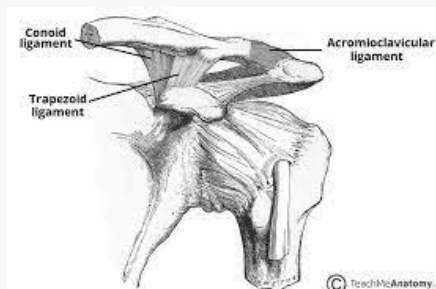


### Ligaments



**Superior, inferior, anterior, posterior AC ligaments** = Prevents A/P shear and provides horizontal stabilisation - superior most important for stability

**Coracoclavicular ligaments** = Conoid and Trapezoid - Resists superior and inferior translation

### Rockwood Classification

**Type I** – mild, unseparated sprain of the AC ligaments with no disruption of the coracoclavicular ligaments.

**Type II** – complete disruption of the AC ligaments with joint separation (less than 4 mm or 40% difference) and sprained but intact coracoclavicular ligaments.

**Type III** – complete disruption of AC and coracoclavicular ligaments with joint separation and inferior displacement of the shoulder complex.

**Type IV** – complete disruption of AC and coracoclavicular ligaments with posterior displacement of the clavicle through the fibers of the trapezius, and detachment of deltoid and trapezius muscles from the distal clavicle.

**Type V** – complete disruption of the AC and coracoclavicular ligaments with significant inferior displacement of the shoulder complex from the clavicle as compared to a typical Type III injury.

**Type VI** – complete disruption of the AC and coracoclavicular ligaments, and the clavicle has dislocated inferiorly, below the coracoid process.

### Mechanism of injury

- Fall onto the shoulder with arm in an adducted position
- FOOSH/Elbow
- Makes up 40-50% of athletic shoulder injuries at 2-4th decade of life
- Rugby, Ice hockey, football, wrestling players are more susceptible



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### Presentation

- Pain and swelling on anterosuperior aspect of the shoulder after trauma
- Symptoms start in the traps, shoulder and neck but move to the AC joint
- Painful with bench pressing, dips or laying on the affected side
- Bruising/defomity on clavicular prominence

### Diagnostic findings

- Swelling, bruising and deformity on clavicular prominence
- Tenderness over AC
- Feeling of giving way on palpation of distal clavicle (+ve Piano Key sign)
- ROM painful and limited - abduction most affected
- +ve Cross body adduction
- +ve BvR
- +ve Paxino
- +ve Buchberger test
- Associated with fractured clavicle, impingement syndromes and neurovascular insults
- Consider active vs passive ROM - Rotator cuff
- Buchberger test distinguishes subacromial impingement from AC joint sprain (more pain in external rotation)
- Evaluate entire clavicle and SC for other injuries
- Perform full neurovascular exam on affected side

### DDx

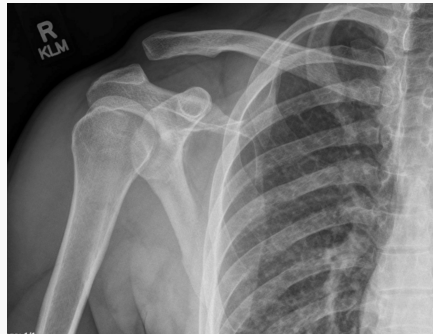
- Clavicular f#
- Rotator Cuff lesion
- Shoulder Anterior impingement syndrome
- Shoulder dislocation
- Labral injury
- Osteolysis of distal clavicle
- Neoplasm
- Rheumatologic disease
- Cervical spine/viscerosomatic referral
- Shoulder osteoarthritis
- Adhesive Capsulitis
- Erb Duchenne
- Septic Arthritis



### DDx (cont)

- CRPS

### Radiographs



AP, lateral, and axillary lateral views

- Not often apparent on x-ray - Zanca view (tilting of beam 10-15 degrees caudal and bilateral AP views), weighted stress views
- MRI only used to rule out other pathologies of the shoulder
- X-ray shows AC joint separation (type 3) due to ligament injury

### Management

Grade I + II - Protection, immobilisation (sling for 3-10 days), mobility and strengthening

- Passive mobility exercises (avoid exercises that involve behind back internal rotation, crossbody adduction and forward elevation)
- Strengthening (closed chain scapula stability exercises - scapula clocks)
- Prognosis is favourable
- Usually regains motion by six weeks and regain normal function within 12 weeks
- Surgery for IV-VI types (six week immobilisation with up to six months recovery time)
- AC joint arthritis and joint pain can occur in future
- Type III-VI should have regular appointments by a orthopaedic surgeon/physician



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