



Inside AANA

ARTHROSCOPY ASSOCIATION OF NORTH AMERICA

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for upcoming events.

Fall AANA Arthroscopy Techniques Symposium

By Michael E. Pollack, MD

This year's fall AANA meeting, true to its mission on the cutting edge of arthroscopy, featured a compelling new symposium. Drs. Brian Cole, Rick Ryu, and John "JT" Tokish presented their innovative techniques from AANA's online video journal, *Arthroscopy Techniques*. (Arthroscopy Techniques is the first open access, peer-reviewed, Pubmed-indexed video journal and can be found at www.ArthroscopyTechniques.org).

The session, moderated by Martin Leland, MD and the presenters, grilled by a relentless and good-natured panel of Drs. Jack Bert, Alan Curtis, and Bob Burks, introduced three promising new concepts.

Dr. Cole presented a case of Lateral Tibial Plateau Osteochondritis Dissecans treated with a subchondral injection of calcium phosphate into the area of subchondral edema. He framed the discussion by explaining the challenging nature of these lesions and that treatment depends on both the status of the articular cartilage and underlying subchondral bone. Preoperative MRI is used to localize the area of subchondral edema and intraoperative fluoroscopy is used to verify this location with the injection cannula. This technique, otherwise known as subchondroplasty, may have a role in unipolar, symptomatic subchondral lesions. While bloodied by the panel, Dr. Cole stood his ground and made the case for this intriguing new technology.

[http://www.arthroscopytechniques.org/article/S2212-6287\(13\)00038-8/fulltext](http://www.arthroscopytechniques.org/article/S2212-6287(13)00038-8/fulltext)

Dr. Ryu introduced the novel use of an arthroscopically-implanted bio-inductive collagen scaffold for treatment of articular-sided partial rotator cuff tears. He emphasized that articular-sided partial rotator cuff tears remain a challenge with many suboptimal treatment options. Remarkably, with this innovative technique, the implant is placed on the

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Message from the President

Jeffrey Abrams, MD

First, a happy and healthy New Year as we enter into 2016. We have many exciting events scheduled for 2016, so you will definitely want to make your travel plans early.

AANA Specialty Day on March 5, 2016 in Orlando, Florida was the highlight of the AAOS Annual Meeting. Dr. J. T. Tokish and the Education Committee organized a full day of innovative and controversial topics presented by leaders in the field of arthroscopic surgery. Sessions highlighted key issues that define success in shoulder instability, overhead throwing athletes, rotator cuff, knee reconstruction, and hip arthroscopy. The afternoon included a number of clinical case panels, utilizing international experts who emphasized similarities and different options to manage complex injuries.

This year's Annual Meeting will be held in Boston, Massachusetts on April 14-16, 2016 at the Hynes Convention Center. The AANA Program Chair, J. T. Tokish, has organized an exciting event with emphasis on innovation, surgical state-of-the-art education, and interactive learning with clinical case panels. Our featured nation is Canada, and visiting lecturers will be highlighted on cutting-edge topics that will impact the treatment of your patients back home. We will also have an opportunity to hear David Epstein, author of "The Sports Gene." In his thought-provoking talk, Dr. Epstein will share his views on what makes an individual a great athlete in today's arena. Boston is a special location this time of year, as spring and warmer weather return. The city will be having its Patriots' Week following our event, which includes the Boston Marathon on Monday.

A combined Biennial Meeting with ASES is scheduled for the early fall. This landmark event in Chicago will include spotlight surgical demonstrations and surgical skills with cadavers. The program will include lectures that combine the arthroscopy of the shoulder and elbow with arthroplasty and trauma. A Spanish-speaking program at the Orthopaedic Learning Center will follow with invitations being extended to surgeons in South and Latin America.

The unique AANA/SOMOS collaboration program continues to expand. The two-day, intensive shoulder course is designed to provide cutting edge, hands-on experience with the latest arthroscopic surgical techniques and treatment algorithms to military surgeons from around the country. AANA is exploring options to secure funding to expand the number of courses hosted annually at the Orthopaedic Learning Center.

AANA continues to be a leader in the way of educational resources. Our new five-textbook series on arthroscopic surgery launched in late 2015 under the leadership of Rick Ryu and myself. Book editors include experts in the fields of knee, shoulder, hip, ankle, foot, and elbow and wrist. The textbooks have been organized into individual volumes that present a complete collection of the current procedures for each joint. In addition, each textbook includes up-to-date references and illustrative video. The design of the chapters emphasizes specifics of patient selection, history and physical features, checklists for procedures, and anticipated postoperative management. These textbooks can be purchased individually for \$99.95 or together as a collection.

The Journal of Arthroscopy has been an important cornerstone to our organization, and its contents are disseminated all over the world. A new addition, "ATech" or "Arthroscopy Techniques" has been developed to create an innovative internet experience to showcase new operative procedures and instrumentation. This peer-reviewed internet publication presents indications, surgical techniques, and specific skills to minimize risks of failure or complications. Computer-based surgical videos are incorporated into the articles allowing surgeons the ability to view and reference procedures and techniques as needed while preparing for surgery.

AANA continues to advocate on health policy and health economic issues that affect you and your practice. We are currently representing arthroscopic surgeons as insurance and government oversight is challenged with bundled reimbursement, which would reduce payment for multiple procedures

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Surgical Outcomes System (SOS): An Extraordinary Member Benefit

By John Kelly, MD

AANA provides countless benefits to its members. **SOS is an extraordinary value-added service and member benefit.** Members are now uniquely privileged to receive, *free of charge*, enrollment into a simple and effective outcomes assessment instrument. This global registry, valued at \$1,800 per year, will enable surgeons to collect and analyze patient outcomes and procedures remotely through electronically-administered questionnaires and surveys.

In this day and age of increasing scrutiny by payors and government agencies, the timing of SOS could not have been better. This user-friendly platform will enable AANA members to demonstrate the **value** of their care to their patients and payors. AANA leadership is working on their behalf to allow this outcomes platform to fulfill regulatory quality improvement requirements that will be part of the Merit-Based Incentive Payment System (MIPS) in the near future. Current performance measures in the Physician Quality Reporting System (PQRS) are woefully inadequate in capturing the value of orthopedic

interventions. The goal is to have the outcomes collection process blend seamlessly with meaningful performance measure reporting for orthopedic surgeons. **Since a significant penalty will be applied to those who do not collect this information**, it is essential that this type of data collection be available to AANA members and all orthopedic surgeons.

Patients can enter data at their initial office encounter or at home through the SOS website. SOS is HIPAA compliant and the data is secure. There are two levels of participation; Core and Research. **The Core is designed for the practicing orthopedic surgeon and does not require IRB approval or patient consent.** The Research module is more robust regarding outcomes metrics and does require consent and IRB approval.

SOS automatically emails follow-up surveys at designated time points. Surgeon portals enable secure entry of surgical findings and annotation of complications. This unique program notifies the surgeon which data points are missing so that superior follow-up is ensured. In

addition to general quality measures, specific validated outcomes instruments, such as the ASES Shoulder Score, are employed. The outcomes metrics included are all validated and have been vetted by AANA and ASES.

An especially unique feature is the **ability for each orthopedic surgeon to compare the outcome of each patient to that particular surgeon's own personal normative data.** In addition, **each surgeon can anonymously compare their outcomes to averages of the de-identified data presented by other participating surgeons from AANA.**

SOS affords an invaluable opportunity to improve outcomes and quality of care! The experience of SOS users thus far has been extremely positive. Patients feel more engaged in their care and ongoing improvements in the service and software have been a natural by-product.

Visit www.aana.org to inquire about joining SOS. Learn more about what you can do better and bring your "A" game to each patient!

Message from the President

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(i.e. treatment of both articular and outside of the capsule) performed at the same time. Since many of our procedures are reimbursed using multiple codes, a bundled payment approach could jeopardize this accepted practice. It takes organizational push-back to present the case of the community physician, and AANA has been a leader on this front.

The CMS is expected to institute a patient response requirement to outcomes in the next two years. All

surgeons will be required to adhere to the requirement or they could be penalized. AANA has explored and will continue to explore ways to collect and retrieve patient outcome data in an effort to insure AANA members are able to satisfy the meaningful use requirements. AANA will continue to work with Surgical Outcome Systems, AAOS, and CMS to provide viable options to our members.

Orthopedic Surgeons Bring Medical Care to the Developing World

By Michael E. Pollack, MD

Seven years ago, Dr. Joseph Marotta, an orthopedic surgeon from upstate New York, became inspired to share his medical knowledge and skills with the people of Africa. With the help and guidance of many others, he founded the organization, Medicus Christi, Ltd.(MC). This non-profit organization, with the assistance of our colleagues in AAOS, ISAKOS, OTA, AAHKS, and POSNA and friends at Stryker, Arthrex, and Smith and Nephew, has assembled highly skilled and fully-equipped medical teams that provide immediate care and training programs for permanent medical providers at locations in need.

MC's first area for service is in the country of Ghana, West Africa. In the village of Berekum, Medicus Christi and its partner the "Giving to Ghana" organization is developing an Orthopedic and Rehabilitation Hospital along with an on-site Orthopedic Learning Center. Groundbreaking is set for next year. The project entity will be known as the Franciscan Orthopedic and Rehabilitation Center (FORCE) of Holy Family Hospital with the West African Learning Center(WALC) for Orthopedic Surgery, a new facility in the well-established network of faith-based hospitals and outreach clinics of West Africa.

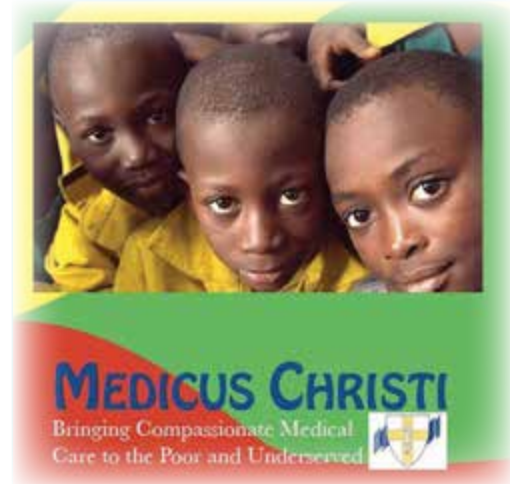
Dr. Marotta, Executive Director of Medicus Christi stated, "The FORCE/WALC projects are unique; we are moving beyond a goal of pure charitable intervention for the needy people of our world. We hope to provide the means for citizens of underserved regions to create their own healthcare initiatives autonomously and for the long term."

Stages of the FORCE/WALC project will include an outpatient clinic and rehabilitation facility, an orthopedic trauma emergency ward, an inpatient hospital along with operating room facilities and an educational facility with laboratory, library, classrooms and computer/internet access for web-based telemedicine instruction and teaching capabilities.

Many regions, such as the Brong-Ahafo Region where the FORCE/WALC will be located, have a severe lack of access to physicians. There are no orthopedic surgeons at all in the Brong-Ahafo Region.

An article by a former orthopedic surgeon at the Ghana Medical School noted that between 1974 and 1997 only four orthopedic surgeons (OS) had been trained in his country. Recent fact-finding trips by MC to Ghana identified only 12 orthopedic surgeons in the entire country whose population is close to 25,000,000 people.

The American Academy of Orthopedic Surgery (AAOS) and the Orthopedic Trauma Association (OTA) among others have donated their time and efforts to bring



temporary improvements in orthopedic care to Ghana. "As important and helpful as these trips have been, their impact on the long-term health of the Ghanaians has been limited," Dr. Marotta commented.

He continued, "We hope to dramatically overhaul the delivery of medical care in Ghana, starting with orthopedic surgery. By bringing modern equipment and experienced teaching volunteers to this underserved area, we can increase the level of access to bone and joint care fairly quickly and then establish a teaching program to train local physicians to be the orthopedic specialists for Africa's future."

It is anticipated that 250,000 Ghanaians will utilize the FORCE facility in the first few years along with 5,000 wealthier patients who will now choose to come to Ghana from surrounding countries and be treated regionally rather than traveling to the West as they currently do. One hundred physicians and surgeons will receive additional quality medical training and will be encouraged to set up practices in local communities.

"By using the lessons learned through this initial project, and by tracking outcomes, Medicus Christi hopes this will serve as a model for future endeavors," stated Dr. Marotta.

"Through our form of medical diplomacy, the people of the regions we serve benefit greatly," said Dr. Marotta. "Volunteers working overseas gain a wonderful and uplifting experience of a lifetime. Most of all, our troubled world and its divergent peoples come a little bit closer together through cooperation, mutual trust, and understanding."

Visit medicuschristi.org to learn more.

To get involved or contribute, please contact Dr. Marotta at joem1515@aol.com.



Point-Counterpoint

Massive Rotator Cuff Tears without Arthritis: Superior Capsular Reconstruction (SCR) vs. Reverse Total Shoulder Arthroplasty (rTSA)

By Casey Taber, MD

Abraham Lincoln once said, “Be sure you put your feet in the right place, then stand firm.” Considering all options and developing a plan applies equally to today’s orthopedic surgeon. Once the decision is made as to how to fix the problem, the surgeon must be focused with their treatment plan; choosing the correct procedure is just as important as performing a procedure well. Often the more complex issue is trying to decide which treatment option suits the individual patient best. Patient outcomes and satisfaction are often a direct result of choosing the most appropriate procedure.

Massive rotator cuff tears without associated arthritis confront orthopedic surgeons with challenging decisions. There are certainly “straightforward cases” where most surgeons would agree on the best treatment plan. Most of our colleagues would agree that a 50 year-old male with a non-arthritic shoulder and an acute traumatic massive rotator cuff tear should be treated with a rotator cuff repair and that a 75 year-old female with a chronic rotator cuff arthropathy secondary to a massive rotator cuff tear would be a likely candidate for a reverse total shoulder arthroplasty (rTSA).

The more challenging situations are the “tweeners.” Surgeons still debate the best treatment option for a massive retracted rotator cuff tear in a non-

arthritic patient. Some surgeons will advocate a simple debridement and partial repair of the torn and retracted tendons. Others may recommend tendon transfers.

Due to emerging techniques, improved surgical skill, and a better understanding of the shoulder’s biokinetics, two techniques in particular have gained recent popularity. The rTSA has become a more popular option in the last 8-10 years and several studies have shown good midterm results. Alternatively, superior capsular reconstruction (SCR) has also shown promise and very good results at this early stage.

To understand which of these treatment options is best suited for our patients, two brilliant and talented surgeons were gracious enough to share their expertise. Dr. Mark Frankle has probably done as many rTSA as anyone in the business and has been a proponent of the rTSA in the right situations for many years. He and his fellow, Dr. Jesse Allert, will help us shed light on this issue. But first, Dr. Steve Burkhart, a true innovator in shoulder arthroscopy, will offer a few words on his experience with arthroscopic SCR and his belief that this is often the best initial treatment for this complex pathology.

I would like to thank Drs. Burkhart and Frankle, pioneers in the field of orthopedics, for taking the time to share their experiences and expertise.

Massive Rotator Cuff Tears: Arthroscopic Repair is Indicated

By Stephen S. Burkhart, MD

To me, it is deeply disturbing to see so many surgeons performing reverse total shoulder replacement (rTSR) in active patients without glenohumeral arthritis because these patients allegedly have “irreparable” rotator cuff tears.

But what is an irreparable cuff tear? Some authors base their decisions about reparability on imaging findings alone (e.g. fatty infiltration > 50%; acromiohumeral interval < 5 mm; etc.). **However, I have found that almost all rotator cuff tears, even massive retracted tears, are completely reparable by using advanced mobilization and fixation techniques.** A review of my

surgical practice over the 11-year period since 2004 revealed that 96% of cuff tears were fully reparable and only 4% were irreparable; and for the irreparable tears, partial repair usually resulted in significant improvement.

Even in patients with pseudoparalysis, 90% of those that had not had a previous attempt at repair regained overhead motion and maintained it at six-year average follow-up (Denard, Jiwani, Burkhart, *Arthroscopy* 2012). Even so, it is important to note that patients who had pseudoparalysis after previous failed cuff repair had a relatively low rate (40%) of restoration of overhead motion with a second repair. Therefore, persistent



pseudoparalysis after failed cuff repair, especially in a low-demand elderly individual, may be the best indication for rTSR.

However, for almost everyone else with a massive cuff tear, I perform a repair. Depending on the patient and the tear characteristics, my repair may be either a complete arthroscopic repair; a partial repair; or a partial repair combined with a superior capsular reconstruction (SCR) with dermal allograft. **My early experience with SCR in 30 patients has been very gratifying, with significant increase in functional scores; decrease in pain; and increase in the acromiohumeral interval associated with reversal of proximal migration. Even so, I must offer the caveat that my longest follow-up after SCR is only 14 months and I hesitate to give an unqualified endorsement of this procedure until I have longer follow-up.**

Surgeons who advocate rTSR for massive cuff tears in older, sedentary individuals typically point out that the major advantage of rTSR is the fact that the properly chosen patient will return to full activities much sooner than a patient who had an arthroscopic cuff repair. But let's examine what "much sooner" actually means. In comparing my post-op protocols for arthroscopic repair of massive cuff tears to the standard protocols following rTSR, the **rTSR patients are allowed to return to a moderate level of activity about six weeks earlier than cuff repair patients. So the upside of rTSR is a return of functional activity levels that may be as much as six weeks earlier than those after cuff repair. But what is the potential downside of rTSR? And does that potential gain of six weeks justify the significantly higher rate and magnitude of complications of rTSR in comparison to arthroscopic cuff repair?**

The biggest downside of rTSR is the high rate of complications, particularly in younger patients. **In fact, Gerber et al. reported that, in patients less than 65 years of age who had rTSR for an irreparable cuff tear, there was a 38% incidence of one or more complications** (JSES 2013). The most feared

complication, infection, occurs in 4% of rTSR patients (Zumstein et al. JSES 2011), whereas the infection rate for shoulder arthroscopy has been reported to be 1 in 15,000 (ISAKOS Complications Registry, 2001).

Clearly, arthroscopic cuff repair has a much lower incidence of infection than rTSR. But the rate of infection is not **the only issue; the magnitude and the consequences of infection following rTSR are much more serious than after arthroscopic cuff repair.** Specifically, an infected shoulder arthroscopy can usually be treated arthroscopically with the expectation of salvaging a normal glenohumeral joint. **On the other hand, an infected rTSR is a devastating life-changing event which necessitates multiple open surgeries and results in a markedly decreased quality of life.**

And what about the revision possibilities in the event of a failed rTSR? These are challenging at best, and nonexistent in many cases. **On the other hand, a failed cuff repair still has a wide range of revision possibilities, including revision cuff repair, SCR, and even rTSR.**

So why do some surgeons perform rTSR as treatment for the same types of cuff tears for which other surgeons perform arthroscopic repairs? **I believe that it boils down to the fact that, for the average surgeon, rTSR is easier to perform than arthroscopic repair of a massive cuff tear.** Such surgeons may rationalize their approach by asserting that "in their hands" the results are better with rTSR than with arthroscopic repair. But that is a very narrow and selfish viewpoint, because what really matters is what is best for the patient; regardless of whose hands perform the surgery. Being a surgeon carries with it a "burden of craft," an obligation to become proficient at whatever procedure is best for the patient. And if that proficiency is not there, then that surgeon has an obligation to send the patient to a surgeon who has attained that proficiency. **The burden of craft is the surgeon's burden, and it is the most critical part of the contract between patient and surgeon.**

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Point-Counterpoint

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Reverse Total Shoulder Arthroplasty for Massive Cuff Tear

By Mark Frankle, MD and Jesse Allert, MD

The treatment of patients with massive rotator cuff tears (>5cm in AP or medial-lateral or more than 1 tendon) without osteoarthritis remains challenging (*JBJS* 1984, 2000). Options for surgical treatment in patients who have failed conservative management are numerous. They range from debridement to partial or complete arthroscopic or open repairs to reverse total shoulder replacement (rTSA) to arthroscopic superior capsular reconstruction (ASCR) or other grafting procedures (*JSES* 2015).

Superior capsular reconstruction has recently become popularized in part due to several retrospective studies showing successful patient outcomes (*Arthroscopy* 2013). Concurrently, biomechanical studies have illustrated the anatomy and importance of the superior capsule (attaches to 30-61% of the greater tuberosity) and the role it plays in the passive stability of the glenohumeral joint (*JSES* 2012). This treatment is an attractive option in that it is arthroscopic and technically involves a reproducible pattern of reconstruction as opposed to difficulties inherent in direct repair of massive, immobile, atrophic rotator cuff tears. **While the outcome data has created optimism for the application of ASCR in treatment of irreparable rotator cuff tears, the procedure is still in its infancy and has not experienced widespread use due to unfamiliarity with the procedure, limited data, and limited long-term results.**

New surgical treatments are often met with trepidation when first implemented. When rTSA was first suggested for use in treating patients with massive rotator cuff tears without arthritis, this was a subject of great debate. **While the outcomes show reproducible patient satisfaction, it can be a hard “sell” at treating soft tissue, rotator cuff pathology with a “bony procedure.”** Its applications are still debated, but we now know that patients with massive rotator cuff tears without arthritis have high likelihood of a successful outcome. This evidence has been reproducible and reliable in a large number of patients (*JSES* 2015, *JBJS* 2010).

Studies have shown that rTSA can be a great index procedure as well as secondary procedure. **Several papers illustrate that previous arthroscopic**

surgeries, specifically debridement, bicep tenodesis or tenotomy and/or rotator cuff repair, have not correlated directly to decreased patient satisfaction and functional outcome with regards to rTSA (*JBJS* 2010). Although it has not been specifically examined, one can hypothesize that an attempt at arthroscopic superior capsular reconstruction is a reasonable index procedure that can be followed by rTSA as a secondary procedure if ASCR fails. One cannot apply the same rationale in utilizing rTSA as an index procedure. A secondary procedure would most likely involve revision arthroplasty, which has not demonstrated the same functional improvements as seen in the initial arthroplasty.

We recently performed a retrospective study on 74 patients who underwent rTSA for massive rotator cuff tear without arthritis. Age <60 year-old, higher preoperative function as measured by Simple Shoulder Test (SST) >7, and preoperative neurologic dysfunction were associated with poor functional improvement (*JSES* 2015). It is of particular note that while previous studies demonstrated poorer outcomes in patients without pseudoparalysis as defined by >90 degrees forward flexion, this study did not have the same findings (*JBJS* 2010). Rather, assessment in function was better correlated with SST >7 (*JSES* 2015). These patients with good preoperative function, as well as patients <60 years old, may be better suited to undergo an initial attempt at superior capsular reconstruction.

Other patients may not be ideal to undergo a less proven ASCR and may be better served with rTSA. **In the ASCR studies demonstrating significant functional improvement, the subscapularis tear was completely repaired. These same patients also had intact or reparable (at least partially) infraspinatus and teres minor (*Arthroscopy* 2007). The question remains what will happen to patients without restored axial force couple (irreparable subscapularis or infraspinatus/teres minor), or with anterosuperior escape, instead of isolated superior migration. While the ASCR studies did well at increasing acromiohumeral interval, there is a 3-dimensional component involved with massive rotator cuff tears and cuff arthropathy that may not be adequately addressed with isolated superior capsular**



reconstruction. These patients may be prone to early failure and would not benefit from the risks inherent in performing two procedures. Further, two separate procedures may not be a cost-effective way of treating this subset of patients.

We must also consider the process of healing necessary for the ASCR to succeed. Those who are less likely to heal, with either allograft or autograft ASCR, include patients who smoke or have diabetes and may be more prone to early failure. These are the same patients who are more likely to fail after massive rotator cuff repair.

Patients who face difficulty healing in the setting of other comorbidities or risk factors are less able to tolerate two separate procedures and would benefit from rTSA as an index procedure.

ASCR is a new and exciting procedure, and its incorporation into the orthopedic surgeon's armamentarium provides a good option for treating patients with massive rotator cuff tears. This less invasive procedure still allows for rTSA as a salvage procedure and has shown functional outcomes comparable to rotator cuff repair in the setting of a massive rotator cuff tear (*Arthroscopy* 2014). **Risks for poor functional outcome after rTSA have now been established, whereas we do not yet know how to optimize patient selection in order to maximize patient outcomes for patients undergoing ASCR. We have defined preoperative neurologic deficit, SST>7, and age<60 as risk factors for poor outcomes with rTSA (JSES 2015).** Restoring the passive stability of the glenohumeral joint by restoring the superior

capsule would be ideal in these patients after they fail conservative management. In other patients, reverse total shoulder arthroplasty has provided reproducible outcomes including restoring function and decreasing pain in patients. **Currently little evidence is available to suggest success with ASCR in patients with degenerative disease, irreparable subscapularis, infraspinatus, or teres minor tears, with 3-dimensional escape, or in patients with multiple comorbidities who are simultaneously more prone to graft failure and would be less able to tolerate secondary procedures. For these patients, rTSA remains the optimal index procedure for surgical treatment.**

In summary, a patient with pseudoparalysis and previously failed rotator cuff repair may be better suited for rTSA. Patients with higher preoperative function and younger than age 60 appear to be better suited with SCR. I think those that do not fall in one of these categories must be viewed individually. We must also consider the pros and cons of each procedure and also consider your "next procedure." Being a "good pessimist" will often influence your decision-making process. One must always assume the potential for a failed procedure. As mentioned by both Mark and Steve, a failed SCR can frequently be salvaged with rTSA. Conversely, a failed rTSA is not as easily addressed. Certainly we do not perform procedures with the expectation of failure, but these potential issues can arise and must be considered.



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AANA Staff Update

Michael Baffes joined the AANA staff as the Director of Marketing & Member Services on February 16. He comes to us with more than a decade of marketing and association experience; including a seven-year stint in the division of communications & marketing at the American College of Healthcare Executives. Mike holds a Bachelor of Science degree in management and quantitative methods and an MBA in nonprofit administration, both from Illinois State University. Outside of the office, he enjoys woodworking, cooking, and trying to convince his nine-month-old son to sleep.

Becca Daly joined AANA as the Governance Coordinator and Executive Assistant to the Executive Director on February 1. Her background includes several years of experience with the American Society for Surgery of the Hand, with an emphasis in meetings and education. The transition was a natural career progression and she is looking forward to the opportunities AANA has to offer. In her free time, she enjoys watching her favorite Chicago sports teams, spending time with family, traveling, and finding new Netflix shows to get hooked on.

Kassie Mueller joined the AANA staff as the Education Coordinator on January 4. She is a recent college graduate from Northern Illinois University, where she earned her Bachelor of Science degree with an emphasis in Hospitality Management with a minor in Marketing. Kassie is looking forward to her future with AANA and pursuing her passion. Her favorite pastimes are to watch a good Netflix show, exercise, and teach dance classes.

Fall AANA Arthroscopy Techniques Symposium

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bursal surface of the tendon and can stimulate a robust full thickness healing response. This straightforward arthroscopic procedure may provide a less-technically demanding option for vexing partial thickness articular-sided tears.

[http://www.arthroscopytechniques.org/article/S2212-6287\(15\)00077-8/fulltext](http://www.arthroscopytechniques.org/article/S2212-6287(15)00077-8/fulltext)

In the final presentation on emerging techniques, Dr. Tokish discussed the hot topic of superior capsular reconstruction. He explained how this all-arthroscopic technique, utilizing an acellular dermal allograft to reconstruct the superior capsule, has the potential

to restore and rebalance force couples necessary for dynamic shoulder function. This technique provides a far less invasive option than reverse shoulder replacement for our patients with chronic, massive irreparable rotator cuff tears and “burns no bridges.” Dr. Tokish emphasized that while short term results are promising, long term data is still needed.

[http://www.arthroscopytechniques.org/article/S2212-6287\(15\)00130-9/fulltext](http://www.arthroscopytechniques.org/article/S2212-6287(15)00130-9/fulltext)

The format for the Arthroscopy Techniques Symposium was dynamic, educational, and highly entertaining and will hopefully become a staple of future Fall meetings.

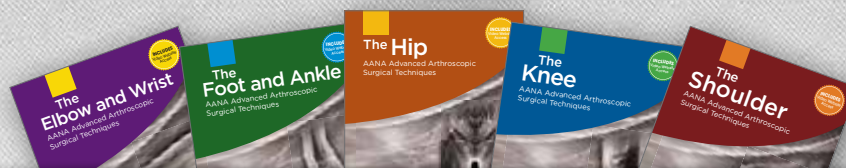
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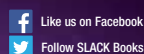
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