



**Subscapularis Management:
How I do it and why its better**

**Lesser Tuberosity Osteotomy with
Anteroinferior Capsulectomy**



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Disclosures

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- This technique is 100% unchanged from the one I learned in fellowship >8 years ago from Gerry Williams

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Lesser Tuberosity Osteotomy...

- Subscapularis insufficiency is real
 - Pain, weakness, early glenoid loosening
 - One of the most common reasons for revision of anatomic TSA
 - Even with complete healing, up to 2/3 have weakness, progression of fatty infiltration (*Miller JSES 2003*)
- LTO
 - Preserves the muscle-tendon-bone unit
 - Bone to bone healing (*Gerber JBJS 2005; 2006*)
 - Improved biomechanics (*Schrock S&E 2017*)
 - Improved results in retrospective review (*Scalise JBJS 2010*)

...with Anteroinferior Capsulectomy

- Capsulectomy potential advantages
 - Capsule is pathologically thickened
 - Improved exposure
 - Easier palpation and location of axillary nerve
 - Decreased tension on subscapularis repair
 - Improved post-operative range of motion



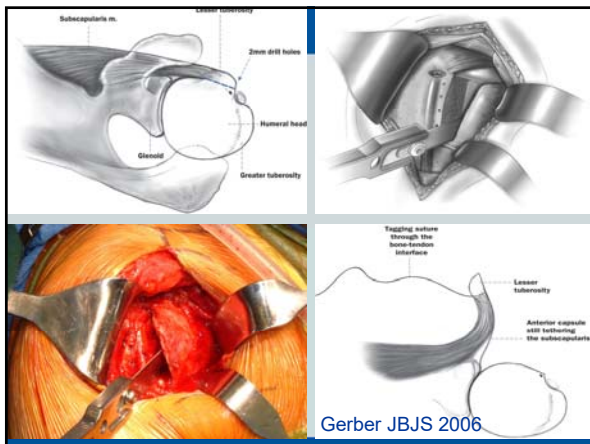
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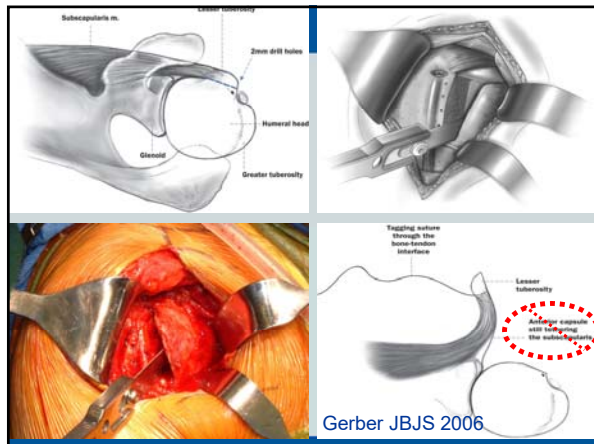
LTO with capsulectomy

- ✓ Exposure
- ✓ ROM
- ✓ Secure repair
- ✓ Robust healing
- ✓ Post-op monitoring



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LTO with mini-stem/stemless

- Reviewed 156 cases with minimum 2-year follow up
- Only complications were
 - Post op: 4 patient trauma or noncompliance
 - Intra op: 2 *greater* tuberosity fracture in obese patients humeral prep with arm in extension and adduction.
- Solution
 - Leave 1-2 mm of bone between LTO bed and humeral head cut
 - Don't remove osteophytes in this area until final implantation

