



The rise of shoulder arthroscopy

After the fantastic success of arthroscopic surgery of the knee for various sports-related injuries, the focus of arthroscopic surgeons has been shifted now to other joints. Amongst all these newer arthroscopic surgeries, the shoulder joint has recently gained maximum attention and has developed maximally. A better understanding of shoulder injuries and pathology, coupled with the availability of appropriate instruments, implants and growing experience of the surgeons to perform complex arthroscopic procedures of the shoulder have been the cornerstone for its success story. The most commonly performed arthroscopic procedures of the shoulder include management of shoulder instability and rotator cuff pathology. In this special symposium of the Journal of Clinical Orthopaedics and Trauma (JCOT), we have included some of the original research and review articles related to the arthroscopic surgery of the shoulder joint.

Arthroscopic shoulder stabilization has now become the gold-standard treatment, for the shoulder instability due to its outstanding success rate. However, it is debatable whether primary repair of glenoid labral tear is superior to a delayed repair. In a systematic review of level I and II studies, the Barlow et al.¹ have reported that although the rate of recurrence was higher in the delayed repair group than in the primary repair group, when pooled, there was not a statistically significant difference between these groups. These results suggest there may be a small benefit in primary stabilization. Glenoid bone loss in chronic recurrent shoulder dislocation is a known cause of instability and was been treated, until recently; with open anterior bone block augmentation procedures, most commonly by the Latarjet's procedure. Nzeako et al.² have discussed the importance and recent popularity of arthroscopic bone block procedures, to decrease the morbidity and to improve the functional outcomes of bone block procedures.

Tears of the rotator cuff tendons remain a familiar source of pain and disability among the adult population. Much debate exists over the gold standard surgical technique, in particular with regards to a single versus double row methods. There is no clear consensus in the present literature to indicate clinical superiority and cost-effectiveness of the double row technique. Khoriaty et al.³ have concluded from the review of literature that the type of repair technique used, be selected according to tear size and surgical experience, and the double row repairs are ideally performed in those with more massive tears or those patients undergoing accelerated rehabilitation. To improve the healing of the repaired rotator cuff various strategies have been used as the use of Platelet Rich Plasma (PRP) injections,⁴ biceps tenotomy and tenodesis.⁵ Although the disorders of the long head of the biceps (LHB) tendon are known to cause of shoulder pain, still the function of LHB remains poorly understood, and the consequences of its 'sacrifice' like residual cosmetic deformity and pain are the cause of concern. Hassan et al.⁵ have discussed the

indications of biceps tenodesis and tenotomy and compared the current literature on the functional outcomes of these procedures for LHB disorders in the absence of rotator cuff tears. Furthermore, controversy exists regarding the rehabilitation protocol after the surgical repair. From the literature review, the Bakti et al.⁶ concluded that the early range of motion is related with an increased risk of re-tear and the delayed passive motion regime reduces this risk, however with the side effect of a reduced range of shoulder movements.

However, the arthroscopic management of degenerative rotator cuff tears and impingement remains under scrutiny. Therefore, a word of caution is necessary here. Similar to the knee joint, we have only recently realized that the arthroscopic surgery is not very useful in most degenerative joint disease. In a recently published Finnish Shoulder Impingement, Arthroscopy Controlled Trial (FIMPACT) suggested that the arthroscopic treatment of shoulder impingement syndrome may not be any better than a placebo surgery.^{7,8} Hence, an appropriate selection of the patients for shoulder arthroscopy be made, with a lot of care and responsibility. Failing to comply with it may result in bad reputation of the surgeons and the surgical procedures!

Apart from the mini-symposium on shoulder arthroscopy, we have included various other articles related to sports injuries and arthroscopy of other joints, hip and knee arthroplasty, basic science, technical tips, and general orthopaedics.

References

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