Arthroscopy Is an Option for Glenohumeral OA

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WASHINGTON — Osteocapsular arthroscopy aimed at reshaping the glenoid bone may—with more long-term experience—be proven an effective treatment for patients with glenohumeral osteoarthritis who do not desire total shoulder replacement, Scott Steinmann, M.D., said at the annual meeting of the American Academy of Orthopaedic Surgeons.

At this point, it’s clear that younger patients with more severe arthritis do not benefit much from debridement, making other alternatives to total shoulder replacement desirable, said Dr. Steinmann of the Mayo Clinic in Rochester, Minn.

There are few reports in the literature and no significant long-term follow-up of patients who have undergone arthroscopic glenoid-plasty, a new, relatively aggressive arthroscopic procedure. However, a 3-year mean follow-up of 14 patients whom Dr. Steinmann and his colleagues treated with the procedure has revealed significant pain relief and high patient satisfaction.

“When we’ve asked patients how they felt, they [have said] they liked the procedure,” said Dr. Steinmann. “I think they liked a couple small holes and being told they could do whatever they want afterward. They agree the surgery was worthwhile. … But we definitely need to follow them longer.”

Total shoulder replacement remains the standard treatment, but a significant number of replacements show that the glenoid loosens over time.

Some patients—like the ranchers and farmers who Dr. Steinmann treats—are young and active and “could put a prosthesis in jeopardy,” he said. “Some also tell me, ‘I don’t want any metal or plastic in my body.”’

Arthroscopic options for glenohumeral arthritis range from the simplest option of synovectomy and removal of loose bodies, to the more extensive option of capsular resection and recontouring of the glenoid and humerus.

Dr. Steinmann said he believes the more aggressive approach may prove the most promising for patients with extensive arthritis.

It usually involves synovectomy, osteophyte removal, and capsule release but goes further by involving the conversion of a biconcave glenoid into a single concavity—a change that, theoretically, can restore the position of the humeral head, reducing the posterior subluxation and helping to relax contracted soft tissues.

Restoration of a single concavity may also increase the surface area of the glenohumeral articulation, decreasing joint pressure, he said.

Auxiliary radiographs taken in his 14 patients show that glenoid depth can be increased by about 3 mm—“a rough measurement, but something to hang our hat on,” he said.

Dr. Steinmann’s patients were about 50 years old, on average; 10 of the 14 had previous osteoarthritis. They all had impingement pain at the end of motion, and about half had rest pain, indicating the presence of synovitis. They had no pain with glenohumeral compression or rotation.

The return of function is much less predictable with this procedure than pain relief, Dr. Steinmann said. “Essentially, the range of motion, we’re telling patients, will be very similar to what they have,” he said. In a total shoulder replacement, “I usually try to restore much more motion.”

What impact, if any, the surgery may have on a surgeon’s ability to perform total shoulder replacement later on is unclear.

One question is, what happens when you cut out that cartilage and start burring down the glenoid? Does it ruin the chance to do a total shoulder later? We need to follow patients longer.”

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