

Arthroscopic Technique, More Mini Open in Tendon Transfer with Pectoralis Major in Massive Irreparable Ruptures of Arthroscopic Cuff

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Abstract

Rotator cuff repair is one of the most common surgical tactics performed in the shoulder. Traditionally, restore required an open incision with elimination of a portion of the deltoid from the acromion. In the beyond decade, an arthroscopically assisted “mini-open” technique has gained popularity. This has been facilitated through advances within the use of arthroscopy. This trend toward an extra minimally invasive method has endured as arthroscopic techniques continue to improve and advance. An all-arthroscopic technique has recently been used to carry out rotator cuff repairs. The arthroscopic approach offers numerous advantages, such as smaller incisions, clean get entry to the glenohumeral joint for treatment of intra-articular pathology, less tender tissue dissection, and less ability harm to the deltoid.

Introduction:

An irreparable anterosuperior large rotator cuff tear with an irreparable subscapular is tear is not common. However, as soon as symptomatic, it would become a tough situation. Treatment options depend at the symptoms, affected person age, and presence of glenohumeral osteoarthritis. Tendon switch is a choice and the pectoralis major is a commonly selected graft source.

However, the reported results of pectoralis major transfer are varied.

Technique:

Arthroscopic-assisted pectoralis major switch is indicated if: sufferers had ache with irreparable subscapularis and supraspinatus tears with or without infra spinatus tears after an unsuccessful minimum three months of conservative treatment (along with anti-inflammatory medications, physical therapy, and activity modification), the supraspinatus tendon retracted medial to the glenoid on the magnetic resonance imaging coronal view and could not be constant to the extra tuberosity without marked anxiety all through the operation, the torn subscapularis retracted medially and couldn't be constant to the lesser tuberosity without marked anxiety after the arthroscopic mobilization, and that they suffered a recurrent tear after the initial subscapularis repair.

Coracoplasty is accomplished to guarantee the space in which the tendon could pass. Two to three millimeters of bone from the backside of the coracoid is removed with the burr. The inferior floor of the coracoid from the neck to the end is skeletonized with an arthroscopic cautery device. Then, arthroscopy is suspended and mini-open tendon practise is completed. A 3- to 4-cm skin incision is re-modeled the coracoid system and the deltopectoral c language is developed.

Goals:

Show the arthroscopic technique used for irreparable massive ruptures of the rotator cuff with hemipectoralis major.

Summary:

Ten patients with indication of transfer of the pectoralis major flap surgery were performed with the sternal beam of the pectoralis major in the form of a mini open for graft and arthroscopic removal in their shoulder insertion, using peek

Extended Abstract

anchors for anchoring in the lateral edge to the bicipital slide of the shoulder, with 8 month follow-up POP.

Material and method:

Fifteen patients with retracted massive ruptures that could be repaired at the time of surgery were excluded.

The retracted massive ruptures of the cuff were predominantly supraspinatus and subscapular, with imbalance in the cuplas, the lesion is first visualized under arthroscopic control, stating that it is irreparable and preparing the reintegration bed so that the sternal fascicle tendon is inserted by a mini open incision runs under the other fascicle, passes over the joint tendon and through the subacromial space is reinserted on the outer superior edge of the bicipital slider, after tenotomy or bicipital biotenodesis, placing 2 PEEK anchors with double reinforced sutures under arthroscopic vision, some were made fixation with anchors without knots. Close by planes, sling with thoracic girdle and postoperative to equal to the cuff.

Discussion:

It can be compared with different techniques such as complete open or arthroscopic pectoral transfers and with techniques that pass under the coracobiceps tendon, we believe that by the direction and dynamic purpose of being a depressor of the humeral head, the sternal fascicle by the provision Oblique acts by lowering the head and returning to the equilibrium of the anterior cups (when the posterior tendons are unscathed). The arthroscopic and mini open technique for graft removal is less invasive and better immediate pop recovery, with less surgical time.

The advantages of using the pectoralis minor tendon over the pectoralis fundamental tendon were less donor web site morbidity, biomechanical superiority, and arthroscopic feasibility. A theoretical problem of the usage of the pectoralis

minor muscle was the small muscle extent. The path of the pectoralis minor tendon transfer simulated that of the superior a part of the subscapularis and may have attained enough substitution of the feature of the subscapularis.

1. Minimum invasive arthroscopic-assisted approach
2. Bone-to-bone restoration and maintaining the tendon-bone junction
3. More similar force vector of the subscapularis compared with the pectoralis predominant

There are disadvantages as well. Those include:

1. Small muscle volume in comparison with the pectoralis most important
2. Technically worrying procedure requiring advanced shoulder arthroscopic and open skills
3. No established long-term clinical outcome studies

Arthroscopic-assisted pectoralis minor tendon transfer can lead to significant upgrades in standard shoulder ache and characteristic, and appears to be an attractive choice in the remedy of young patients with restrained reconstruction options.

Conclusion:

We believe that it is a valid and useful technique for patients who present irreparable ruptures of the rotator cuff with a predominance of the anterior tendons in patients without humeral gleno-osteoarthritis.