

Date (CSS Member)	Message	Attached Documents
4/12/18 (Dr. JP Warner)	<p>Dear Members of the Codman Shoulder Society,</p> <p>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.</p>	Case Presentation PPT
4/13/18 (Dr. John Costouros)	<p>Dear JP,</p> <p>Thanks for sharing this very challenging case. I've encountered a similar scenario (powerpoint attached) – a 25yo patient with epilepsy and profound recurrent grand-mal seizures who developed instability bilaterally with profound bone loss of the glenoid (~50%) and humeral head.</p> <p>Before proceeding with surgery, I required a seizure-free period of 8 months documented by his neurologist. Unlike your case, I had the opportunity to perform the index procedure. I elected to go with ICBG for the glenoid and size-matched humeral-head allograft for the humerus. He has done very well at 6 years postop from a pain and functional improvement standpoint. He has developed some radiographic evidence of arthritis progression, but not significant.</p> <p>Given that he had similar symptoms and radiographic features of the contralateral shoulder, approximately 1 year later, I performed the same procedure on the other, non-dominant side.</p> <p>I did consider using distal tibial allograft for the glenoid instead of ICBG for both shoulders, but elected not to given my concern for possible resorption of tibial allograft over time. I have personally not had issues of resorption using humeral head allograft for Hill-Sachs or reverse Hill-Sachs deformities of the humerus. Interestingly, my patient did suffer a recurrent seizure 2 times following his reconstructions but thankfully did not dislocate either shoulder.</p> <p>Your case poses additional challenges that may preclude a good result using this technique – more advanced arthritis and questionable subscapularis integrity in the context of a prior latarjet with subscapularis split, and a non-anatomic prior reconstruction (latarjet). Reverse would provide the most predictable result but he is so young I would be very concerned if he suffers another seizure.</p>	

	<p>Thank you again for your leadership and for continuing to create opportunities for us as a group to collaborate, share knowledge, and innovate.</p> <p>Best regards, John Costouros</p>	
<p>4/13/18 (Dr. Michael Freehill)</p>	<p>JPW, Very challenging case. Glenoid: distal tibial allograft HH: HH allograft (lesion looks very large on some of these cuts)</p> <p>MTF</p>	
<p>4/14/18 (Dr. Peter Millett)</p>	<p>Here's three articles that might be of help for cases where there is no bone loss. Great cases to think about and challenge us.</p> <p>Peter</p>	<p><i>“Two-year outcomes of open shoulder anterior capsular reconstruction for instability from severe capsular deficiency” (Dewing et al Arthroscopy 2012)</i></p> <p><i>“Anterior capsule reconstruction technique with an acellular dermal allograft” (Kwapisz et al Arthroscopy Techniques 2017)</i></p> <p><i>“Anterior capsular reconstruction for irreparable subscapularis tears” (Pogorzelski et</i></p>

		<i>al Arthroscopy Techniques 2017)</i>
4/15/18 (Dr. Philippe Valenti)	<p>Thanks JP to share this difficult case !</p> <p>Two problems for me; huge anterior lack of bone and subscapularis deficiency (CTScan Y view)</p> <p>ICBG with a pre op CTscan 3D of the controlateral side to evaluate the width of the glenoid.</p> <p>The capsule should be bad ! and you could combine a latissimus dorsi transfer as described by Bassem E to pull back the humeral head</p> <p>This is a proposition ! i never did it !</p> <p>Nice Saturday</p> <p>Philippe</p>	