

◀심포지움 III (Rotator Cuff) 16:50 ~ 17:00▶

Arthroscopic Rotator Cuff Repair Revo Anchor

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Rotator Cuff Pathology is successfully treated with arthroscopy. Early anatomical and clinical arthroscopic studies demonstrated success in treating impingement, acromioclavicular joint osteoarthritis, and rotator cuff tears.

Rotator cuff surgery has progressed from open procedures to arthroscopic subacromial decompression, acromioclavicular joint arthroplasty, mini-open repair and now to a completely arthroscopic rotator cuff repair. This success has been due to the progression of surgical skills and technology development.

The first step in the arthroscopic repair of the rotator cuff is the evaluation of the glenohumeral joint for superior labral pathology, loose bodies and examination of the humeral side of the rotator cuff. There is an association of superior labral tears with rotator cuff pathology. Once the superior labral pathology is addressed and there is noted to be a partial tear of the supraspinatus tendon or a small full-thickness tear, this is marked with a #16 gauge spinal needle from the anterolateral edge of the acromion through the tear and into the joint. Once the tear has been localized with the needle, a #1 PDS suture is fed through this needle and into the joint for easier visualization on the buried side of the rotator cuff tear. Large tears do not need this localization. The arthroscopy is then placed through the posterior subacromial portal into the subacromial space. Then a lateral acromial incision is made in line with the posterior border of the clavicle. The subacromial bursectomy is performed and the coracoacromial ligament is released. If the acromioclavicular joint is degenerative and there are interior osteophytes, then a distal claviclectomy is carried out because non-planing leads to acromioclavicular joint symptoms and a repair procedure for a distal claviclectomy. Once the subacromial procedures are completed, the arm is placed in external rotation slight flexion and abduction for rotator cuff tear visualization. The mobility and anatomy of the tear in the rotator the L-shaped tear is noted than a side-to-side repair of the L-shaped tear is addressed. The arthroscopy is moved to the lateral acromial incision. A straight curved suture hook is used to feed suture from anterior to posterior, using either PDS or a suture shuttle for passage of nonabsorbable suture. Once the side-to-side repair is performed the mobilization of the tear is tested to the greater tuberosity. The corn edges are debrided with an arthroscopic shaver through the lateral acromial incision. Next a small round bur is used to decorticate the greater tuberosity. Drill holes are then made with the Rove Guide and drill hit into the decorticated bed. Rove screws with #2 nonabsorbable sutures, which are standard, are used through the guide for normal bone. If the bone is osteoporotic, ultra-fix anchors are used. All sets of sutures, which are standard, are used through the guide for normal bone. If the bone is of the anterior portal. The rotator cuff edge is grasped with the modified casperi suture punch turned upside down. Either a looped #2-0 prolene or suture shuttle is passed into the subacromial space through the suture punch. This is taken out the anterior cannula end one limb of the #2 nonabsorbable suture is placed in the loop of #2-0 prolene or the suture shuttle. The suture punch is removed and the #2-0 nonabsorbable suture is passed through the rotator cuff edge using the suture passer. The same procedure is

carried out in sequential fashion from anterior to posterior. This allows for better visualization as each suture is passed into the rotator cuff edge. The knot is placed on the superior surface of the rotator cuff edge, thus mimicking an open repair. This method results in a horizontal mattress suture which permits for the distribution of tension over the repair. The arm can be further abducted for ease of reduction of the rotator cuff. The sutures are tied in sequential fashion from anterior to posterior and then cut. The arm is mobilized for testing of the suture repair.

Postoperatively an is machine and sling are used. The postoperative rehabilitation protocol allows for removal of the sling on postoperative day one. Immediate mobilization is required to prevent adhesion. Exercises include aggressive passive range of motion with active range of motion to pain tolerance. This assumes a good strong rotator cuff repair. Progression to sports, like golf, are started as early as six to eight weeks and return to full activities as early as four months.