

Date (CSS Member)	Message	Attached Documents
5/8/18 (Dr. Jon Warner)	<p>Dear CSS Members and Interested Colleagues:</p> <p>Attached please find the shorter version of the case presentation. Thank you in advance for your help.</p> <p>Best Regards,</p> <p>JP Warner, MD</p>	Case Presentation PPT
5/8/18 (Dr. Joaquin Sanchez-Sotelo)	<p>Dear JP:</p> <p>Tx for sharing this case. Difficult! (as usual) ☹️ . The bony changes on the humeral side are pretty impressive: bone loss at the calcar and loss of most of the bulk of the greater tuberosity. With change in radiographic projections, it is hard for me to tell if there has been a change in component position, but this patient's pain is likely multifactorial: polyethylene were at the medial aspect of the bearing leading to osteolysis, with possible humeral loosening. Also, I get the impression that the superior aspect of the glenosphere is closer to the acromion, again that might be projectional, but the glenoid could have also migrated, hard to tell for sure. I suspect infection workup has been completed and negative.</p> <p>If the patient feels that her pain is bothering her enough to justify another operation, I would offer this patient revision surgery. If the glenoid component is well fixed, this would be a humeral side only revision. I do not know the diameter of the sphere that you used, but if compatible with a humeral component with a 135 degree polyethylene bearing, I would mismatch manufacturers, keep the current glenosphere or change for one compatible, and revise to a 135 degree poly to decrease the chance of recurrent symptomatic PE wear. I would be ready to cement the humeral component if you cannot get adequate primary stability with a cementless one, and I would also be ready to exchange the glenoid component if found to be loose. Unfortunately, this patient could lose some internal rotation, as you point out. I would try my best to repair the subscapularis if still intact, and preserve pect major and lat during exposure, to provide best chance of good strength in internal rotation.</p> <p>Hope this helps!</p> <p>Joaquin.</p>	
5/8/18 (Dr. Ron Navarro)	<p>That looked like a complete miss on the Glenoid baseplate placement initially. It's loose in my view.</p> <p>Depending upon pain and dysfunction, a revision may be necessary.</p> <p>Navarro</p>	

<p>5/8/18 (Dr. George Athwal)</p>	<p>Hello JP, Interesting case. How is her deltoid insertion? Is there any chance that she may have ruptured her proximal deltoid insertion?</p> <p>George</p>	
<p>5/8/18 (Dr. Warner)</p>	<p><i>Not based on my exam but perhaps I missed that. Have you seen this with a reverse? She has one arm so she may be using that side quite a bit more than someone with a good arm on the other side.</i></p> <p><i>JPW</i></p>	
<p>5/8/18 (Dr. Athwal)</p>	<p><i>yes, I have seen it post RSA, and the patients also have the superiorly inclined scapula, as do some pts with secondary deltoid dysfunction due to scap spine nonunion... I think related, compensation from periscap muscles.</i></p>	