Date (CSS Member)	Message	Attached Documents
8/2/18 (Dr. Jon Warner)	Dear Members of the Codman Shoulder Society, Attached please find a case presentation from Dr. Min. Any comments or advice on this case would be greatly appreciated. Thank you in advance for your help. Best Regards, Jon J.P. Warner, MD	Case Presentation PPT: AG-Shoulder OA
8/2/18 (Dr. Stephen Parada)	Kyong, You will unfortunately see a lot more of these types of patients with what Matt Provencher termed "sergeant major shoulder"; post-traumatic arthropathy in a young military patient with a giant osteophyte limiting motion. I saw a lot of these patients in the army as well. I would start with an arthroscopic CAM procedure addressing any associated pathology (biceps, AC joint) but usually for me, as I would peel the inferior capsule off the osteophyte to perform my arthroscopic resection, the capsule would become attenuated and I would worry about the close proximity of the axillary nerve due to the size of the osteophyte. With osteophytes that large I would almost always convert to open and work through a inferior L-shaped tenotomy of the subscap to complete the resection, leaving the upper border intact. The continued integrity of the subscap is probably as important as any other factor in this patient to give him options for a future arthroplasty. These patients generally can "deal" with the pain and are most unhappy about the loss of motion. If your patient fits that profile, he may do very well with this approach. Good luck! -Steve	
8/2/18 (Dr. Jon Warner)	I think it would be useful to have other members and Steve weigh in on the success of such an approach. I know Peter Millet popularized this but I'd like to know what experience you all have had. If positive then good area for multicenter study. I am pessimistic, but please convince me! JPW	

8/2/18 (Dr. Ruth Delaney)	There is an ASES study group, led by Joe Abboud, who are just starting to look at this challenging cohort of patients in a multicenter fashion. As far as I know, it is open to any ASES members who may be interested. We are only just getting started...	
8/2/18 (Dr. Gregory Mallo)	Hi Dr. Warner, Re CAM procedure- I have about WC heavy laborers that I have done CAM on in the last 2 yrs. Anecdotally, their results seem to depend on the main source of their pain which is hard to isolate given the multiple pathologies in the degenerative arthritic Shoulder. For example- one patient with severe OA but a hypertrophic LHBT, with groove and Tenderness over biceps, that temporary responsed well to U/S biceps injection did extremely well postop..I suspect bec open tenodesis of biceps addressed the main "source" of his pain. Similarly- as Steve said, if stiffness and ROM is the chief problem, capsulectomy can resolve this and cause some residual mild to moderate pain improvement. My personal approach/ algorithm given my prior military practice and current Long Island,NY practice for the OA patient "too young" or "too active" for arthroplasty is the following: 1) if very Symptomatic from biceps on exam and get at least moderate relief from ultrasound guided injection they would be indicated for procedure Not expected relief from the Tenodesis portion 2) If stiff and painful with passive range of motion But minimal pain at rest, I expect some relief and improved function from the capsulectomy portion of the surgery 3) If their main complaint is the typical OA deep, dull, toothache type pain - I try cortisone or visco and recommend against CAM and would not expect much relief or benefit from surgery.. Just my thoughts and experience- hope it helps, Greg	

8/2/18 (Dr. Jon Warner)	Thanks. Anecdotal not scientific so good area for study. JPW	
8/2/18 (Dr. Jon Warner in response to Dr. Ruth Delaney)	So, are you suggesting they should do this or we should? My personal experience is that the politics and commitment often dilute efforts in national organizations. JPW	