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| **Date (CSS Member)** | **Message** | **Attached Documents** |
| 11/8/19 (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 |
| 11/8/19(Dr. Gilles Walch) | Dear Ron, I’ve never seen such a case of congenitally absent acromion. Before taking any decision, I would like to see the RC muscles as well as the deltoid muscle and the glenoid on a standard CT scan.As soon as you can send it, I will let you know what I thinkbest regardsgilles  |  |
| 11/8/2019(Dr. Ron Navarro) | Thank you Gilles! Will get the studies to you all once done.  |  |
| 11/8/2019(Dr. Pascal Boileau) | Ron, I have never seen such a case. Congratulations!… ;-)It is probably possible to implant a RSA with a good result ... However, based on the poor results (with loss of AFE) seen after a spine fracture in shoulder with a RSA, I would be afraid to do so.I would not like to take the risk of breaking the fragile muscle balance of this shoulder That’s why I would probably propose a HA to this patient. For sure, the results would be probably less ”glorious”, but I would not burn any bridgeIn case of poor result, I could still covert to a RSA.Let me know what you will doBest,Pascal  |  |
| 11/8/2019(Dr. Ron Navarro) | Thanks Pascal!!!! I am glad to face a facinoma and do not want its potential complications to bear my family name so I will consider Hemi significantly. A question: in sizing the head would you just be as anatomical as possible or under vs oversize (I doubt the latter)?Thanks and happy weekend.  |  |
| 11/9/2019(Dr. Pascal Boileau) | Anatomical. But again, before taking any decision, you need a CT-SCAN to make a full diagnosis and evaluate bone and potential muscle deficiencies Best, Pascal Pascal Boileau, MD |  |
| 11/9/2019(Dr. Christian Gerber) | Dear Ron: I have never seen that, but as you know I am still young.——Thoughts which are probably irrelevant but thoughts anyway:1. very unusual malformation associated with ? Is is associated with other regional malformations, particularly of nerve and vessels?2. I would get CT as on conventional axillary bone looks very retroverted, potential identification of other bony malformations. 3. MRI for assessment of muscular state: Does the patient have what we think is a normal cuff? pectoralis muscles etc.[3.](https://nam04.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.com%2Fv3%2F__http%3A%2F%2F3.io__%3B!7TrXCGkIugIq!6PLse7SA58Vki_1FgwLHBdBQzsMBzp2eF32K6EkxA2DbaXEVRoaE3MZgc1HWhrpP8_k%24&data=02%7C01%7C%7C2198fcd253754f43d55508d7651b6fce%7C84df9e7fe9f640afb435aaaaaaaaaaaa%7C1%7C0%7C637089040816700500&sdata=qdZ7Luw00xZMfguRgeBqmeZzAL6AbahLZyFdUyyOEuQ%3D&reserved=0)I would get prbably an MR angiography to be sure that I do not have to expect some vascular malformation4. If the shoulder has previosly functioned without the acromion, it will function without the acromion thereafter. Like the perfectly performed acromionectomies of the times of Armstrong, hammond or Bosley. The sleeve would haver to be preserved at all cost to prevent the development of a poorly performed acromionectomy which gave the results reported by Neer.5. Although i would probably go with pascal and first try resurfacing, given no contraindications from 1-4 i think rtsa and as a matter of fact atsa are galid options ( the latter with convertible glenoid and convertible humerus however)Kindlychristian |  |
| 11/9/2019(Dr. Ron Navarro) | Thank you very much Christian. CT and MRI planned/ordered and the MR Angio is an excellent suggestion.  |  |
| 11/9/2019(Dr. Jon Warner) | Dear Gilles, Pascal and Christian: Thanks so much to all of you for offering input. It is of great value to have you as friends and experienced advisors. Our patients benefit more than they know from your wisdom. Ron: I am sure everyone would like to see outcome of treatment so please share with me so that I can post to CSS along with the case story and comments. This can be helpful to someone in the future who has a similar case. JPW |  |
| 11/10/2019(Dr. Ron Navarro) | Yes will add images and then eventual Rx. Thx |  |
| 2/21/2020(Jon JP Warner) | Dear Members of CSS:This is a follow-up to an interesting case that was previously sent on behalf of Dr. Ron Navarro with input from various experts. Please click the link below to access the case presentation. Attached, please find the articles referenced in the case presentation. Any further thoughts or advice would be greatly appreciated. Click here to view case presentation: [https://www.dropbox.com/s/rvh45everjoembn/Edited%20Updated-no%20acromion%20SA.pdf?dl=0](https://urldefense.com/v3/__https%3A/www.dropbox.com/s/rvh45everjoembn/Edited%2A20Updated-no%2A20acromion%2A20SA.pdf?dl=0__;JSUl!!BZ50a36bapWJ!9UjudAj2UVBYc3Eprej1cRGQhSS3SuJSLB_LSAkHWcjn1y1jQaSpL100XR_gWENykqk$)Kind Regards, JP Warner, MDFounder, CSS |  |
| 2/24/2020Ron Navarro | Thanks JP.Hello all,I would politely ask if you could take the time to open the DropBox as the images from many different imaging modalities are now included. This made the file too large to share independently.I also included the initial thoughts of Dr.s Boileau, Gerber and Walsh as they were provided to me individually.My patient and I look forward to your sage advice.If after review, you could potentially answer these questions:SOME NEW Q’S•WITH THIS IMAGING INFORMATION, ANY NEW THOUGHTS?WHAT IMPLANT IF ANY WOULD YOU CHOOSE?THANKS |  |
| 2/24/2020Mark Frankle | I would do rsp with inset unreal socket at 135 Lateral used sphere 10 mmWith smaller diameter place baseplate in center of glenoid This will allow more idealized function of the cuff  |  |
| 2/24/2020Moby Parsons | Interesting case. I have seen one of these in a patient with normal shoulder function. If you want to burn limited bridges you could consider a stemless ATSA and a glenoid component put in slight inferior inclination to resist superior migration urge. Planning and PSI or navigation could help dial this in. If there is significant retroversion then an augmented glenoid could be considered. If this fails then a reverse  with some degree of lateralization to get compression through deltoid wrap (controversial). I would probably use a system with in inlay humerus to limit distalization so as not to overstretch the deltoid aponeurosis. Inlay glenoid to limit glenoid bone loss also a consideration but might be hard to put this in inferior inclination. Suspect you will get 50 different thoughts and no consensus. Love the input of the masters. Moby Parsons |  |
| 2/24/2020John Macy | Hi Ron, very interesting case. Thanks for sharing. I have tried to “respond to all”, but my provider settings will not let me respond to such large group so I’m just respond to you.                I would perform a CAP/TSA with the Tornier Resurfacing CAP, sized appropriately (based off the   A-P dimension, NOT the S-I dimension) to make sure not to over-stuff joint and stress RTC. On glenoid side, I would use Surgical Innovations InSet glenoid, prob the 22x6mm implant. I would place it where it lies on the retroverted glenoid and NOT try to correct the version much at all (unless there was significant posterior wear or B2 wear pattern. It has live there like that for years and I believe the soft tissues have adapted to this anatomy. This implant only requires 2mm of reaming, not violating the subchondral bone at all. It has the in-line pegs and cemented with minimal cement.cid:image001.jpg@01D5EB55.D90022F0cid:image002.jpg@01D5EB55.D90022F0 I have used this technique now for over 100 cases for almost all my primary TSA’s in the last 2 yrs and it does so damm well radiographically and clinically (very high PRO’s, higher than and standard TSAs in my hands). I have done this on two patients with aggressive anterior “acomionectomies” with good RTC function, (not total absence of acromion) and see no problems in short term. Not only is this a true “bone-sparing” procedure, with minimal blood loss, it is easy to revise to Reverse, should that ever be indicated.               I do have a COI, as I am a “design surgeon”, working with Surg Innovations. That being said, Steve Gunther has recently published his >10 year f/u of his initial series with the insert glenoid with excellent long-term results and he used this glenoid for severe deformities/B3/C glenoids. See Gunther, S. JSES Sept., 2019.               Best of luck, keep us posted. Great discussion!JcMacy |  |
| 2/25/2020(Tom Norris) | Jon:  I am inclined to agree with Dr Macy. The Shoulder Innovations InSet glenoid makes sense with less potential for deep loosening if any anatomical construct will work. I only had the opportunity to do 62 cases before retiring in December, but did not operate this last year. My inset glenoids look much more promising than my only glenoids. Interesting cases. Thank you for sharing,Tom |  |
| 2/26/2020(Bassem Elhassan) | Dear Ron,Very interesting and complex case.I do have around 8 patients who presented with symptomatic shoulder arthritis in the setting chronic complete deltoid paralysis (some of them more than 40 years)I know it is not the same situation here, but I want to assume that the present deltoid in this patient may not be good enough without acromial origin to power the shoulder function alone.If this patient Rotator cuff are still preserved then I would do hemi arthroplasty on him (this is what I did on 5 of the above patients who had still good Rotator cuff, but I also added pedicled pect transfer to reconstruct anterior deltoid, which your patient already has)If rotator cuff are deficient then I would do RSA with less lateralization Let us know what you decide to do Best of luckCheersB :) |  |