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| **Date (CSS Member)** | **Message** | **Attached Documents** |
| 10/29/19 (Dr. Jon Warner) | Dear Members of the Codman Shoulder Society,    Attached please find a case presentation on my patient. Any comments or advice on this case would be greatly appreciated. Thank you in advance for your help.    Best Regards,  JP Warner, MD | Case Presentation PPT |
| 10/29/2019 (Dr. Bassem Elhassan) | Dear JP It is impressive how long did Latarjet stabilize this total shoulder. I am not sure if there is anyone in the group who has done this type of intervention for subscap insufficiency in the setting of TSA.  For her current findings, I would rule out infection first and then perform revision with  bone grafting and reverse TSA.  Cheers  B :) |  |
| 10/29/2019  (Dr. Mark Frankle) | I think this is the result of osteolysis from the poly  I think likely you will find that there will be an area where the poly is worn near the metal rim  The metal on metal probably led to the progressive bone and tendon loss  The revision will be a challenge first the wear debris will be everywhere  So you will be faced with extensive soft tissue and bone defects  I would be prepared to have a Midas Rex to remove the glenoid base plate  I would also consider having a replacement poly but I think that ship probably has sailed .therefore revise to reverse  To deal with glenoid bone loss I would use alt center line  Fem head allograft and  infuse.  For the humerus u might require grafting as well  Have to discuss further  Send videos of similar cases  Mark.A Frankle M.D.  Vice President, American Shoulder and Elbow Surgeons |  |
| 10/29/2019  (Dr. Bassem Elhassan) | JP it is unlikely but with history of progressive pain, though it looks like a PE wear, I would still like to r/o P acne specifically that she may need bone grating  Cheers  B :) |  |
| 10/29/2019  (Dr. Karl Wieser) | Bassem, what’s your algorithm to rule out infection in a case like this?  CRP, aspirations, scope and biopsies?  Best regards,  Karl |  |
| 10/29/2019  (Dr. Bassem Elhassan) | Dear Karl  I would do CBC, ESR, CRP and WBC tagged bone scan and aspiration, and if these are negative in this specific scenario I would not do biopsy. Cheers  B :) |  |
| 10/29/2019  (Dr. Jon JP Warner) | Thanks for all comments. |  |
| 10/29/2019  (Dr. Jon JP Warner) | THANK YOU MARK. Very encouraging ):  . Very much appreciate your input as I know my patient will as well. This is a great vehicle to deliver added value to patients. JPW |  |
| 10/31/2019  (Dr. Patrick Denard) | The glenoid looks challenging. I'm curious if anyone would use a custom augment for it? Send CT off to see if they can process as is but would likely require a 2-stage procedure - one for removal of components, followed by CT for custom augment with less metal artifact, followed by revision with custom augment.  Best,  Patrick |  |
| 10/31/2019  (Dr. Jon JP Warner) | Thanks Pat. Have never used custom Augment but doubt possible to create with metal artifact.  JPW |  |
| 10/31/2019  (Dr. Patrick Denard) | Agreed. I’ve seen Biomet be able to do with a hemi in place but doubt they could do with the metal back and anchors in this case. |  |
| 10/31/2019  Dr. Oke Anakwenze | I think conversion to reverse is the most predicatble option. I would remove the metal glenoid component. There is some osteolysis (from what I can see) around the metal component so may not extremely challenging. I would be prepared to graft what may be a large cavitary defect in a young patient with iliac crest/dbx structural graft and try to ensure that my primary fixation captures the area of best bone stock within the scapula while being in satisfactory inclination and position. |  |
| 10/31/2019  (Dr. Greg Mallo) | Gentleman-  I have heard anecdotal experience of surgeons treating painful arthroplasty with 2 weeks of oral doxycycline as a “test.” If pain improves with doxycycline the assumption is pain is related to indolent infection and revision is indicated.   Does the collective of CSS have any experience with this? I have not seen it in the literature but have heard a few well respected shoulder leaders mention this to me in conversation.  Any thoughts, dosing, experience would be appreciated. Thanks  Greg Mallo |  |
| 10/31/2019  (Dr. Mark Frankle) | I’ve heard this too but have yet tried it  Unsure how to interpret if it works then would that suggest surgical management for pji is warranted?  Mark.A Frankle M.D.  President -elect American Shoulder and Elbow Surgeons |  |
| 10/31/2019  (Dr. Jon Warner) | Seems very doubtful given the nature of C. Acnes. I wonder if anyone has an ID expert to weigh in on this. Ours would say “definitely not.” |  |
| 11/5/2019  (Dr. Christian Gerber) | In our hands AB treatment of painful periprosthetic c. acnes infections has usually neither cured the pain nor the infection.  Kindly  Christian Gerber |  |
| 11/5/2019  Dr. Joaquin Sanchez-Sotelo | Hi. I would discuss with the patient how willing and interested she is in going all in. One safer, limited goals option, would be to consider removing the glenoid component, using a larger humeral head and simply convert her to a hemiarthroplasty with tight impaction grafting of cancellous allograft in the glenoid, hoping some bone reconstitutes. The other alternative is revision to another reverse prosthesis; I worry about intraop fracture of the greater tuberosity and obviously glenoid fixation. I have no experience with the vault reconstruction system from Zimmer. I have used iliac crest autograft and a screw-based base plate, aiming almost always for the alternative scapular centerline Mark Frankle described. On the humeral side, cementing a stem a little proud may be the best option; alternatively, you could consider a Revive stem. Difficult case!    Best, Joaquin. |  |
| 11/5/2019  (Dr. Jon Warner) | Thanks Joaquin:    First, I am not sure they make the humeral heads for this implant any longer. I have no experience with Revive but would be happy to hear your input on advantages to Fracture stem cemented. My concerns are available bone when I take out metal glenoid. It may be lose but if not do you think I need a Midas Rex? Also, on the humeral side may have significant bone loss. Perhaps I can call and discuss. |  |
| 11/5/2019  (Dr. Joaquin Sanchez Sotelo) | Yes, I agree with your concerns. I am almost sure that Smith and Nephew can provide humeral heads as long as this is the Cofield2 (modular). Yes, you may need Midas Rex. On humeral side, you could potentially need an APC but hopefully that will not be the case. |  |
| 11/9/2019  (Dr. Christian Gerber) | Dear JP:  This is a most interesting case.  I think most of it is osteolysis by poly but there may be a lot of metallosis because of metal and metal wear. I anticipate that removal of the debris is goind g to be a major undertaking and frankly the poly should have been changed no later than 2014)  I would  remove the prostheses and  convert into reverse most probably in two stages  Firt step  1.on the humeral side I would take the prosthesis out because you will need to take it out anyway when you want to reimplant, it will be in your way for revision of the glenoid, so that leaving it in is so or so not a good option. It is for the CT to decide ho high up there is no destruction of the cortical humeral bone. certainly at the cement level it is good and I would not consider taking the cement plug out. if the corticals are good even higher, the impaction grafting does not have to go beyond teh compromised zone. I would then probably use a prosthesis either for cemented use without cement (very easy removal) or a non cemented definitely convertible stem with a bipolar head and (temporarily) stabilize it in the shaft using impaction grafting.  2. I would remove the glenoid implant with as much of the debris as possible. It seems to me that there is really very little bone support and I would fill the cavitiy with iliac crest bone graft. It may be necessary to use two (jugger knot type anchors in the middle of the cavity to hold a graft in place or to press it against the cancellous graft that will form the floor of the cavity.  I would probably add some inductos (bmp) to promote bone formation and let that glenoid reform for 6 months, then go back with a rtsa. I would not use a megaglenoid prosthesis as I would then not know what to do next.. The arm would essentaîally remain in a sling for six weeks then slight movements goals revision at six months. The glenoid bone would not be normal but probably sufficient to hold a good rtsa implant. Iam not sure but hopwe that the coracoid is not disconnected from the glenoid.  Second step  Anaverse at 6 months  Chr :) may be I would send her to Boston |  |