

Massive Cuff Repair 2020 Tampa Shoulder

Pro: SCR

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Disclosures

Are Available in
the brochure, on
the APP and @
AAOS website



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The use of Acellular Human Dermal Matrix is considered “on-label” by the US FDA for augmentation and bridging of rotator cuff defects < 1cm.

- The portions of this presentation that describe the use of AHDM to bridge defects > 1cm are off label. If a surgeon chooses to use AHDM in this manner the patients should be informed of the FDA status.



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Demonstrative Case

- 49 yo Female Animal Control Officer
- 18 month h/o shoulder pain and weakness after pulled by 100 lb dog
- Night pain and ongoing weakness
- Failed 24 sessions of PT
- Cortisone injection x 2, last 6 mo. ago



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Demonstrative Case

- 49 yo Female Animal Control Officer
- Out of Work—used all modified duty available to her
- “Wants to go back to work”Actually!

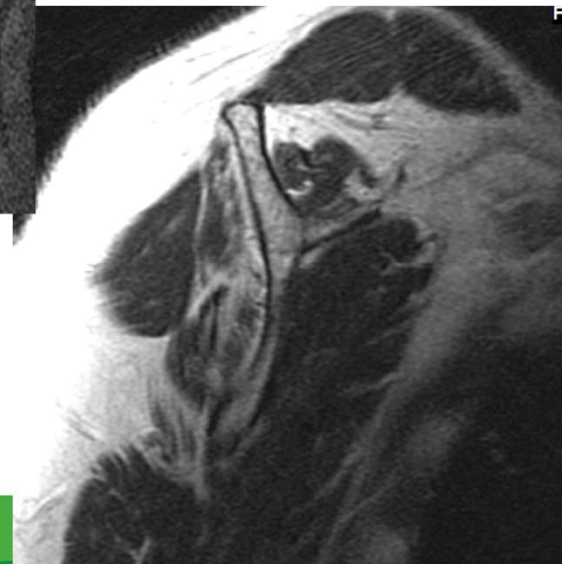


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Demonstrative Case



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What Can We Do at This Point?

- Debride the cuff, partial repair and tenodesis?
- Interval Slides-we will get it repaired?
- Add a Balloon
- DMA interposition?
- Superior Capsular Reconstruction?

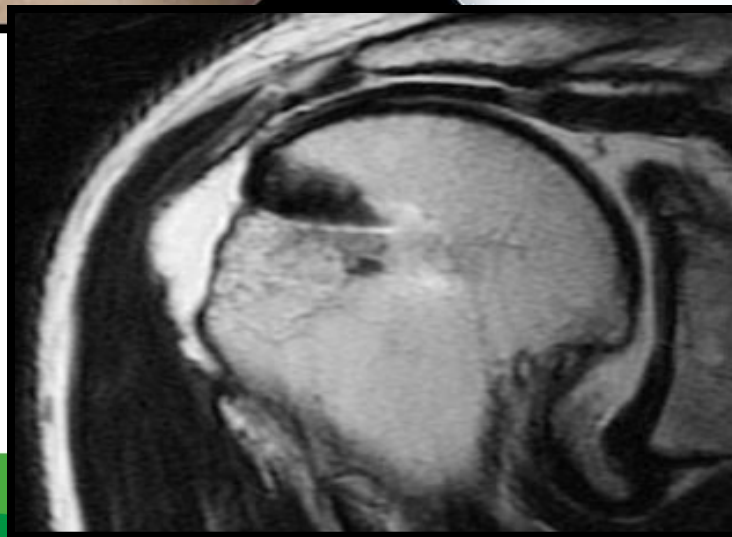
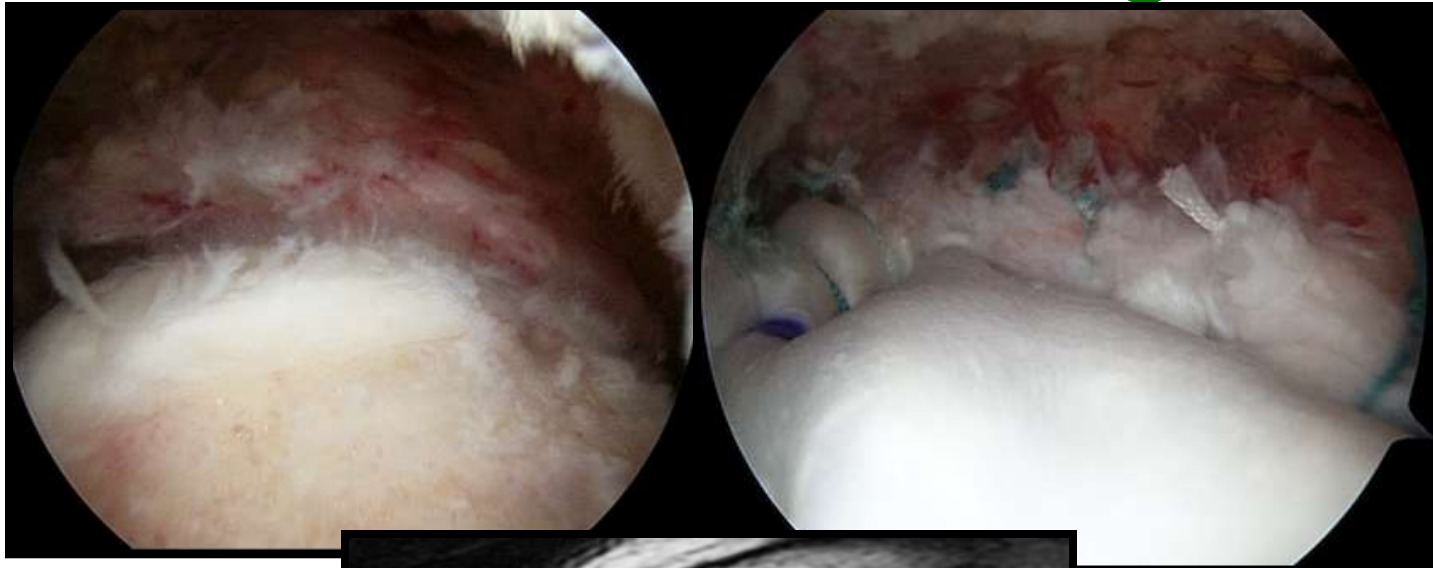


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Our Choice: Human Dermal Matrix Allograft



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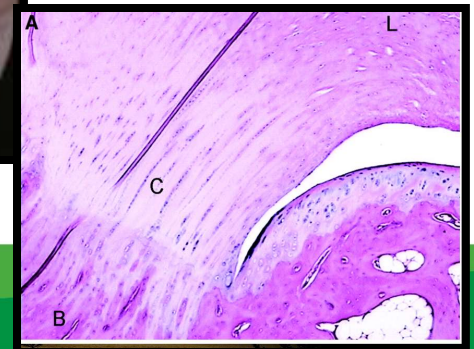
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Allografts have a well accepted, safe and successful history in orthopedics!



- ACL Tears...



The Real Question in My Mind

- How do we best employ the graft:

Bridging vs. SCR



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Systematic Review

Bridging!

Graft Utilization in the Bridging Reconstruction of Irreparable Rotator Cuff Tears: A Systematic Review

Matthew R. Lewington, MD, FRCS(C), Devin P. Ferguson, MD, T. Duncan Smith, MD, Robert Burks, MD, Catherine Coady, MD, FRCS(C), Ivan Ho-Bun Wong, MACMMA, MD, FRCS(C), Dip Sports Medicine† [Show less](#)

Conclusion:

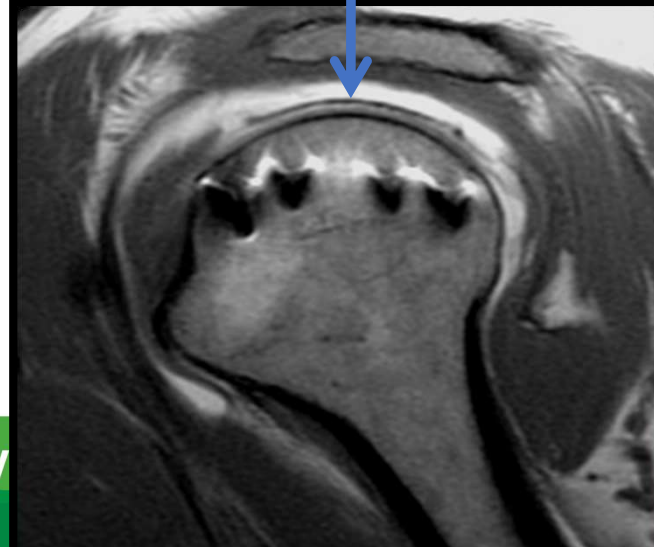
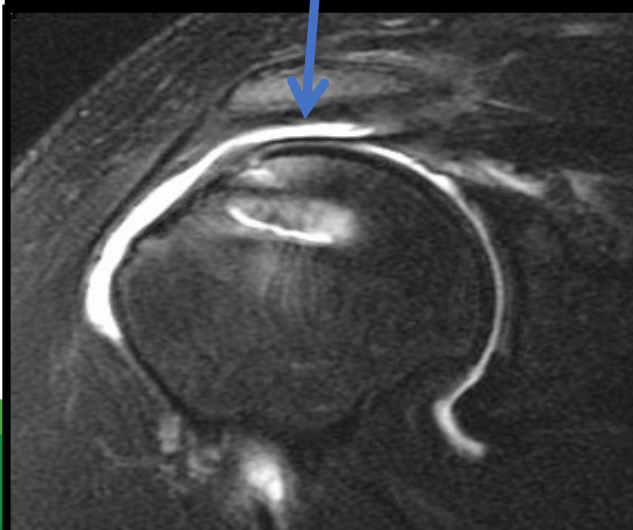
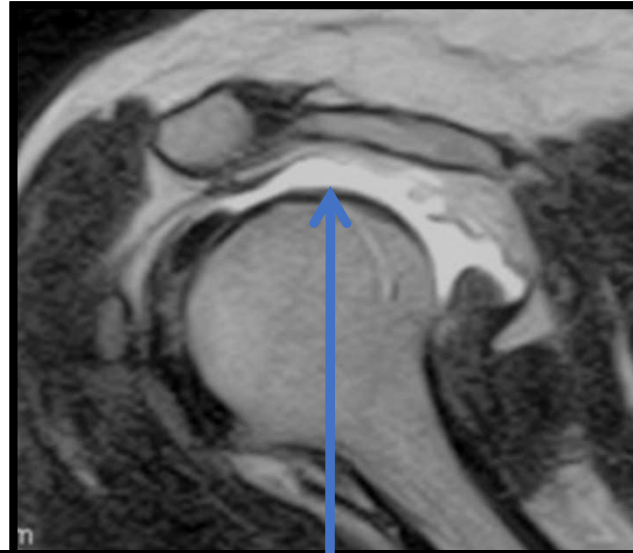
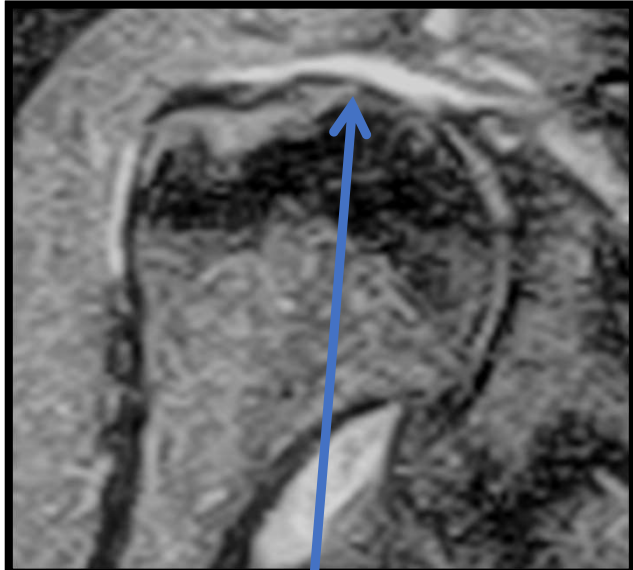
Using a graft for an anatomic bridging rotator cuff repair results in improved function on objective testing and may be functionally better than nonanatomic or partial repair of large to massive rotator cuff tears. Allograft or xenograft techniques appear to be favorable options, given demonstrated functional improvement, imaging-supported graft survival, and lack of harvest complication risk. More high-quality randomized controlled studies are needed to further assess this technique.

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SCOI Experience with Bridging In Massive Non-Repairable Cuff Tears



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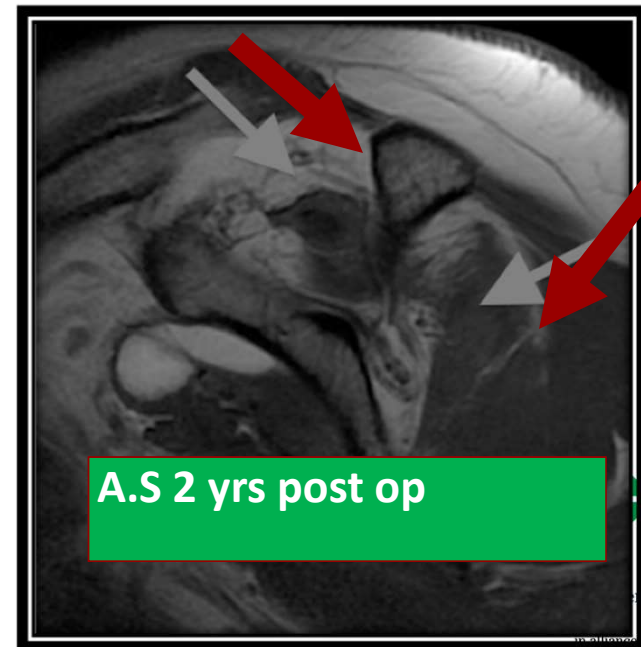
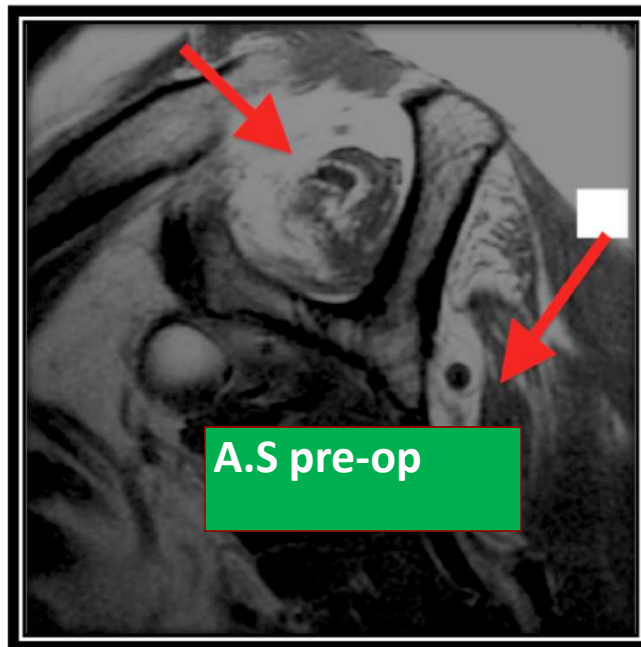
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Why does the DMA rotator cuff replacement work?

Perhaps

Connecting any remaining viable supraspinatus and infraspinatus muscle fibers back to the humerus- may salvage them and prevent more atrophy



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There has been a shift though toward SCR

SCOI (Snyder, Burns, Getelman) has the world's largest experience on interposition
Dating back to 1994---approaching 1200 cases!

Felt to be challenging and remains Off Label

Since the advent of SCR there have been over 20,000...in the last 5 years!



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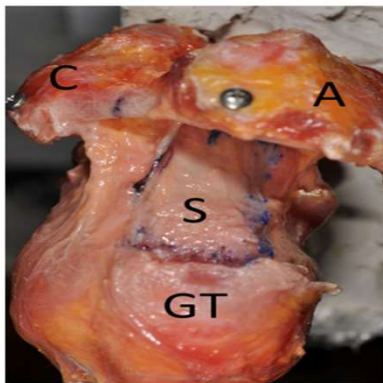
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Superior Capsular Reconstruction:

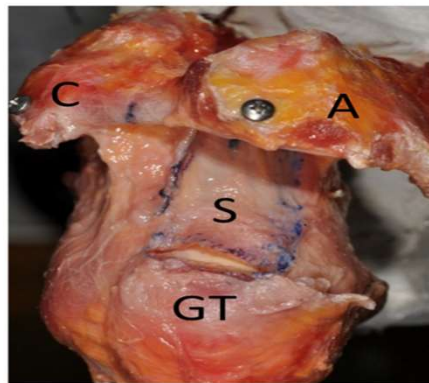
The Shoulder Capsule an important static stabilizer of the joint, esp anteriorly.

With posterior superior RC tears the Superior Capsule can be damaged as well

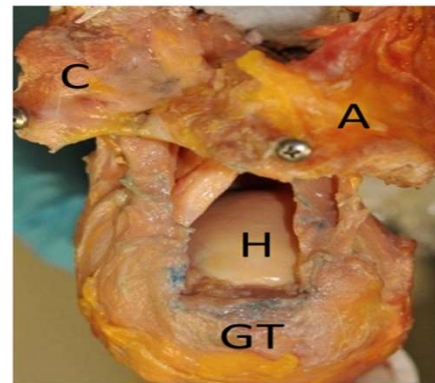
There is increased superior translation with SC defects Biomechanically



Intact superior capsule



Superior capsule tear



Superior capsule defect



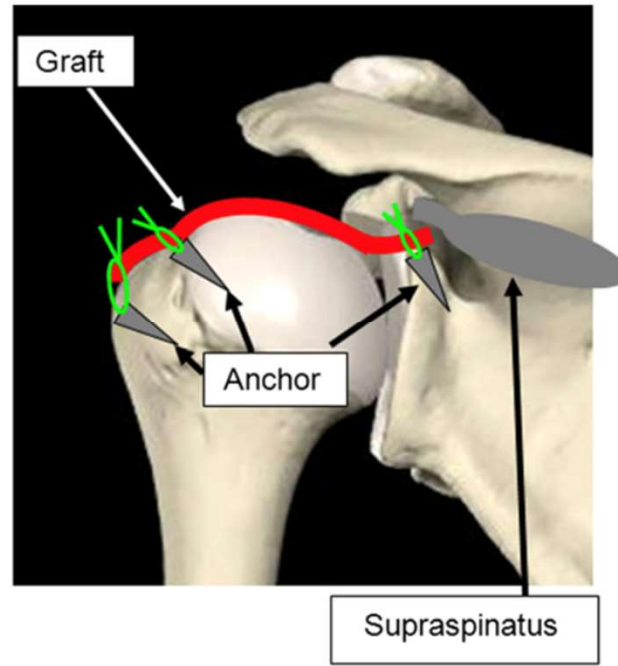
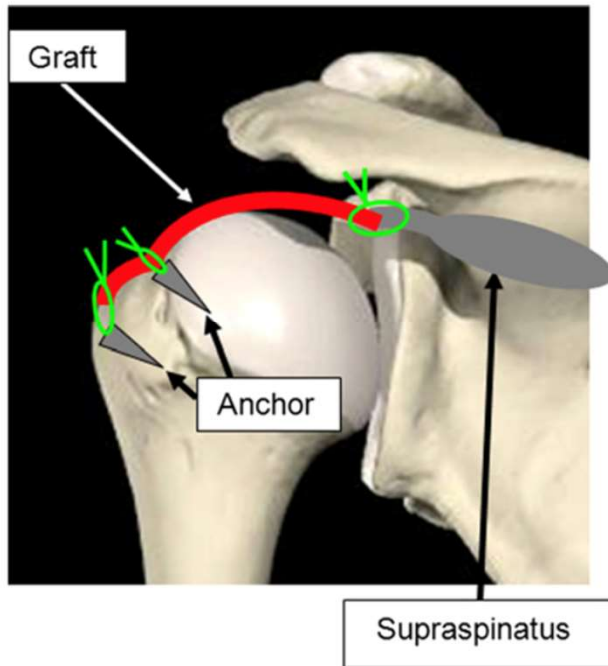
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Superior Capsular Reconstruction Mihata

Clinical Results of Arthroscopic Superior Capsule Reconstruction for Irreparable Rotator Cuff Tears

Teruhisa Mihata, M.D., Ph.D., Thay Q. Lee, Ph.D., Chisato Watanabe, M.D., Ph.D.,
Kunimoto Fukunishi, M.D., Mutsumi Ohue, M.D., Tomoyuki Tsujimura, M.D.,
and Mitsuo Kinoshita, M.D., Ph.D.



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Superior Capsular Reconstruction: Mihata

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June 2016 Volume 25, Issue 6, Pages e188–e190

[Next Article >](#)

Arthroscopic superior capsule reconstruction for irreparable rotator cuff tears: a prospective clinical study in 100 consecutive patients with 1 to 8 years of follow-up

[Teruhisa Mihata](#), MD, PhD, [Thay Q. Lee](#), PhD, [Yasuo Itami](#), MD, [Yukitaka Fujisawa](#), MD, PhD, [Mutsumi Ohue](#), MD, [Masashi Neo](#), MD, PhD

Department of Orthopedic Surgery, Osaka Medical College, Japan

Orthopedic Biomechanics Laboratory, VA Long Beach Healthcare System and UC, Irvine, Irvine, California, USA

Time and EBM will tell if the U.S. technique with Dermal Matrix Allograft will mimic the Mihata results for SCR!



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Superior Capsular Reconstruction: Mihata

Collagen Graft with Fascia Lata

4mm graft

8 mm graft

4mm graft-decreases SA contact but not distance

8mm graft- decreases SA contact and Sup Translation

Mihata prefers the Autograft FL Graft and
besides...Allograft use is NOT allowed in Japan

US Equivalent: Acellular Dermal Matrix Allograft: 3mm?



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Which repair is best?

SCR



Bridge



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How do I decide to best use the DMA

If there is good quality RC tissue to sew to:

- I do an interposition and hope to get some dynamic cuff control and function

If the native RC is medial to the glenoid or poor quality:

- I do SCR and then augment anterior and posterior cuff to graft tissue...try and use the LHB to get thicker graft
- The 3mm issue is concerning...Fascia Lata Autograft as done by Mihata may prove to be a better long-term option for SCR...but is it better than interposition

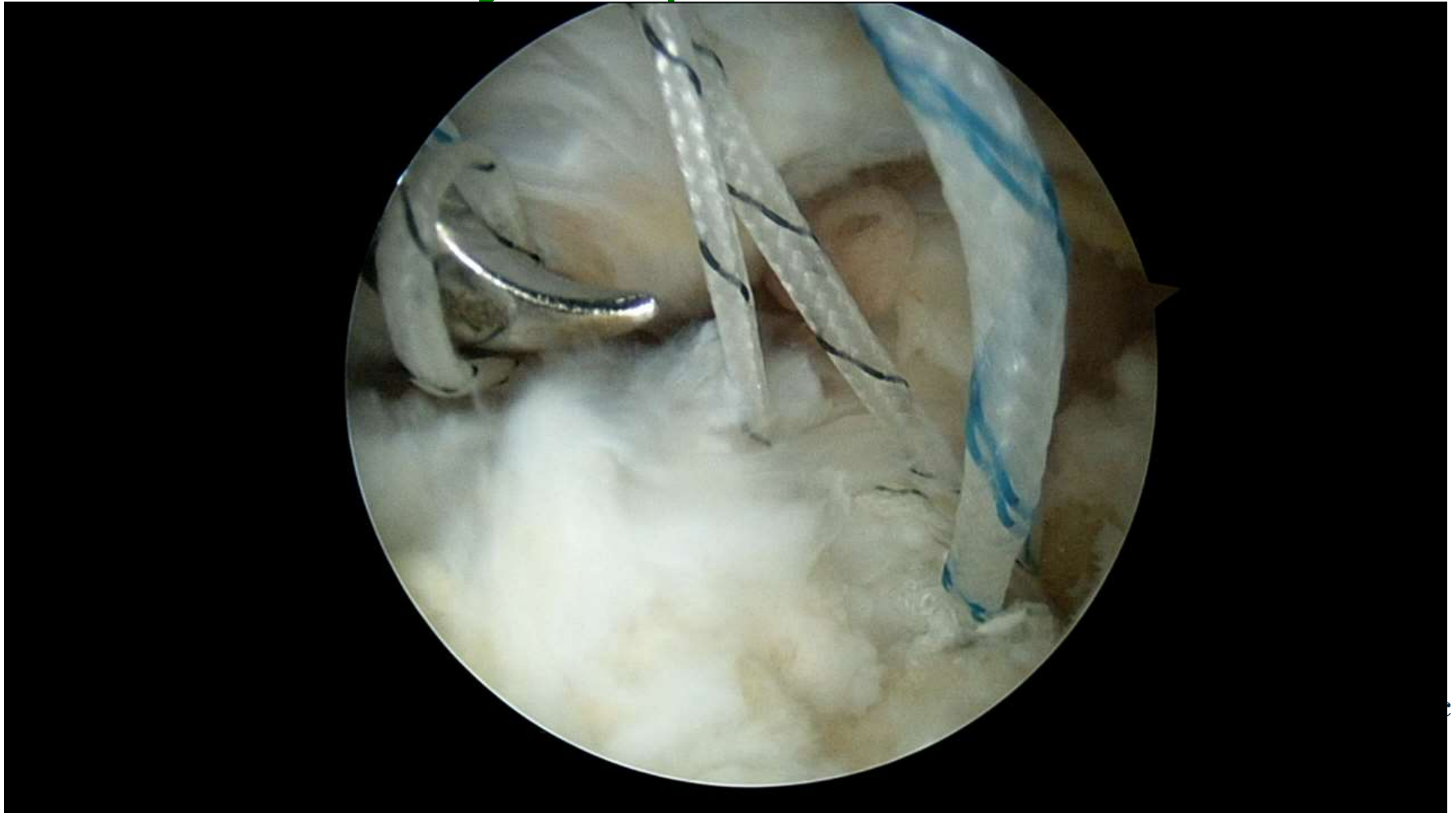


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Safe "Easy" Option



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Post-op X Rays



The FDA and Coding:

- Using Acellular Dermal Matrix Allograft may be our best option
- Off Label for bridging greater than 1cm defect and ON LABEL for Augmentation...But it is still only a RCR-Code 22 Modifier
- On Label for Capsuloraphy & there is a CPT code!



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For Massive RCT...

- Hard to Believe that this is not Better...

Thank You!



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Than this...



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Literature Background

<i>Authors</i>	<i>Re-tear (%)</i>
Liu 1994	70%
Galatz 2004	94%
Boileau 2005	29%
Bishop 2006	47%
Lichtenberg 2006	24%
Cole 2007	22%
Charousset 2007	35%
Ko 2009	21%
Shane 2009	36%

Failed Rotator Cuff Repair!



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