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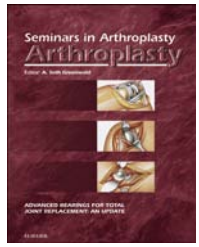

What would you do? Challenges in shoulder surgery

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ABSTRACT

Dr. Evan Flatow moderates a panel of experts and discusses complex shoulder arthroplasty cases dealing with bone loss, malunions, arthroplasty revision, implant failure, and more. Panel includes Dr. Jon P. Warner, Dr. Gerald Williams, Dr. William Levine, Dr. William Seitz, and Dr. Evan Lederman.

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Dr. Flatow: So now that we have learned all these brilliant lessons from this esteemed faculty, we should never make any mistakes again. But one of the problems of being in practice as long as I have is that you can't escape your mistakes. You operate, they come back, you think you've solved the problem, and they keep showing up. You will see a few of them here that showed up 5, 10, and 15 years later asking you "What's going on here, Doctor?"

1. Case 1

Dr. Flatow: This is a 76-year-old woman with bilateral shoulder pain and loss of motion with classic osteoarthritis (Figs. 1 and 2). Both shoulders are equally symptomatic. The question of timing seems to come up a lot in my practice: right versus left and how to space them. Let's start with you, Dr. Warner; what do you tell patients about bilateral shoulder arthritis? Is it evidence based, or is it based on your preferences?

Dr. Warner: I'm unfamiliar with what evidence you would use here, but it's a discussion with the patient about which is most symptomatic and which they can manage best with, but of course we won't do them at the same time. Gerber, I think, is the only one who inflicts that on the poor, unsuspecting Swiss population.

Dr. Flatow: Does he do that routinely?

Dr. Warner: I don't know about routinely, but he's done it before. And so I'll do one, and then the other I'll stage usually around four months later.

Dr. Flatow: Dr. Lederman?

Dr. Lederman: I don't do bilateral. I think that's unfair to the family.

Dr. Flatow: It can be pretty dramatic. I've been forced to operate on a few bilateral shoulder traumas and it's hard: they can't eat, they can't get dressed, and IV placement is difficult.

Dr. Lederman: I've done bilateral distal biceps and bilateral radiuses, and those patients were very unhappy. So, all things being equal, I would do the dominant arm first because I think they'll rehab a little bit quicker, and then the timing would be about 3 months or when they're comfortable with their daily activities of personal hygiene.

Dr. Flatow: Dr. Levine?

Dr. Levine: Whichever is the most painful one is the one I usually tell them to do first because you never know what's going to happen postoperatively. Then, for those that really want staged, three months is the earliest that I do it because by that point they're usually pretty functional after the first one.

Dr. Flatow: Dr. Williams?

Dr. Williams: I do pretty much the same. There are people who will ask to have both done at the same time, and I just tell them then you're really going to find out who your very close friends are.

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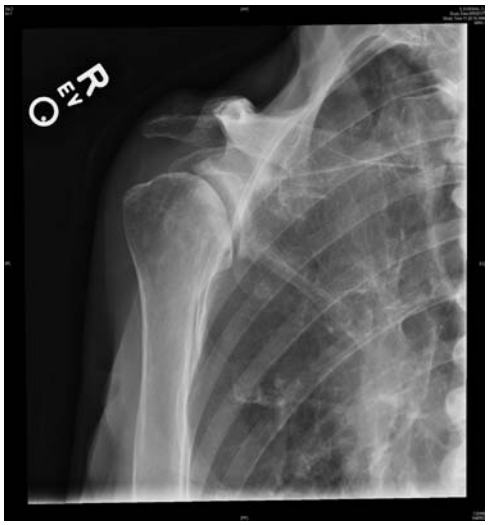

Figure 1 – Right shoulder AP view showing severe glenohumeral arthritis.

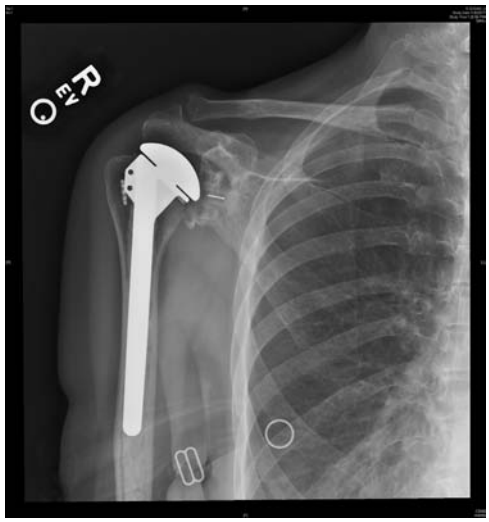

Figure 3 – Right shoulder Grashey view following anatomic shoulder replacement.

Dr. Flatow: You know, I tried doing this as quickly as four days apart and 2 weeks apart. It wasn't a real study, but I did it, and I came to the same conclusion that you guys just picked right out of your head, that three months makes the most sense. It's very hard to do it sooner than that.

Dr. Williams: However, sometimes if you get one arm working really well they can live with the other one a lot longer.

Dr. Flatow: Well, I've found when I tried to schedule them, that about half the people wanted it immediately because they can't believe they waited that long, but the other half, now that they have one good arm, the other one hurts less because they have a good arm to do things. Those patients will say, you know, it's great, I don't want to go through that again, and they cancel, so I had all these holes in my schedule when I scheduled people bilaterally. So, now I just schedule the one that hurts the most, or the dominant one if the pain is roughly equal, and then we see how they do.

So, here are the postoperative radiographs—we did her surgeries about three months apart, and she did very well, although I think her subscapularis didn't work well on the right. This is the 5-year follow-up (Figs. 3 and 4).

2. Case 2

Dr. Flatow: This is a 38-year-old, right-hand dominant police cadet whose original diagnosis was recurrent dislocation. He had four prior operations, with two being open. Now he presented with pain and stiffness, had an abnormal belly

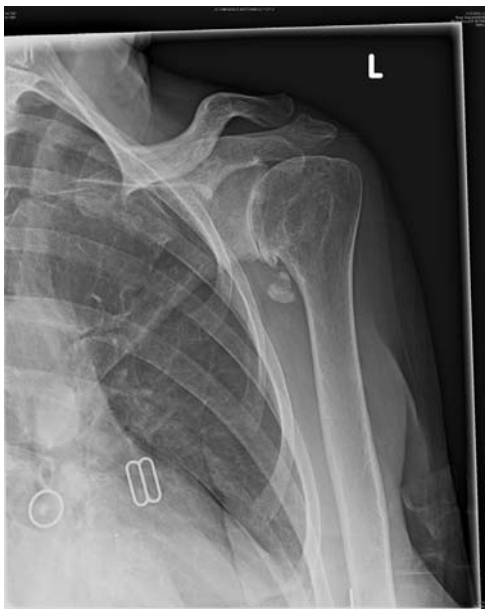

Figure 2 – Left shoulder AP view showing severe glenohumeral arthritis.

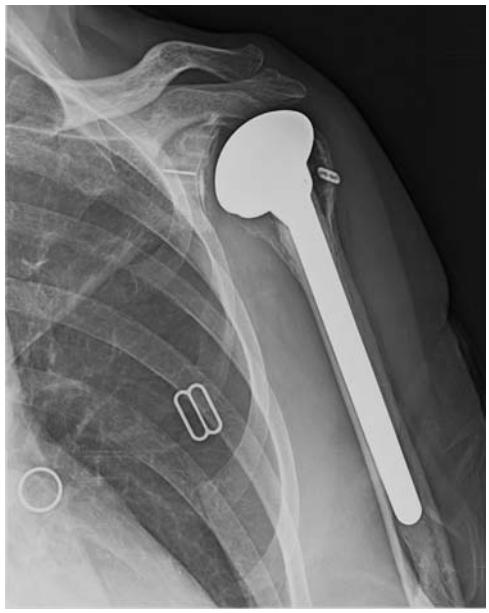

Figure 4 – Right shoulder Grashey view following anatomic shoulder replacement.

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