Case Discussion: Yoga Instructor with Osteoarthritis

***6/4/2021***

Dear CSS Colleagues:

Enclosed is a challenging case not just because of the deformity but the age and expectations of the patients. Please take a quick look and tell me what you would recommend as treatment for her.

To view the case presentation and video, click the following link to download:

[https://www.dropbox.com/scl/fi/t3wold1ubj40hxzmtxfr2/Codman-Case-Presentation-LC.pptx?dl=0&rlkey=xx5efaivicdq5xavzeesk44zn](https://secure-web.cisco.com/1l1d4vi-8VnOQjoh7ssKAAVqs7hyintvjgwZ2SdxmX5LmPSqgHmmHQamCpz5-Eqg_NIRsMVr85deHQzbcQGarcUZDBBbU1049PrJJD8uI6WZcXUXVUxCPRl9nBFuytz_mNGNG8Ww_HjJKGZSpfXhk92YYp3OAvqEWAV2u4PwbtHRlphbPu1yhcopHlOFAcurC7unbwcMfZCFYsLHZjLS6GxOUCNTHG_8KOBd11tP4E1iqpLrph5VSQe7bFzXEnRzAQ_nuGlZjx4jEHLzQ-LbLEw/https%3A//na01.safelinks.protection.outlook.com/%3Furl%3Dhttps%253A%252F%252Fsecure-web.cisco.com%252F1d_wPQT9rc5mSJOjdVT9TJaeL0443hhfmzRjxGtqrZLMXw4WnreLiS0YebJvNFCJ3jYMvwvGbhs5ikYNzAsWrZ_CSARYoQq0Ya1TzwoADx2QyYXN3FLwZxNvg4eEG3S8MMLU9dKeJRSb8Wevzl2EL-i5Z-R8LtLPqzW6jIlhJ7y4pXxfaNLkRNHGX4jLKfPP43tsOOT3yKBLMgxKQJTa5ZJefe_WLMvMOSkCajqIxliVDtGY9VrN40dK4A0PLIov3ZLPOZ2paaCSga9I9DMAF6Q%252Fhttps%25253A%25252F%25252Fna01.safelinks.protection.outlook.com%25252F%25253Furl%25253Dhttps%2525253A%2525252F%2525252Fwww.dropbox.com%2525252Fscl%2525252Ffi%2525252Ft3wold1ubj40hxzmtxfr2%2525252FCodman-Case-Presentation-LC.pptx%2525253Fdl%2525253D0%25252526rlkey%2525253Dxx5efaivicdq5xavzeesk44zn%252526data%25253D04%2525257C01%2525257C%2525257Cfed35a999e16470e197a08d92520d135%2525257C84df9e7fe9f640afb435aaaaaaaaaaaa%2525257C1%2525257C0%2525257C637581645170600459%2525257CUnknown%2525257CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%2525253D%2525257C1000%252526sdata%25253DYzNsLa1liZae5uPi76l2%2525252Bj3ZF7LemgaTxJGdU3DEQP0%2525253D%252526reserved%25253D0%26data%3D04%257C01%257C%257C75118ec892d44b48e03508d926c86792%257C84df9e7fe9f640afb435aaaaaaaaaaaa%257C1%257C0%257C637583464432860792%257CUnknown%257CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%253D%257C1000%26sdata%3DwRMLDYgVaPdwWrXo6oqw1MweGs5uEGoQsVZD9VaoWpk%253D%26reserved%3D0)

Kind Regards,

“JP” Warner MD

Founder, The CSS

***6/10/2021***

***Andrew Jawa***

This is a C glenoid case with good flexibility. I had a case with more advanced OA and severe glenoid retroversion (see enclosed ppt).  In your patient’s case I would wait as long as possible with discussion of loss of motion as we discussed in conference.

aj

***6/11/2021***

***Jon Warner- in response to Andy Jawa’s case (see ppt)***

Wonderful result. Just a few question:

1. Size of Sphere?
2. No bone graft?
3. Do you ever have trouble to dislocate Metaphysis anteriorly after you place the glenosphere?

JPW

***6/11/2021***

***Andrew Jawa***

-32+6

-There is bone graft- if you look closely you can see it has incorporated well posteriorly, but I didn’t try to correct significant version, just get some bony coverage. I left retroverted.

-I certainly have troubles in many small women (and some men)  who are stiff, to bring the head forward. However, this seems to me, to be in all glenoid types and depends on patient laxity, shoulder stiffness, size of patient, and amount of erosion. Occasionally I will release the leading edge of Supra to being forward or ream the head prior to glenoid prep to create space. In your C patient, who is quite lax and with good ROM, I don’t think this will be a issue (but I could be wrong).

Andy

***6/11/2021***

***Andrew Jawa***

Yes! Agree with both points. Generally speaking (even in B glenoids) I don’t try to overly correct. Preserving bone and back side coverage is a priority to me. I haven’t made any general observations of deficits or baseplate failures from keeping retroverted.,

But hard to prove without postop CTS.

Andy

***6/11/2021***

***Bassem Elhassan***

Great

I always favor baseplate placed in retroverted fashion rather than anteverted because I have seen anterior dislocation with these

Thanks Andy

Cheers

B 😊

***6/11/2021***

***Jacob Kirsch***

Awesome case!

 The idea of correcting version in the dysplasic glenoid raises a few interesting things. First, can we reliably distinguish acquired bone loss (B3 glenoid) from congenital bone loss (C glenoid)? When we can, how should this influence treatment and should it be different in acquired vs congenital? Does it matter if you are doing an anatomic vs reverse? DJO has planning software that can do this, and Andy seems to think that it rings true to his observations. Very important area for AI and tech in the future.

 The point I made yesterday about why correcting version in the dysplasic glenoid may be a bad idea is from Dr. Williams experience. One time he used a 7 mm augmented anatomic component (similar to the 35 deg wedge) when he thought it was acquired bone loss. At the end of the case when checking motion he realized the patient had no IR because the posterior capsule was so tight!

Jacob

***6/12/2021***

***Jon Warner***

Good points….I think this will be an area of debate and future research. jPW

***6/13/2021***

***Bassem Elhassan***

Good points Jacob

There is a true distinction between dysplastic glenoid and B3 glenoid. We can present these based on G Walsh classification.

The point I raised was based on my experience with obstetric brachial plexus injuries.

I have done more than 50 posterior glenoid reconstruction for this problem with variable results mainly because all the bones and soft tissues around the glenohueral joint change. And in pediatric patients, we may have a chance to correct them.

However, when someone lived for 50 years with this deformity and then started to have problems, it makes you wonder if you could look at them and treat them the way you do for non-dysplastic shoulder

To be more clear, we don’t know when the B2 glenoid starts. I know that Walsh showed one time how these evolve. So if you see them on xryas, they start to evolved. However, the patients are usually born with dysplastic glenoid and with this deformity the length of different muscles and the configuration of the bone.

I wish we could study this, however, it is very hard to create in the lab a model of dysplastic shoulder because of it is congenital occurrence.

The patient that JP presented who is a Yoga instructor, had bilateral shoulder dysplasia. Assuming that all her pain was coming from arthritis, can we reconstruct this shoulder and restore it biomechanically to normal with an anatomic shoulder????

I truly believe the answer is NO and the only option would be RSA

This is a topic worth discussing and exploring

Cheers

B 😊