ACROMIOPLASTY & DISTAL CLAVICLE EXCISION

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COI

• Royalties: none
• Stock: none
• Stock option: Cayenne Medical
• Consultant: DePuy Mitek, Smith & Nephew, Exactech
SYMPTOMS

- Pain on top of shoulder (point tender)
- Pain/clicking on adduction movements
- Lying on side?

EXAMINATION

- Point tender
- Pain on cross body checking
- Clicking with resisted adduction / abduction at 90 degrees flexion
- Pain on manual shifting

INITIAL TREATMENT

- NSAID
- Injections
- Topical creams
- Scapular retraction exercise and bracing
IMAGING

- Radiographs
  - Narrowing
  - Spurs
  - Cysts
- MRI
  - Edema
  - Cysts

SURGICAL INDICATIONS

- Failure of other treatments
- + exam and radiographic findings
- In conjunction with other surgeries

SURGICAL OPTIONS

- Open surgical excision (Mumford procedure)
- Indirect arthroscopic
- Direct arthroscopic
SYMPTOMS

Open resection Mumford  
Arthroscopic resection : Ellman

- JBJS 1941; 23: 799-802

DCE: TECHNIQUE

- Set up lateral decubitus or beach chair
- Lateral viewing portal : line up with anterior acromial border down 3 cm: will give you a direct view of the AC joint

- Trim top of CA ligament off acromion to access AC joint
- Resection of anterior acromion gives easier access and visualization to the AC joint
DCE: TECHNIQUE

• Keeping burr in back trim underside and anterior aspect of distal clavicle

DCE: TECHNIQUE

• Move the burr to the anterior portal in line with the ac joint;
• Resect clavicular facet of acromion
• Begin distal clavicle resection

DCE: TECHNIQUE

• Work on superior aspect of distal clavicle by elevating, not resecting the superior capsule
DCE: TECHNIQUE

- Continue to resect and remove all cysts
- Preserve superior and posterior-superior capsule

DCE: TECHNIQUE

- Continue to resect until 10 mm space created on POSTERIOR ac joint

RESULTS

Tulane Orthopaedic Surgery
COMPLICATIONS
- Failure to resect posterior Distal clavicle
- Horizontal instability
- Over-resection with complete instability

KEY POINTS
- Accurate PE & diagnosis
- Non operative Rx includes diagnostic injections
- Arthroscopic resection works well

ACROMIOPLASTY: WHEN
HISTORY
- Insidious onset
- Pain with out and up
- Night pain sometimes, especially when rolling onto shoulder or with arm up and hand behind back

EXAMINATION
- Neer +/-
- Hawkins usually +
- Lateral impingement +
- IGT negative
ACROMIOPLASTY: WHEN

INITIAL MANAGEMENT: SAME
• Injection into sub-acromial bursa along anterior lateral acromion: I do this from posterior
• Diagnostic and therapeutic
• Scapular retraction exercises, shoulder rehab with no active abduction

SURGERY: INDICATIONS
• Failure of non-operative management
• Functional impairment
• Patient doesn’t want to live with discomfort
• Results when all these "fit" are greater than 95% get "well"

ACROMIOPLASTY

ACROMIOPLASTY: IT’S ALL ABOUT THE ROTATOR CUFF (RETEARS)
Think about CSA and morphology preoperatively
Intra-op: LOOK before doing anything
Start the decompression on the lateral side of the acromion
Have a reproducible endpoint
Xray post-surgery

Define the lateral border
Define the anterior border
Cutting block technique
My endpoint is to have the anterior acromion be posterior to anterior clavicle when viewing from lateral portal (from Rockwood)

Post-op rehab:
- Depends on other pathology
- Protect lateral deltoid tendon
- Avoid active lateral abduction until RC strength is normal: work thumb up in plane of scapula instead
ACROMIOPLASTY

- Still an indicated procedure, just a little different in concept and surgery
- Gerber’s CSA is most important concept
- Continue to evaluate and manage the pathology individualized to the patient

ACROMIOPLASTY: SHOULD YOU DO IT?

- YES, if it is part of the problem based on exam and imaging
- NO, if it isn’t
- How about with RCT?
  - As a routine without specific reason? NO
  - To improve visualization & decrease pain and retear rate, YES
  - Zumstein, et al. /JBI 2008: retear rate correlated with CSA > 35

THANK YOU