these factors.
 - Expect 6 months until your return to heavy labor, 12 months until your recovery is complete.
 - You will be clear to do desk work within 0-2 weeks from surgery.
 - Heavy labor and sports are allowed once you are healed and strong enough (3-6 months).
 - I recommend discussing work restrictions (and vocational training if needed) with your employer as soon as possible.

Finger Range of Motion



Cycle through the above motions with the assistance of your other hand

*This will prevent stiffness and swelling

Chad Myeroff, MD
Twincitiesshoulderandelbow.com



Figure 4 Finger range of motion

Elbow Range of Motion



Types of Motion

Passive: An outside force moves your arm for you entirely

Active assist: Using the power of your injured arm with the assistance of your uninjured arm or an outside force

Active: Using the power of only your injured arm

*Tuck your elbow at your side for all exercises

*Can be done sitting, laying, or standing

Chad Myeroff, MD
Twincitiesshoulderandelbow.com



Figure 5 Elbow range of motion

Shoulder Range of Motion



Types of Motion

Passive: An outside force moves your arm for you entirely
*relax the shoulder like a wet noodle

Active assist: Using the power of your injured arm with the assistance of your uninjured arm or an outside force

Active: Using the power of only your injured arm



Chad Myeroff, MD
Twincitiesshoulderandelbow.com

Figure 6 Shoulder range of motion

Want More information?

- Please visit:
 - twincitiesshoulderandelbow.com
 - <https://orthoinfo.aaos.org/en/diseases--conditions/shoulder-trauma-fractures-and-dislocations> Please contact my care team with questions: 651-254-8300 option 2
- Regions Hospital / Health Partners Specialty Center
 - Clinical questions: 651-254-8300 option 2
 - To schedule appointments: 651-254-8300 option 1
 - To schedule surgery: 651-254-8399 or 651-254-8338
 - Fax employer or insurance related paperwork ASAP to 651-254-8127.
- TRIA Orthopaedic Center
 - Clinical questions: 952-977-3301
 - To schedule an appointment: 952-831-8742
 - To schedule surgery: 952-977-3414
 - Fax employer or insurance related paperwork ASAP to 952-977-3459.