Date (CSS Member)	Message	Attached Documents
3/30/18 (Dr. JP Warner)	Dear Members of the Codman Shoulder Society, Attached please find a case presentation of my patient. Any comments or advice on this case would be greatly appreciated. Thank you in advance for your help.	Case Presentation PPT
3/31/18 (Dr. Lawrence Gulotta)	JP, Great cases, thanks for sharing. When I see patients like the two you present, I always feel like I'm watching a car accident happening in slow motion. My bias is that the vast majority of "posterior instability" patients really just have early osteoarthritis. Unfortunately, I don't know of a surgical intervention that can change that natural history. When we try, we tend to accelerate the degenerative process as you so nicely showed in the two cases. This is a concept that most of the pure sports surgeons don't realize. It would be great if we could truly develop a "joint preservation" strategy for the shoulder. But then again, there is no fountain of youth. At the very least, we as a group could help define the characteristics that distinguish younger patients with acute injuries to the posterior labrum that would benefit from surgical fixation, from older patients with no clear trauma who are really just exhibiting the beginnings of the degenerative process. Happy Easter/Passover to all who celebrate. Best, Larry	
3/31/18 (Dr. JP Warner)	*Larry:* *That is exactly the purpose of these cases. Going forward we will try to set up some kind of chat-group perhaps on Facebook page, etc. This can generate ideas for multi center study or research. My point is that these discussion should catalyze us to ask important questions which need answers and transcend the individual centers in which we work.* *That said, I agree that it is a problem to treat such individuals. What we don't realize is that if we measure true retroversion by measuring cartilage not bone, a labrum tear functionally increases this and promotes posterior movement of the humeral head on the glenoid. We know from kinematic*	

	studies with biplanar fluoroscopy (Work we published with Massimini in JBJS and in JOR years ago) that the contact point of the humeral head on the glenoid tends to live in the posterior-superior quadrant of the glenoid so when a labrum tear happens this contact point certainly shifts more posterior. This can cause attritional damage to the joint and loss of cartilage further enhances the functional or acquired retroversion and so begins the B-1 and then B-2 glenoid (remember Iannotti's recent article showing evolution of posterior glenoid erosion.)...so perhaps one of us has an answer on joint preservation here???....	
3/31/18 (Dr. Guillaume Dumont)	Dr. Warner, Thank you sending these interesting cases. In patients with excessive glenoid retroversion and posterior labral tear, does Distal Tibia Allograft have a role prior to the development of bone loss? Though these case may not have true glenoid "bone loss," effectively the retroversion likely results in increased joint contact forces at the posterior joint. It would be interesting to know if an appropriately positioned posterior DTA could correct these forces (and delay the development of osteoarthritic changes), or if it would simply be a victim to them over time (osteolysis, graft resorption). If there is a role for DTA in these cases (retroversion, no bone loss yet), defining a "retroversion cut-off point" would be useful. Looking forward to seeing the remaining of the discussion about these cases. Best regards, Guillaume	
3/31/18 (Dr. JP Warner)	*Thanks Guillaume: As I indicated this mechanism is well defined biomechanically if we review the literature. The latest attempts to bone graft the posterior glenoid occur after the damage is done and the arthritic process is probably not changed. Even Lafosse's small series on arthroscopic posterior bone grafting suggest this. We recently did a similar case with a young man (not sure if sent to CSS yet but will follow-up on this). It went well until the humeral head continued to shift posteriorly and the bone graft resorbed and*	

	screws broke and his arthritis accelerated. He is, I believe, in his 30's. *Distal Tibial allograft (thanks Matt P) has been popularized as an alernative to ICBG for anterior instability with glenoid bone loss, but not specifically considered for posterior instability. I am still concerned about two things. 1. Cost of the graft and overall value proposition for the patient and the institution. 2. Resorption and incorporation of allograft on a weight-bearing surface.* *Best,* *JP Warner*	
3/31/18 (Dr. Gregory Mallo)	Good morning Dr. Warner, In my military patients prior as well as more recently in my private patients, occasionally I am able to identify some compensatory scapular winging as a result of the posterior labral/retroversion issue. If their symptoms improve even slightly with scapula compression test, I will have them get a posture correcting/scapula stabilizing shirt such as those offerered by inteliskin (no conflict/disclosure). PT with K-taping has also been somewhat helpful. Admittedly these are band-aids but sometimes can be the difference between getting through a labor intensive work day, versus being unable to work/function. Happy holidays! Greg	
3/31/18 (Dr. JP Warner)	*Hi Greg: There is no denying the intercalate relationship of GH:ST motion and implication for vector of force and loads across the glenoid; however, there is no evidence, to my knowledge, that we change the contact position of the humeral head on the glenoid with change in scapular position... though perhaps someone in this group knows otherwise.* *JP Warner*	
3/31/18 (Dr. Neal Chen)	Good morning I recall a number of articles describing Walch's experience with static posterior subluxation where at one time he found some improvement with anterior capsular release. Although it	

	is not exactly the same problem as these cases, some of the ideas may be transferrable. Has anyone in the group had experience with this approach? Thanks Neal	
3/31/18 (Dr. Michael Freehill)	JP- at Paris shoulder there was some discussion of the Acromial Pediculated Bone Block (a posterior Latarjet if you will). Does this procedure have a role? Does anyone have experience with this type of procedure?	
3/31/18 (Dr. JP Warner)	*Mike: Unless I missed it Walch was very nihilistic about this group of patients as evidenced by the article enclosed. He recently spoke with me on this and nothing has changed. Perhaps you can ask him this question this June at the CSS Meeting in San Diego* *Best,* *JP Warner*	*Static posterior subluxation of the humeral head: An unrecognized entity responsible for glenohumeral osteoarthritis in the young adult (Walch et al 2002, JSES)*
3/31/18 (Dr. Bassem Elhassan)	Good morning JP Great cases and great discussion. I think we had similar discussion in the past among the group and we didn't real reach a consensus about what to do. I recall they presented similar case during one of the ICL at the AAOS and Gille Walsh at that time mentioned: in my hands nothing work for this group if they become symptomatic, and recommended try to delay with therapy and observation because he expressed that they would need replacement in the future. And that was specifically for patients with significant retroversion and posterior subluxation especially if they started to have arthritis. I do have two population of patients: 1- patients with obstetric brachial plexus injury who present with very similar picture but worse because of muscle imbalance secondary to weakness in addition to bony changes in the acromion and coracoid. 2- Patients who have dysplasia: excessive retroversion with subluxation. Some of them who started to develop arthritis.	

	I have done more than 50 in group 1 and around 30 in group 2. Essentially all of them underwent bone grafting to the posterior glenoid using: coracoid, iliac crest autograft or osteochondral glenoid allograft with or without anterior shoulder release. After I did more than half of the cases I noticed that the results were variable and some times unpredictable. Some patients did amazing while others did very well for the first 1-2 years and then started to progressively subluxate again mainly because the humeral Head articulation was mostly over the bone graft and because of muscle imbalance. Then I started to perform anterior and inferior capsular release with the addition of the lower trapezius transfer MAINLY as a stabilizing muscle not for external rotation and these patients so far have done very well. We are in the process of analyzing our data to try to determine predictive factors that lead to good/bad outcome and I will keep the group posted about what we find. Happy Easter everyone :) Cheers B	
3/31/18 (Dr. Buddy Savoie)	I have tried a lot of different strategies; I agree that first step is to fix the dyskinesia which is present. I do triple scapular bracing and also mcconell taping into retraction and a lot of pec minor and major stretching along with Infra and teres minor strengthening. Early on- before the arthritis, you can "pull" the humeral head back in place by shortening the CHL and SGHL; most try to do something in the back to push it back in , and while it seems logical has never worked for me,just worsens the arthritis and hastens the process. Once the arthritis develops, if mild and primarily on the glenoid side I can do a microfx, put the labrum on top of the defect and then - quite illogically- release the inferior capsule and tighten the chl and sghl . seems to buy time and lack of symptoms.	

	I tried in place humeral head resurfacing in situ thinking I could then rehab in back into the center but didn't have much success so abandoned it in these eccentric arthritis patients. Once the degeneration is on both sides the only thing I have found is TSA. Started a long time ago with eccentric reaming, then step cut even though it was often not really B2 just retroverted and now with post augment- usually just 8 degree; the couple of 16 degree offsets I tried were too tight and symptomatic. Just my thoughts on this. tough problem but actually very common, especially if you start doing bernageau views on every arthritic patient Buddy Savoie	
3/31/18 (Dr. Anshuman Singh)	I really appreciate this manner of sharing cases and learning from surgeons that are experienced, thoughtful, and follow their patients closely. As stated by Dr Savoie and others, I have had poor results with posterior bony augmentation once there are fixed degenerative changes and posterior subluxation. It's good to know I am not alone! In this particular case I would personally perform TSA with anterior-inferior capsulectomy and a wedge glenoid. There is little mid or long term evidence that supports centering of the head with this approach. On my travelling fellowship I can tell you that the Europeans would likely perform BIO RSA here Thanks for this JP! Anshu	
3/31/18 (Dr. Ronald Navarro)	Hi JP and Codman squad, For the sake of keeping the convo going... Younger patient - scope labral surg and posture shirt w rehab. When this patient gets to 50 see below. Older patient - get em to 50 then RTSA. More predictable result than all the fancy stuff in my hands (and it sounds like in all the folks hands who do the fancy stuff). A visit to Zurich last year has informed this thinking (echoing Anshu comments). Of course concerns about the longevity of a	

	reverse in a young patient will be a potential future hurdle for many of us. My best to all of you on this Passover/Easter weekend.	
3/31/18 (Dr. JP Warner)	*Thanks Ron What if the patient is 48 ½ years old?*	
3/31/18 (Dr. Ronald Navarro)	*Rehab, posture shirt, multimodal non-narcotic pain control regimen and behavioral modification (my go to answer as you have seen in the past) to get to 50.* *As you know I am in a prepaid system so if the patient doesn't like that answer they can seek out Anshu or Ed Yian and others capable within our system of care for a different answer. I would encourage them to do same (within system) if the patient didn't like my answer. Sorry to open that aspect of the discourse. Just wanted to overtly address what some would see as a bias and others as a benefit to provision of care to this pathologic issue and it's possible best treatment and outcome.* *Thanks for continuing to make us all consider all of the aspects of Shoulder Care to further define a better way via this Codman thought partnership.*	
4/1/18 (Dr. Ed Yian)	J.P. and others, Thanks for the insight on a difficult topic (for me). I remember discussing Walch's original static posterior subluxation article with J.P. in '03 when I was his fellow! On a side note, had related case (45yo) of a Walch B0/B1 glenoid (early djd) with -15 degrees retroversion and static posterior subluxation who had prior ant bankart repair 15 yrs ago and developed gradual recurrent anterior instability-like symptoms (pos apprehension and relocation tests) with anterior glenoid bone loss (subjective symptoms of pain and subluxations). Walch's recent Jses B0 glenoid review article reinforced how PPSHH can be mistaken for anterior instability! At least in this patient, seems he is destined for limited surgical gains even if anterior bone loss and/or posterior soft tissue pathologies are addressed.	