

IX CONGRESSO NAZIONALE DMSA

NOVITA' ORTOPEDICHE NEL TRATTAMENTO DELLE PATOLOGIE SPORTIVE

DOTT. ALBERTO RESIDORI

CHIRURGIA GINOCCHIO e SPALLA
Ospedale P.Pederzoli
Peschiera del Garda (VERONA)

TEAM

Dr. Michele Malavolta
Dr. Alberto Residori
Dr. Andrea Cescatti
Dr. Silvio Mezzari
Dr. Gianpietro Lista

IX CONGRESSO NAZIONALE DMSA

QUALE FUTURO PER IL CHINESIOLOGO
DEL TERZO MILLENNIO?

FITNESS, MEDICAL FITNESS, PHYSIO,
FUNCTIONAL TRAINING, CHINESIOLOGIA,
AQUAWELLNESS, INDOOR CYCLING

MEDICAL FITNESS SUMMIT

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Segreteria Organizzativa:
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VERONA - Colà di Lazise
29 - 30 Settembre 2018



NEW TEAM

GINOCCHIO

Dott. Malavolta
Dott. Residori
Dott. Mezzari
Dott. Lista

SPALLA

Dott. Residori
Dott. Cescatti
Dott. Mezzari

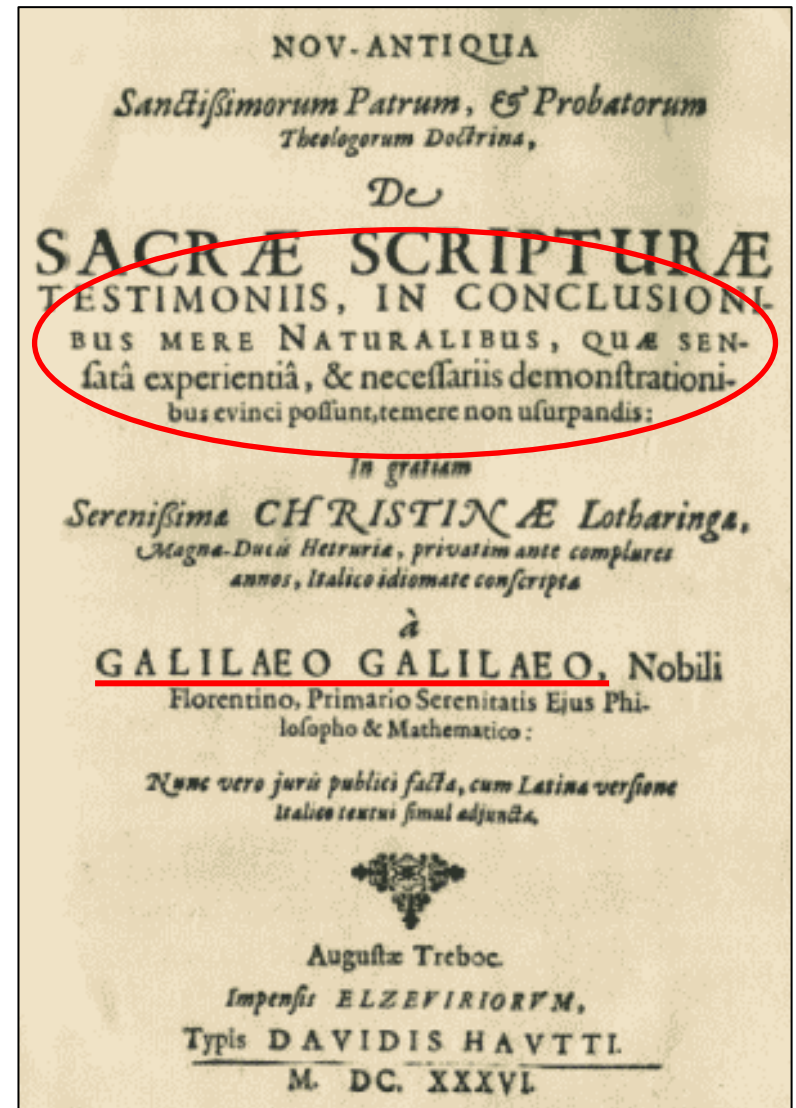
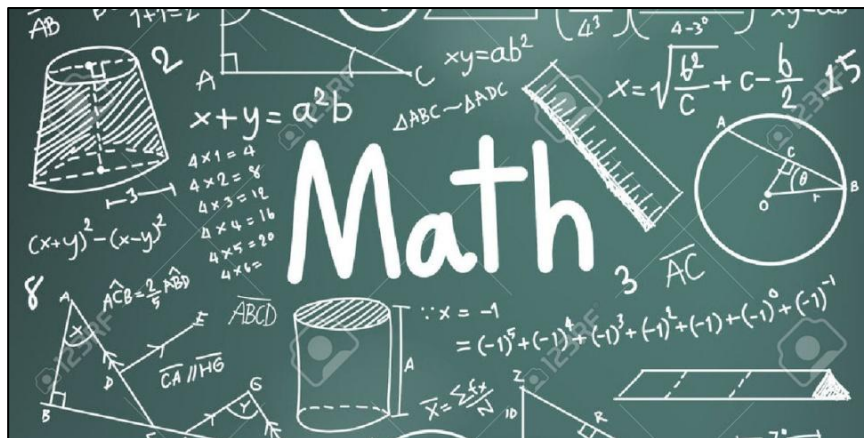


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MEDICINA NON E' UNA
SCIENZA ESATTA...

MA CI SI DOVREBBE
AVVICINARE...

E DEVE BASARSI SU UN
METODO SCIENTIFICO E NON
SOLO SU ESPERIENZE
PERSONALI



INSTABILITA'

GINOCCHIO

Lesione LCA



SPALLA

Lussazione
gleno/omeroale
antero-inferiore

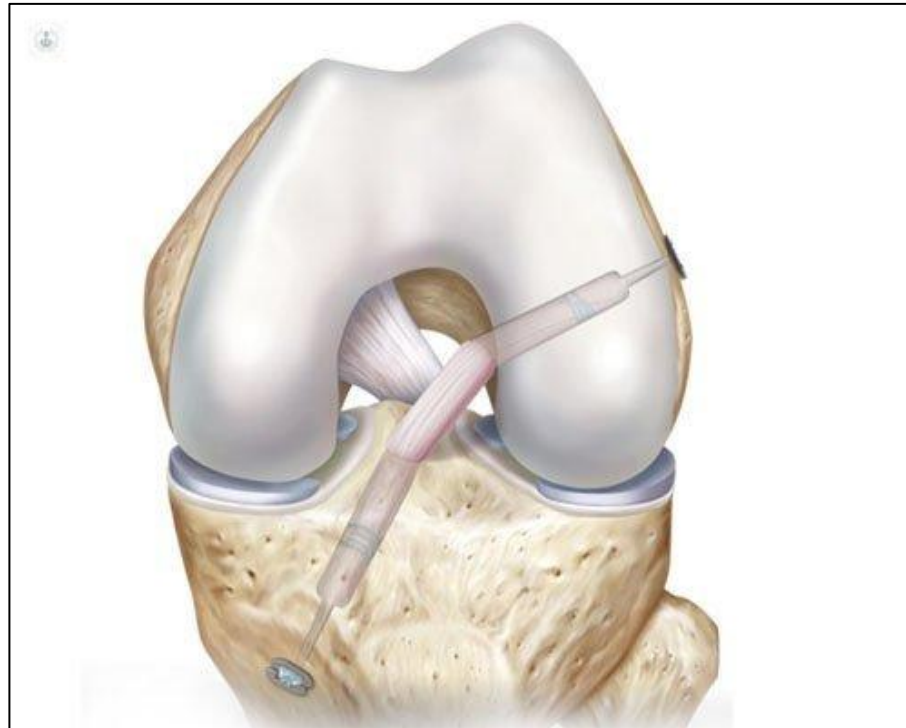
MEDICINA RIGENERATIVA

- PRP
- LIPOGEMS

**NOVITA' ORTOPEDICHE NEL
TRATTAMENTO DELLE
PATOLOGIE SPORTIVE**



**INSTABILITA' GINOCCHIO
DA LESIONE LCA**

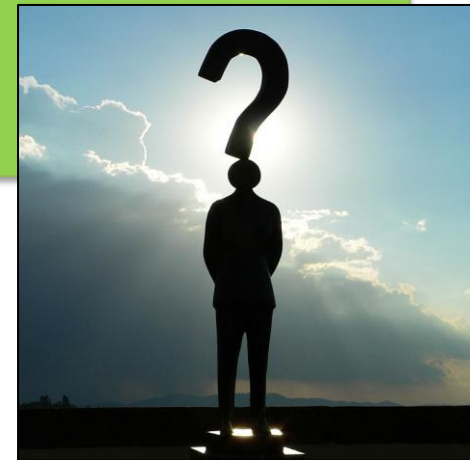


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RICOSTRUZIONE LCA

Risultati letteratura...fino a 20% recidive...

...il problema è solo LCA o c'è ALTRO???

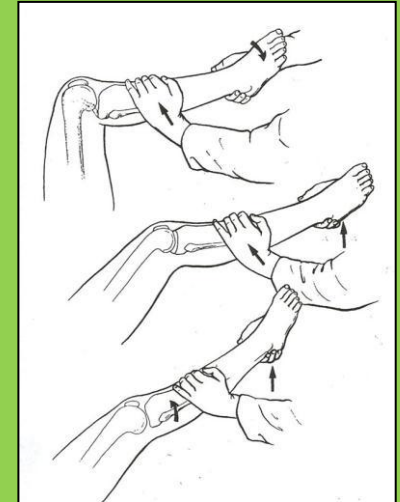


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RICOSTRUZIONE LCA

ANALIZZARE I FALLIMENTI

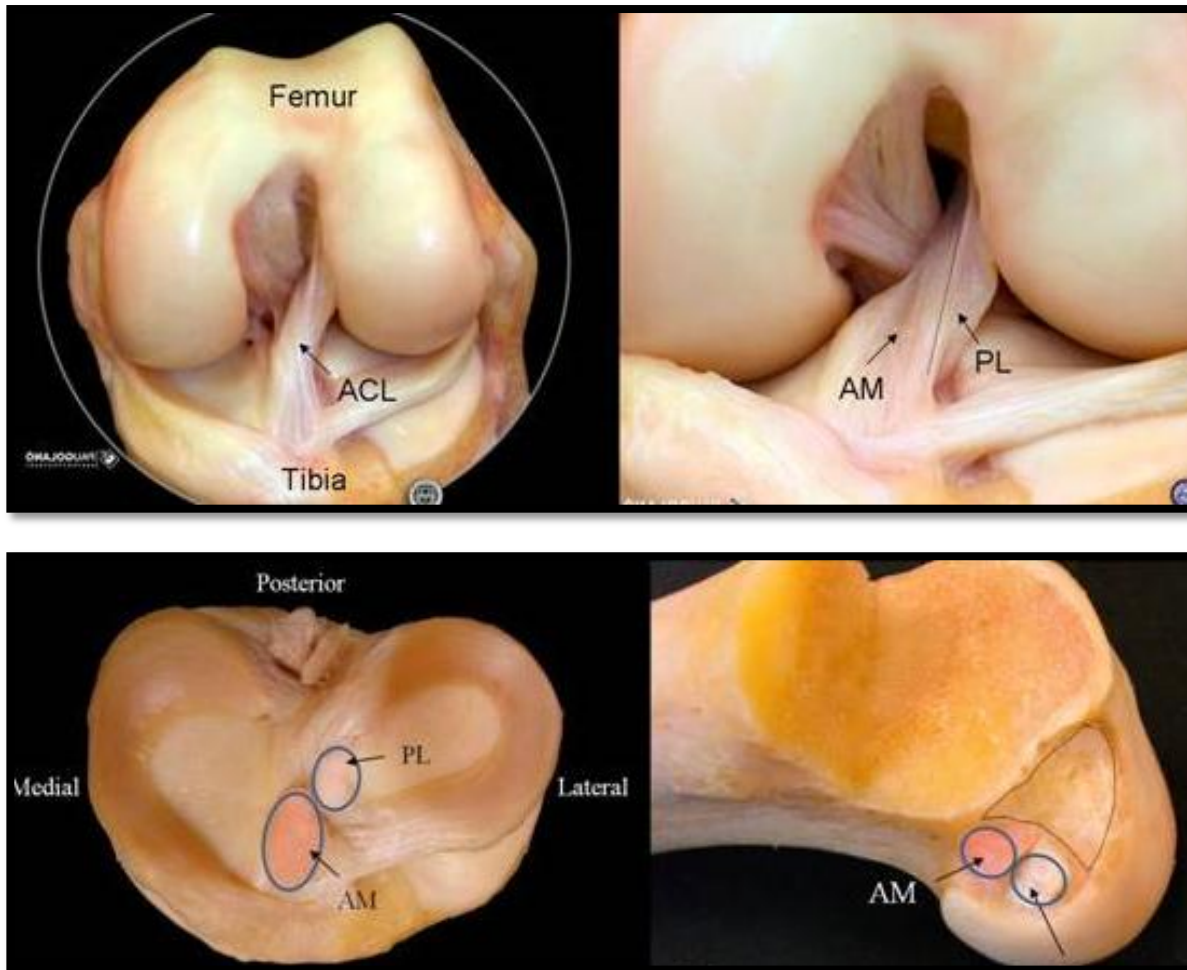
- Et  inferiore ai 20 anni
- Ginocchio recurvato
- Lesione LCA controlaterale
- Pivot shift ++
- Teoria genetica??? (>F)
- Posizionamento non anatomico dei tunnel tibiale e femorale
- Mancato trattamento delle lesioni periferiche



INSTABILITA' ROTAZIONALE!!!

Sonnery-Cottet B, Daggett M, Fayard JM, Ferretti A, Helito CP, Lind M, Monaco E, de P dua VBC, Thauat M, Wilson A, Zaffagnini S, Zijl J, Claes S. Anterolateral Ligament Expert Group consensus paper on the management of internal rotation and instability of the anterior cruciate ligament - deficient knee. J Orthop Traumatol. 2017 Jun;18(2):91-106.

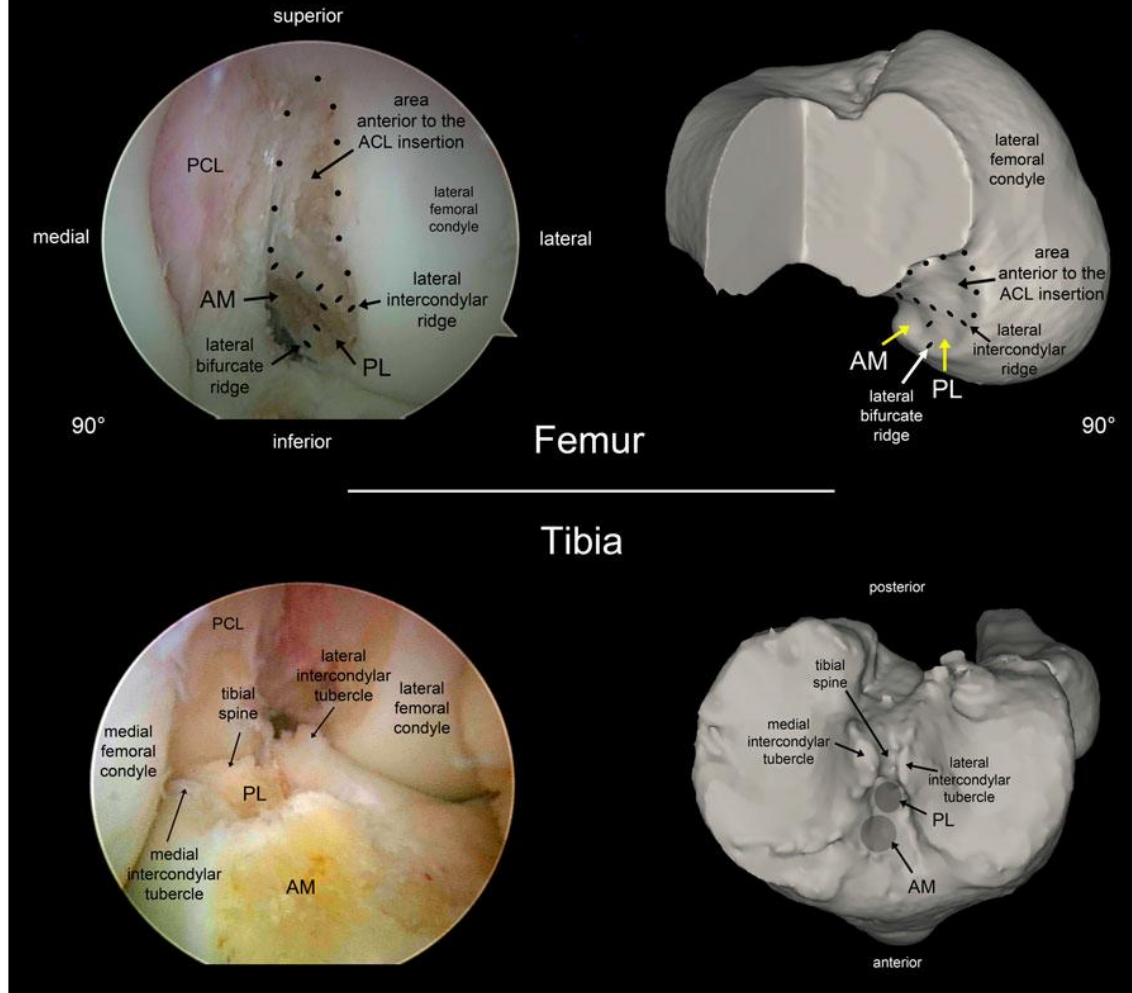
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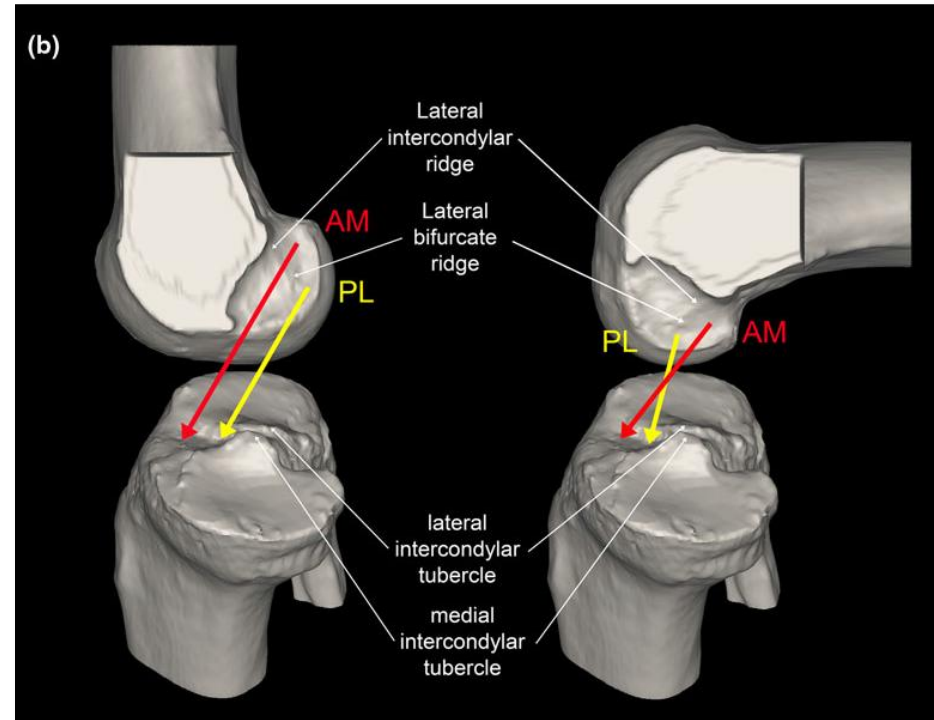
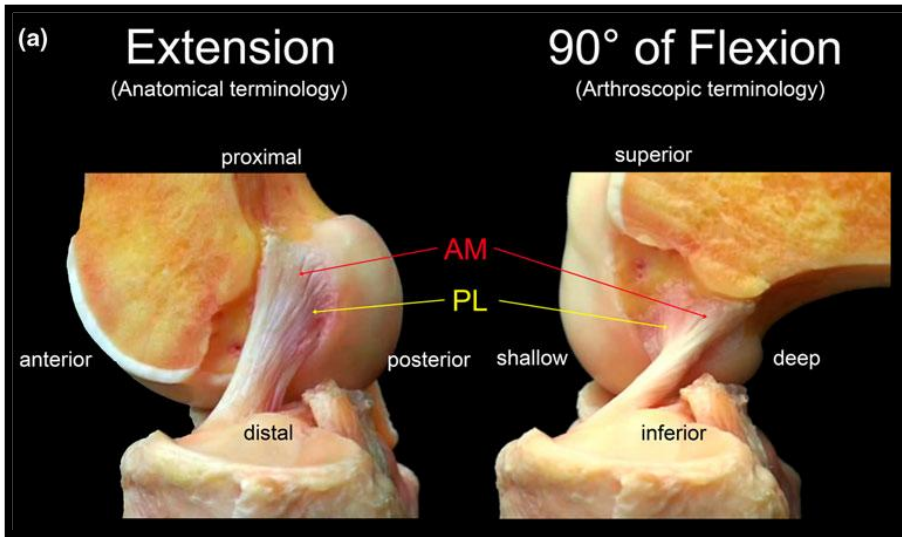
Loh JC, Fukuda Y, Tsuda E, Steadman RJ, Fu FH, Woo SL. **Knee stability and graft function following anterior cruciate ligament reconstruction: Comparison between 11 o'clock and 10 o'clock femoral tunnel placement.** 2002 Richard O'Connor Award paper. *Arthroscopy*. 2003 Mar;19(3):297-304.

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ACL Insertion Site Anatomy



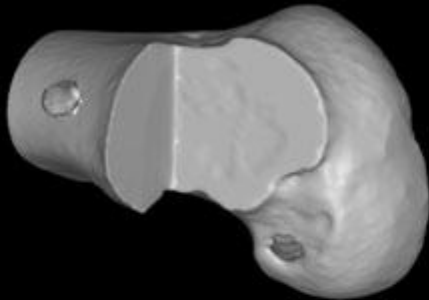
IX CONGRESSO NAZIONALE DMSA



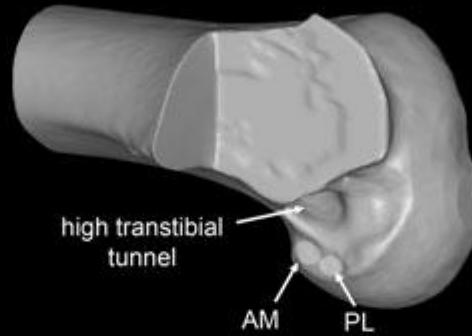
Rayan F, Nanjayan SK, Quah C, Ramoutar D, Konan S, Haddad FS **Review of evolution of tunnel position in anterior cruciate ligament reconstruction.** World J Orthop.2015 Mar 18;6(2):252-62. doi: 10.5312/wjo.v6.i2.252. eCollection 2015.

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1980's open surgery



1990's transtibial SB



2000's early DB



Anatomic SB



Anatomic DB



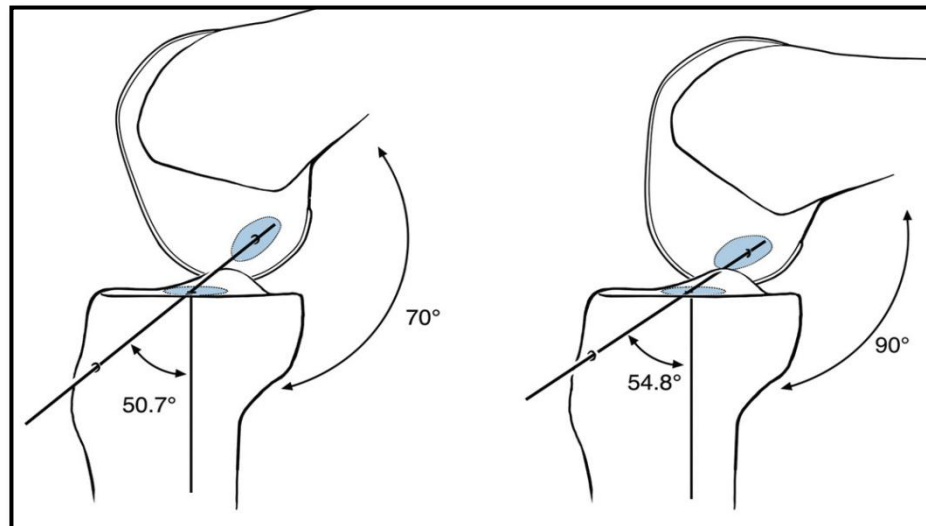
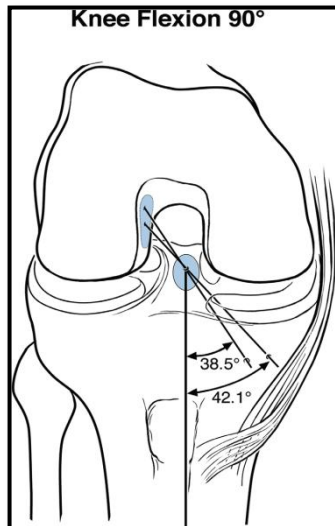
~ 90° of knee flexion

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Anatomical Limitations of Transtibial Drilling in Anterior Cruciate Ligament Reconstruction

James F. Heming, Jason Rand and Mark E. Steiner
Am J Sports Med 2007 35: 1708 originally published online July 30, 2007
DOI: 10.1177/0363546507304137

The transtibial technique can produce tunnels centered in the anterior cruciate ligament footprints, but a starting point close to the tibial joint line is required. This will result in a relatively short tibial tunnel. If tunnels centered in the anterior cruciate ligament attachment sites are desired with the transtibial drilling technique, then a short tibial tunnel is necessary. A short tibial tunnel may compromise graft fixation and graft incorporation, or it may result in a tunnel length-graft length mismatch. An alternative drilling strategy might be employed.



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[Arthroscopy](#). 2009 Jan;25(1):95-101. doi: 10.1016/j.arthro.2008.10.012.

Anteromedial portal technique for the anterior cruciate ligament femoral socket: pitfalls and solutions.

[Lubowitz JH](#)¹.

⊕ Author information

Abstract




Creating the anterior cruciate ligament (ACL) femoral socket using the anteromedial (AM) portal technique has advantages. Furthermore, the technique is ideal for anatomic double-bundle (particularly posterolateral bundle) and all-inside ACL techniques. However, although the AM portal technique has advantages, the learning curve is steep when making the transition from familiar, transtibial reaming to the AM portal technique for ACL femoral tunnel creation. Complications and challenges are many when learning the AM portal technique. The purpose of this technical note is to describe tips and pearls for surgeons contemplating the transition to the AM portal technique for the ACL femoral socket.

Comment in

Challenges and risks of the anteromedial portal. [Arthroscopy. 2009]

The anterior medial portal. [Arthroscopy. 2009]

PMID: 19111224 [PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms ▾

LinkOut - more resources ▾

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NCBI Resources How To

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Abstract Send to: ▾

Arthroscopy, 2008 Dec;24(12):1349-57. doi: 10.1016/j.arthro.2008.07.018. Epub 2008 Oct 1.

Tunnel enlargement after double-bundle anterior cruciate ligament reconstruction: a prospective, randomized study.

Järvelä T¹, Moisala AS, Paakkala T, Paakkala A.

Author information

Abstract

PURPOSE: The aim of this study was to compare tunnel enlargement in patients with double-bundle and single-bundle anterior cruciate ligament (ACL) reconstruction.

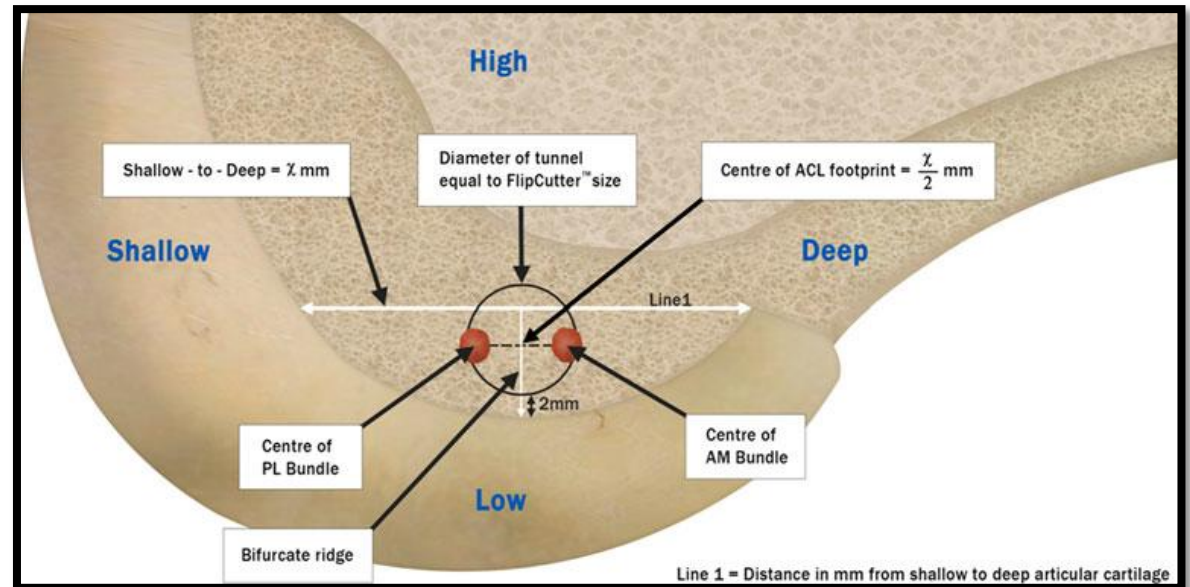
METHODS: Sixty patients were randomized by closed envelopes into 2 different groups of ACL reconstruction with hamstring tendons: double-bundle technique with bioabsorbable screw fixation (n = 35) and single-bundle technique with bioabsorbable screw fixation (n = 25). Magnetic resonance imaging evaluation was performed in 53 patients (88%) (32 in double-bundle group and 21 in single-bundle group) for a mean of 27 months' follow-up (range, 24 to 36 months). Tunnel enlargement was determined by digital measurement of the widths perpendicular to the long axis of the tunnels on an oblique coronal and sagittal plane. The magnetic resonance imaging measurements were compared with the intraoperative drill diameter.

RESULTS: No significant differences were found between the double-bundle group and the single-bundle group in tunnel enlargement on the femoral side. However, on the tibial side, tunnel enlargement was greater in the single-bundle group than in the double-bundle group in each tunnel (P = .051). In all knees, tunnel enlargement both on the tibial side and on the femoral side correlated significantly with the anterior and rotational laxity of the operated knee. In the double-bundle group, no tunnel communication between the anteromedial and posterolateral tunnels was seen in any of the patients on either the tibial side or femoral side.

CONCLUSIONS: This prospective, randomized study showed that our double-bundle ACL reconstruction technique results in less tunnel enlargement in each tunnel on the tibial side than the single-bundle technique with similar fixation methods, graft material, and rehabilitation. In addition, no tunnel communication was observed in the patients undergoing double-bundle ACL reconstruction. The clinical results were good in both groups. However, the patients who had more tunnel enlargement had significantly more anterior and rotational laxity of the operated knee as well.

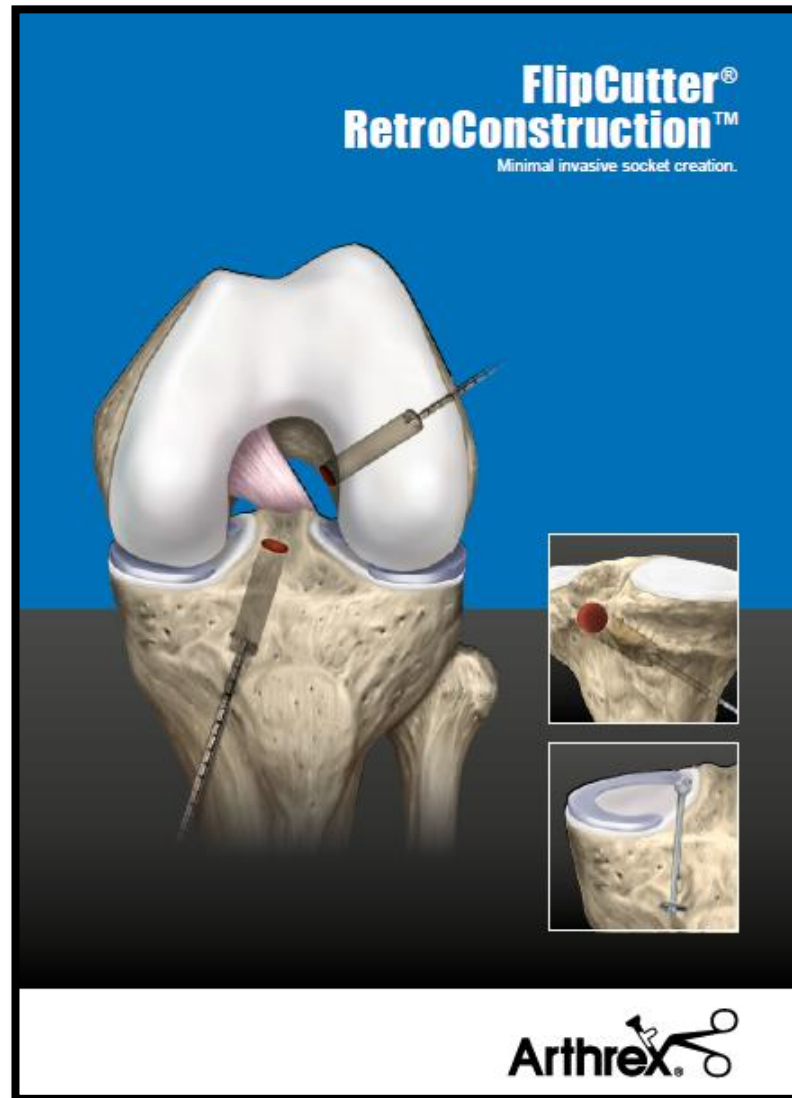
LEVEL OF EVIDENCE: Level I, therapeutic randomized controlled trial.

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1. James Lubowitz, MD, et al, ACL Femoral Footprint Anatomy: Systematic Review of the 21st Century Literature, Arthroscopy, accepted for publication, 2012.
2. Lubowitz J, Konicek J, A 3.5 mm Diameter Anterior Cruciate Ligament Tibial Retrograde Socket Drilling Pin is More Accurate than a 2.4 mm Diameter Pin. Arthroscopy 2011; 26:666-671.

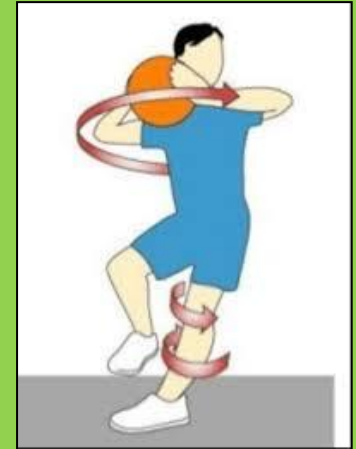
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RICOSTRUZIONE LCA

ANALIZZARE I FALLIMENTI

- Et  inferiore ai 20 anni
- Ginocchio recurvato
- Lesione LCA controlaterale
- Pivot shift ++
- Teoria genetica??? (>F)
- Posizionamento non anatomico dei tunnel tibiale e femorale
- Mancato trattamento delle lesioni periferiche



Ricostruzione anatomica < recidive...ma comunque tassi ALTI!!!

Sonnery-Cottet B, Daggett M, Fayard JM, Ferretti A, Helito CP, Lind M, Monaco E, de P dua VBC, Thaunat M, Wilson A, Zaffagnini S, Zijl J, Claes S. Anterolateral Ligament Expert Group consensus paper on the management of internal rotation and instability of the anterior cruciate ligament - deficient knee. J Orthop Traumatol. 2017 Jun;18(2):91-106.

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ArthroLab Workshop Knee

ArthroLab | Erwin-Hielscher-Str. 9 | 81249 Munich

Faculty	Dr. Malivoita Dr. Kluzik Dr. Residori Dr. Mezzari
Date	Friday, April 15, 2016
Location	ArthroLab Erwin-Hielscher-Str. 9 81249 Munich

Program | Friday, April 15, 2016

08:00 - 08:30	Welcome & Coffee	Doctor's Lounge
08:30 - 09:45	Presentation: <ul style="list-style-type: none">• Introduction	Dr. Malivoita, Dr. Kluzik
09:45 - 10:15	Presentation: <ul style="list-style-type: none">• ACL and ALL Reconstruction	Dr. Malivoita, Dr. Residori
10:15 - 11:30	WetLab Session – Part #1 <ul style="list-style-type: none">• All-Inside ACL Reconstruction using GrafLink®• ALL Reconstruction using SwivelLock®	
11:30 - 11:40	Coffee Break	Doctor's Lounge
11:40 - 13:00	WetLab Session – Part #2 <ul style="list-style-type: none">• MPFL Reconstruction using SwivelLock® & Bio-Inference Screw• TrochleoPlasty	
13:00 - 13:30	Lunch Break	Arthrex Cafeteria
13:30 - 14:30	Presentation: <ul style="list-style-type: none">• Knee Arthroplasty using iBalance® UKA	Dr. Malivoita, Dr. Mezzari
14:30 - 15:00	Coffee Break	Doctor's Lounge
15:00 - 17:00	WetLab Session – Part #3 <ul style="list-style-type: none">• Knee Arthroplasty using iBalance® UKA	
17:00	End of Course	

ArthroLab™



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MECCANISMO LESIONE VALGO ROTAZIONE ESTERNA (lcm, lca, impatto osseo esterno)...MA PRIMA VARO ROTAZIONE INTERNA CON LESIONE COMPARTO ESTERNO

J Orthop Traumatol (2017) 18:91–106
DOI 10.1007/s10195-017-0449-8



EMERGING TOPIC (REVIEW ARTICLE)

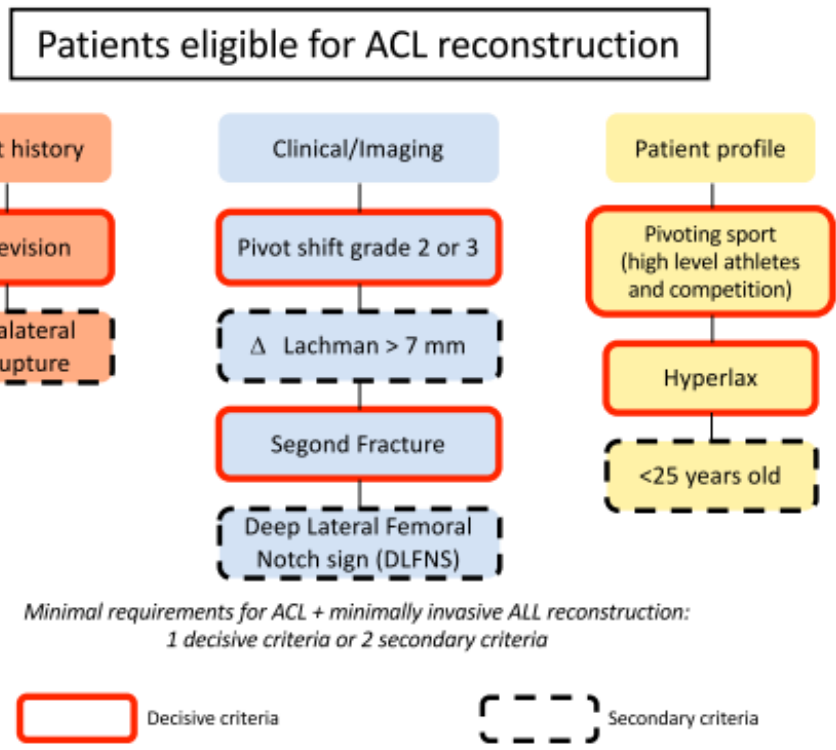
Anterolateral Ligament Expert Group consensus paper on the management of internal rotation and instability of the anterior cruciate ligament - deficient knee

**Bertrand Sonnery-Cottet¹ · Matthew Daggett² · Jean-Marie Fayard¹ ·
Andrea Ferretti³ · Camilo Partezani Helito⁴ · Martin Lind⁵ · Edoardo Monaco³ ·
Vitor Barion Castro de Pádua⁶ · Mathieu Thauinat¹ · Adrian Wilson⁷ ·
Stefano Zaffagnini⁸ · Jacco Zijl⁹ · Steven Claes¹⁰**

Published online: 20 February 2017

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Fig. 5 Decision tree



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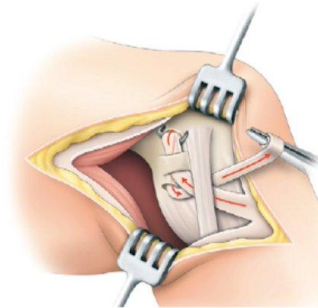


The pioneers: Isolated lateral tenodesis

- Marcel Lemaire, 1967



Lemaire M. Rupture ancienne du ligament croisé antérieur du genou : fréquence, clinique, traitement (46 cas). J Chir 1967;83:311-20.



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POMERIGGIO ORTOPEDICO



FACULTY

F.Azzola
G.Bonaspetti
V.Condello
A.Ferretti
V.Madonna
M.Malavolta
F.Mafassi
S.Mozzari
M.Ricci
A.Residori
P.Sembenini
G.Zanon
G.Zappalà



Steven Claes et al. J Anat 2013

Organizzatore

Michele MALAVOLTA
Responsabile
CHIRURGIA GINOCCHIO
CdC dott. Pederzoli
Peschiera del Garda
VERONA

IL COMPLESSO ANTERO ESTERNO DEL GINOCCHIO

Il punto & Relive Surgery

VENERDÌ 10 MARZO 2017
ore 15:00

CdC DOTT. PEDERZOLI

Via Monte Baldo 24 - 37019 Peschiera d/G (Verona)

ISCRIZIONE GRATUITA PREVIA PRENOTAZIONE
Richiesto accreditamento ECM per medici ortopedici e fisiatrici

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PREMIO MIGLIOR POSTER S.I.A. 2017

PLASTICA ANTERO-ESTERNA DI LEMAIRE MODIFICATA ASSOCIATA ALLA RICOSTRUZIONE DEL LEGAMENTO CROCIATO ANTERIORE



XXIII Congresso Nazionale S.I.A. - Società Italiana di Artroscopia
Palazzo Mauro de Andrè, Ravenna 12-14 Ottobre 2017



A. Residori, S. Mezzari, G. Lista, M. Malavolta

Divisione Chirurgia del Ginocchio, Ospedale P. Pederzoli, Peschiera del Garda (VR)
Responsabile: dott. Michele Malavolta

OGGETTIVO: Come evidenziato in letteratura la ricostruzione del legamento crociato anteriore (LCA) è gravata da significativi tassi di recidiva. I fattori che influenzano i fallimenti sono: età inferiore ai 20 anni, ginocchio recurvato, marcato pivot shift, sport da pivot, lesione del LCA controlaterale, il posizionamento non anatomico dei tunnel tibiale e femorale e il mancato trattamento delle lesioni periferiche [1]. Le plastiche periferiche non sono certamente un argomento nuovo [2,3]; il merito di aver portato il focus sulle lesioni del comparto antero-esterno va attribuito a Claes con la (ri)scoperta del legamento antero-laterale (ALL) [4]; in realtà ancora molto dibattuti sono sia la reale esistenza che l'effettivo ruolo del ALL. Utilizzando la tecnica anatomica originariamente proposta da Claes abbiamo riscontrato alcune problematiche, in particolare la difficoltà nell'individuare i punti isometrici di inserzione. La nostra proposta è quella invece di una tecnica non anatomica, che ha come base la tecnica di Lemaire [5] della scuola Lionese modificata da D. Dejour [6], con l'obiettivo di proteggere il neo-LCA dall'intra-rotazione che sembra essere il primum movens nella biomeccanica delle lesioni del LCA. In tal senso Ellison descriveva l'LCA come 'il mozzo della ruota', notando come è più facile controllare la rotazione di una ruota dal suo bordo che dal mozzo [7].

MATERIALI E METODI: Ricostruiamo l'LCA a livello femorale con tecnica out-in con retro drill (Flip Cutter Arthrex) che ci permette di posizionare il neo-

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PLASTICA ANTERO-ESTERNA DI LEMAIRE MODIFICATA



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FISIOTERAPIA???

**STESSI PROTOCOLLI UTILIZZATI PER LA RICOSTRUZIONE ISOLATA
DEL LCA**



**INSTABILITA' SPALLA
DA LUSSAZIONE ANTERO-INFERIORE**



Articolazione gleno-omerale

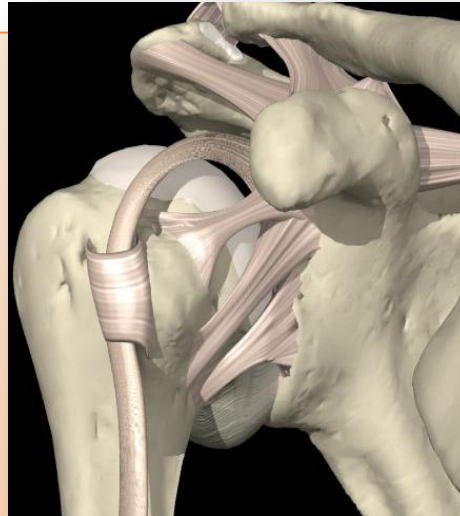
- ROM maggiore
- Articolazione più instabile (solo 1/3 testa omerale articola con la glenoide)
- 2% della popolazione generale
- 94% antero-inferiori
- < 5% posteriori
- < 0,5% erecta



Stabilità gleno-omerale

FATTORI STATICI

- Versione articolare
- Strutture ossee
- Conformazione articolare
- Labbro glenoideo
- Pressione intra-articolare
- Adesione/Coesione
- Strutture capsulo-legamentose



Stabilità gleno-omerale

FATTORI DINAMICI

- Cuffia dei rotatori
- CLBB
- Scapolo-toracica
- Propriocezione



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L'instabilità dell'articolazione gleno-omerale è una condizione patologica in cui i capi articolari perdono la loro naturale congruenza biomeccanica, generando per eziologie diverse stati clinici differenti.

Clinicamente si presenta con reperti obbiettivi che possono essere sia eclatanti che subdoli, generando quindi difficoltà sia nell'inquadramento diagnostico che successivamente in quello terapeutico.



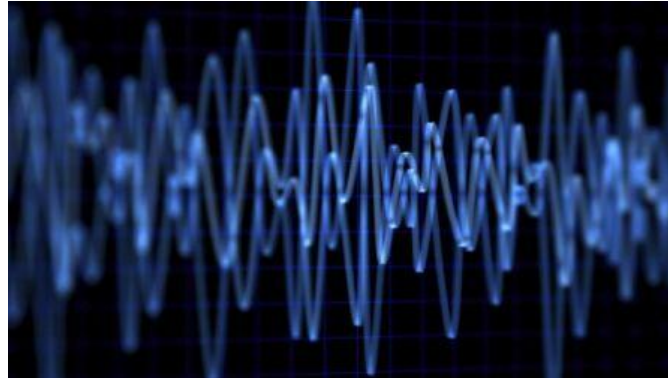
Classificazione instabilità gleno-omerale

GRADO DI INSTABILITA'

- Lussazione
- Sublussazione
- Microinstabilità

FREQUENZA DI INSTABILITA'

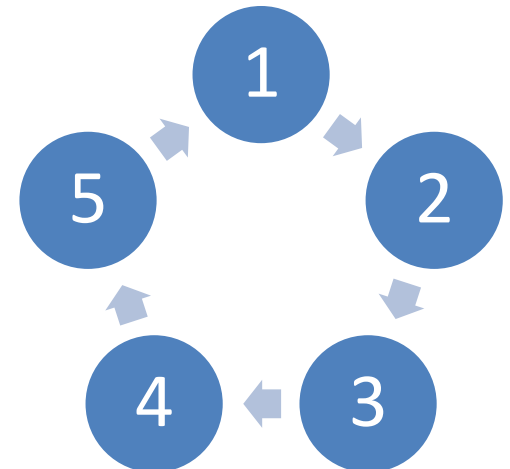
- Acuta
- Cronica



Lussazione cronica

- Lussazione **recidivante** se un soggetto subisce un trauma e per la seconda volta la spalla si lussa
- Dopo il IV-V episodio di lussazione siamo di fronte ad una lussazione **ricorrente / abituale**

Ma la differenza **NON** è solo un fattore numerico



Classificazione instabilità gleno-omeroale

Acronimi che si basano:

- sulle lesioni anatomo-patologiche riscontrabili
- sulla direzione dell'instabilità
- sull'orientamento terapeutico
- sulla causa principale dell'instabilità

TUBS (96%)

AMBRII

AIOS

Thomas SC, Matsen FA. An approach to repair of avulsion of the glenohumeral instability. J Bone Joint Surg Am 1989;71:506-13.

Classificazione instabilità gleno-omerale

Lesioni ossee

Hill Sachs (90%)

Bony-Bankart (5-55%)

Lesioni labbro-legamentose

Bankart (53-72%)

Perthes

ALPSA (28-47%)

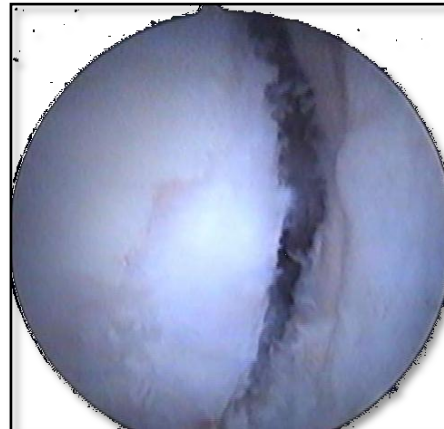
HAGL

SLAP

Rotture capsulari

Lesioni tendinee

TUBS



Rowe (JBJS, 1956): 96% traumatic/ 4% atraumatic.

Storia naturale instabilità gleno-omerale

- **Rockwood (JBJS, 1992)**

16% risultati positivi trattamento conservativo nei pz traumatici,
80% atraumatici

- **Bottoni (2002)**

recidiva 75% conservativo/ 11,1% artroscopico

- **Kirkley (2005)**

recidiva 47% conservativo /15,9% artroscopico

- **Cole (JBJS, 2002)**

fallimento 24% trattamento artroscopico / 18% open



Fattori prognostici

- ETA' < 20 ANNI
- IPERLASSITA' CAPSULO-LEGAMENTOSA
- TEORIA GENETICA???
- SPORT CONTATTO
- **BONE LOSS GLENO-OMERALE**



Fattori prognostici

Burkhart, DeBeer

Recidiva 4% in assenza di bone loss significativo / 67% bone loss significativo (6,5% VS 87% atleti)

Bois, Fening, Polster (AJSM, 2012)

Difetti glenoidei

22% primo episodio / 73% instabilità cronica

Hill-Sachs

90% primo episodio / 100% instabilità cronica

BONE LOSS GLENO-OMERALE



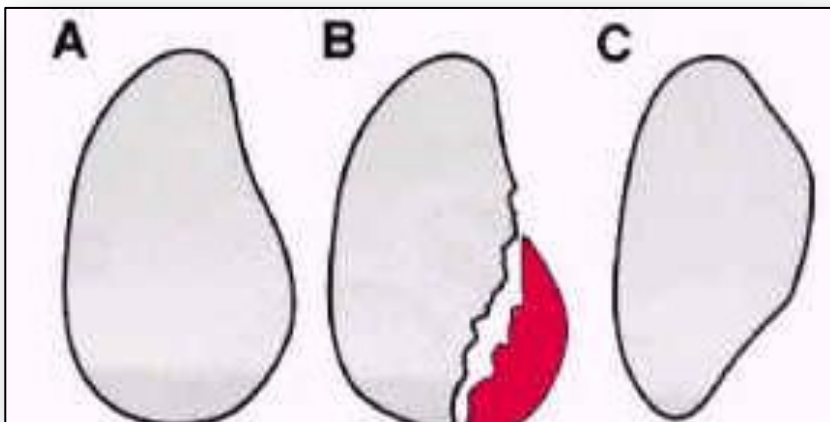
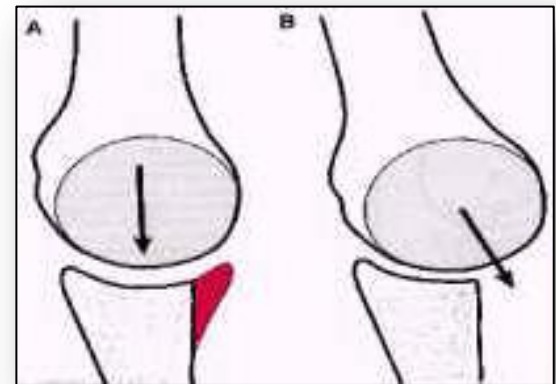
Bone loss glenoideo

Bigliani (AJSM, 1998)

Bony Bankart

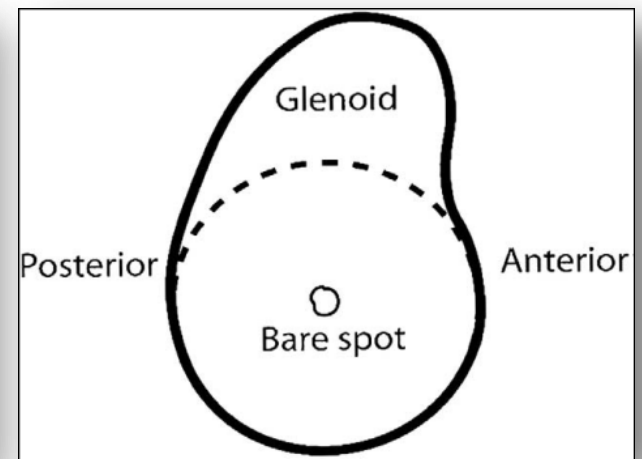
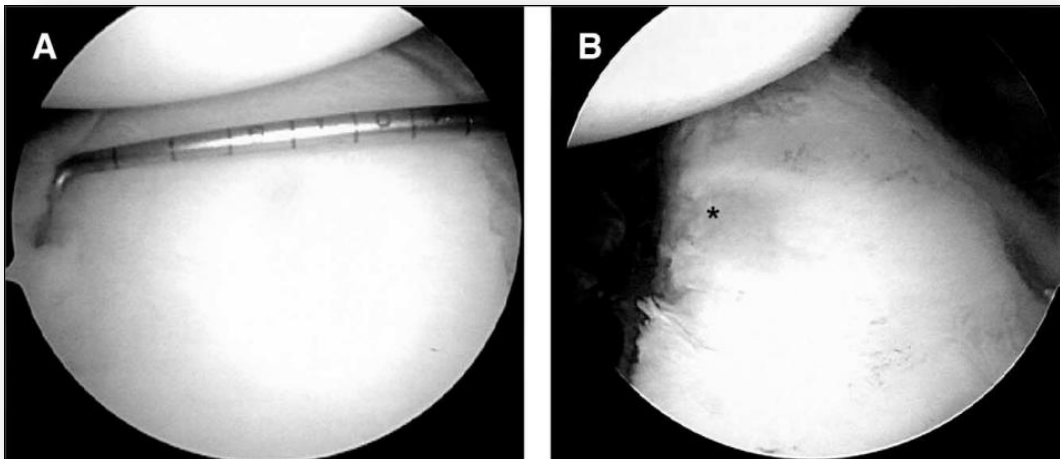
Inverted Pear

Compression Bankart



Quantificare il bone loss glenoideo

- Bigliani (AJSM, 1998)
> 25%
- Itoi (JBJS, 2000)
> 21% studio biomeccanico
- Altri studi
20-25%

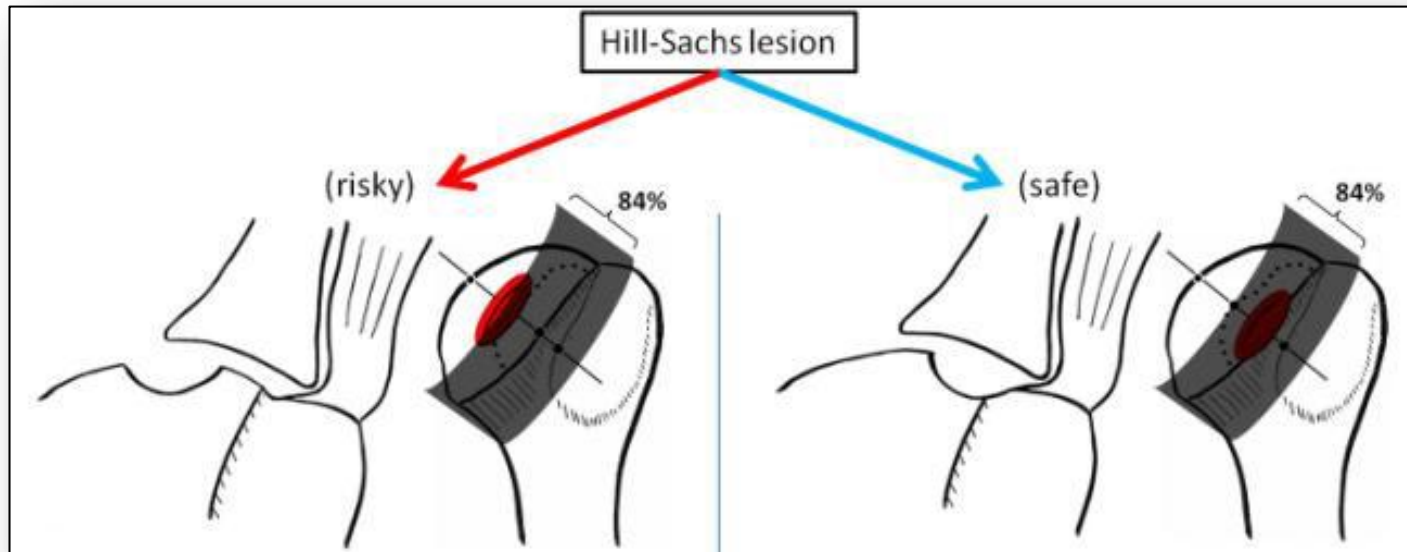


Bone loss omerale

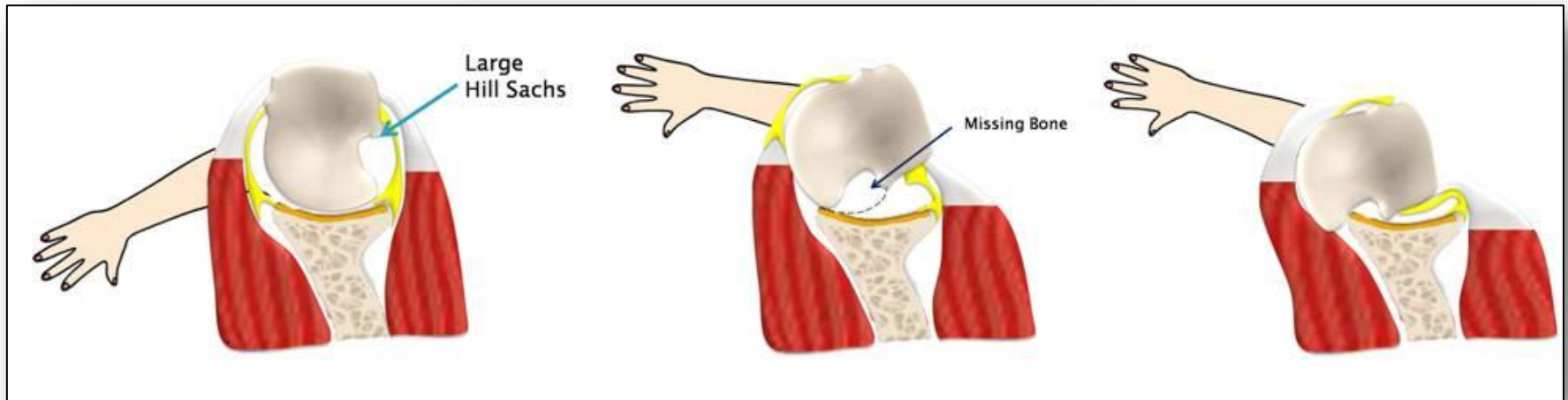
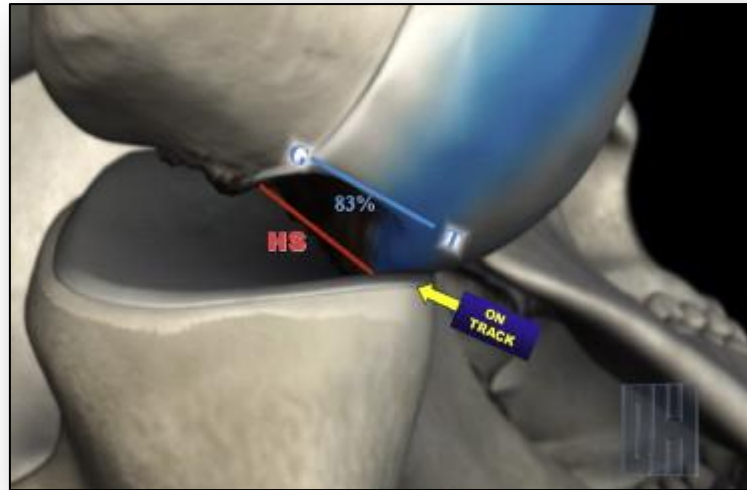
Yamamoto, Itoi (JSES, 2007)

La sede della lesione HS è più importante della dimensione: GLENOID TRACK / ENGAGING

100% instabilità recidiva se engaging HS



Engaging Hill-Sachs





Instability Severity Index Score Boileau, Balg (JBJS Br, 2007)

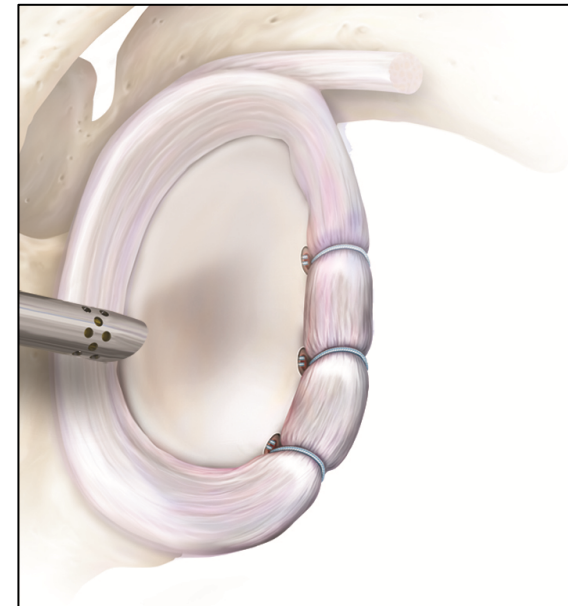
Prognostic Factors	Points
Age at Surgery	
• ≤ 20	2
• > 20	0
Level of Sport	
• Competitive	2
• Recreational	0
Type of Sport	
• Contact/forced ABER*	1
• Other	0
Clinical Exam	
• Hyperlaxity	1
• No hyperlaxity	0
AP X-ray (IR [†] and ER [‡])	
• Hill-Sachs on ER [‡] view	2
• No Hill-Sachs visible	0
AP X-ray	
• Glenoid contour loss	2
• No glenoid contour loss	0

ABER = abduction and external rotation; †IR = internal rotation;
ER = external rotation

- **A score of ≤ 6 points** = an acceptable recurrence risk of 10% with **arthroscopic stabilisation**
- **A score of > 6 points** = an unacceptable recurrence risk of 70% and should be advised to undergo **open surgery** (i.e. Laterjet procedure)

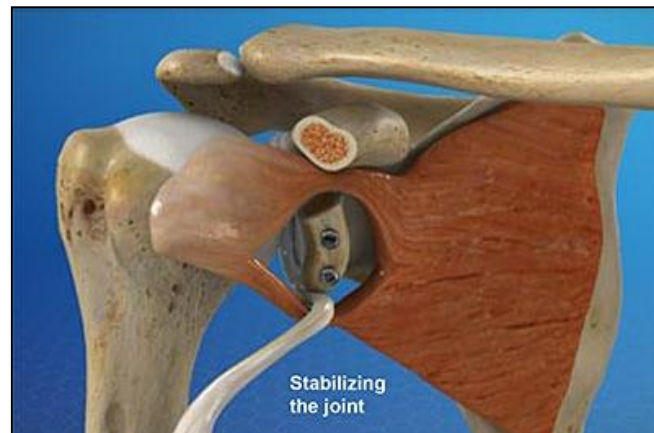
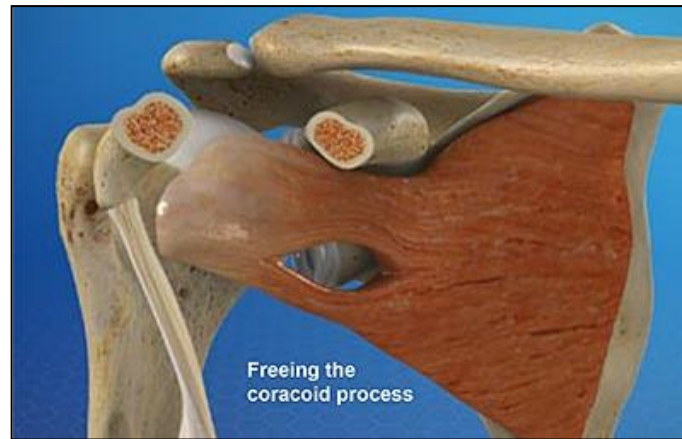
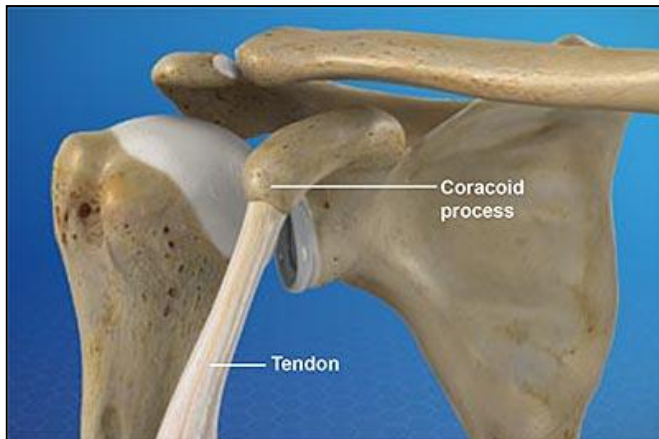
IX CONGRESSO NAZIONALE DMSA

CAPSULOPLASTICA ARTROSCOPICA No bone loss



IX CONGRESSO NAZIONALE DMSA

STABILIZZAZIONE SECONDO LATARJET (open/artroscopica) Bone loss > 20-25%



IX CONGRESSO NAZIONALE DMSA

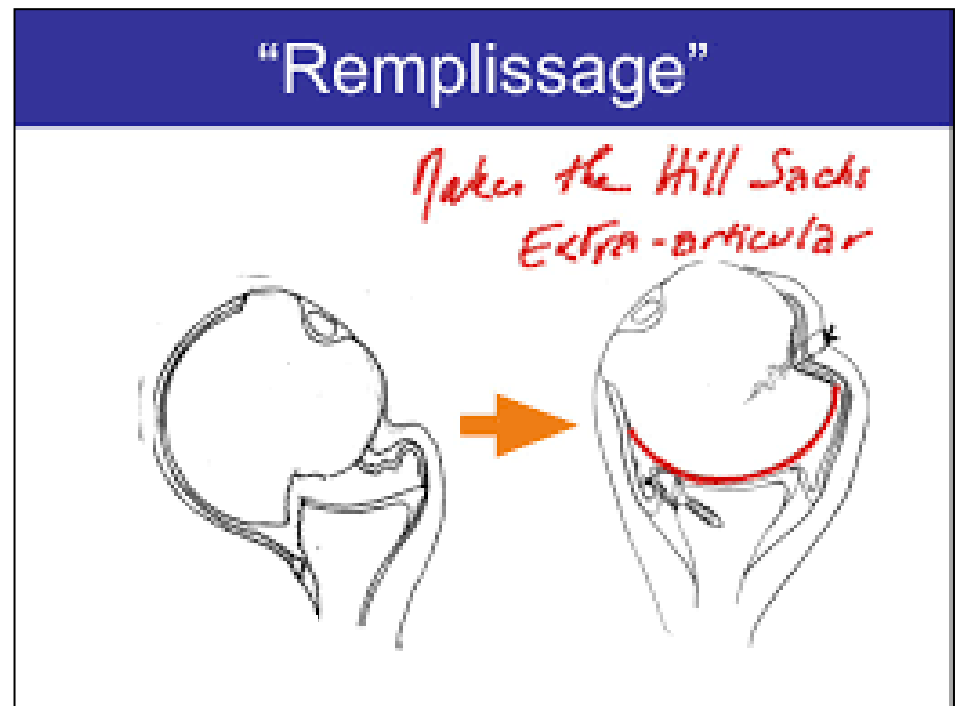
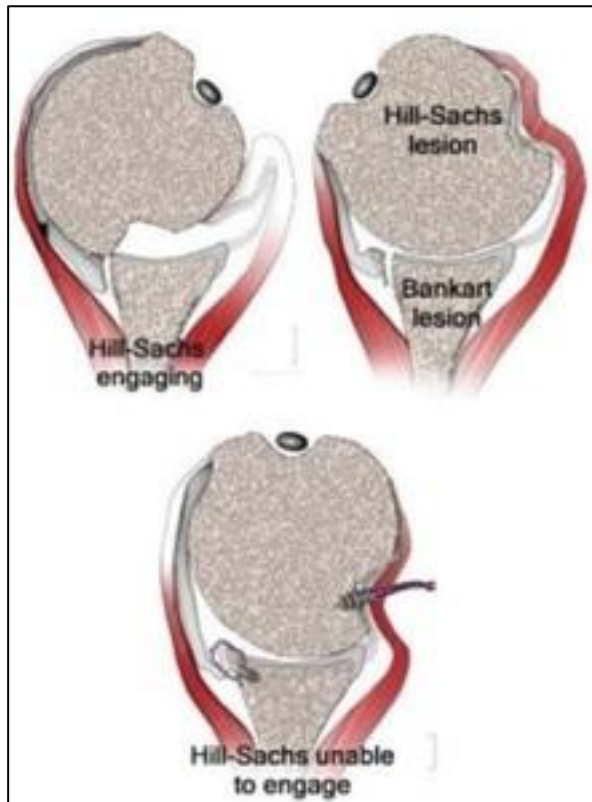
STABILIZZAZIONE SECONDO LATARJET (open/artroscopica) Bone loss > 20-25%

	NUMBER OF PROCEDURES PERFORMED	FOLLOW-UP DURATION	REDISLOCATION RATE
ALLAIN (1998) ¹⁴	95	14 years	0%
BURKHART (2007) ¹³	102	5 years	3.9%
HOVELIUS (1983) ¹⁹	112	2.5 years	6%
HOVELIUS (2004) ¹⁵	118	15 years	3.4
SINGER (1995) ²⁰	14	20 years	0%
WALCH (1991) ¹²	354	3 years	1%
WALCH (2000) ⁷	160	3 years	1%

IX CONGRESSO NAZIONALE DMSA

ZONA GRIGIA Bone loss < 20-25% ????

REPLISSAGE ARTROSCOPICO ASSOCIATO ALLA CAPSULOPLASTICA



IX CONGRESSO NAZIONALE DMSA

ZONA GRIGIA Bone loss < 20-25% ????



Orthop Clin North Am. 1993 Jan;24(1):71-88.

Arthroscopic shoulder capsulorrhaphy using metal staples.

Detrisac DA¹, Johnson LL.

+ Author information

Abstract

Staple capsulorrhaphy on the shoulder using a metal staple for traumatic anterior instability has the advantages of increased diagnostic accuracy, microdebridement of the pathology, accurate assessment of the glenohumeral ligament pathology, and selective repair of the ligament pathology. Although the same advantages should apply to staple capsulorrhaphy for traumatic posterior instability, our experience remains very limited. Staple capsulorrhaphy on the shoulder has multiple disadvantages, including being technically difficult with a slow learning curve, not being applicable to all unstable shoulders, an average failure rate of 12% that may be related to inadequate postoperative immobilization, no extra-articular reinforcement, and the use of a metal implant that may need to be removed at a second operation. Staple capsulorrhaphy is currently performed for traumatic anterior instability in the shoulder, with a selected repair of the pathology using a single, well-placed staple and prolonged postoperative immobilization. The design of the staple affords a simpler insertion technique than rivets, screws, and intra-articular sutures. The advent of a biodegradable staple should eliminate inherent problems of metal implants while preserving the advantages of this method.

IX CONGRESSO NAZIONALE DMSA

ZONA GRIGIA Bone loss < 20-25% ????

TECNICA ASA ASSOCIATA ALLA CAPSULOPLASTICA



[Arthroscopy](#). 2017 May;33(5):902-909. doi: 10.1016/j.arthro.2016.09.008. Epub 2016 Nov 19.

Arthroscopic Subscapularis Augmentation of Bankart Repair in Chronic Anterior Shoulder Instability With Bone Loss Less Than 25% and Capsular Deficiency: Clinical Multicenter Study.

Maiotti M¹, Massoni C², Russo R³, Schroter S⁴, Zanini A⁵, Bianchedi D⁶.

Author information

Abstract

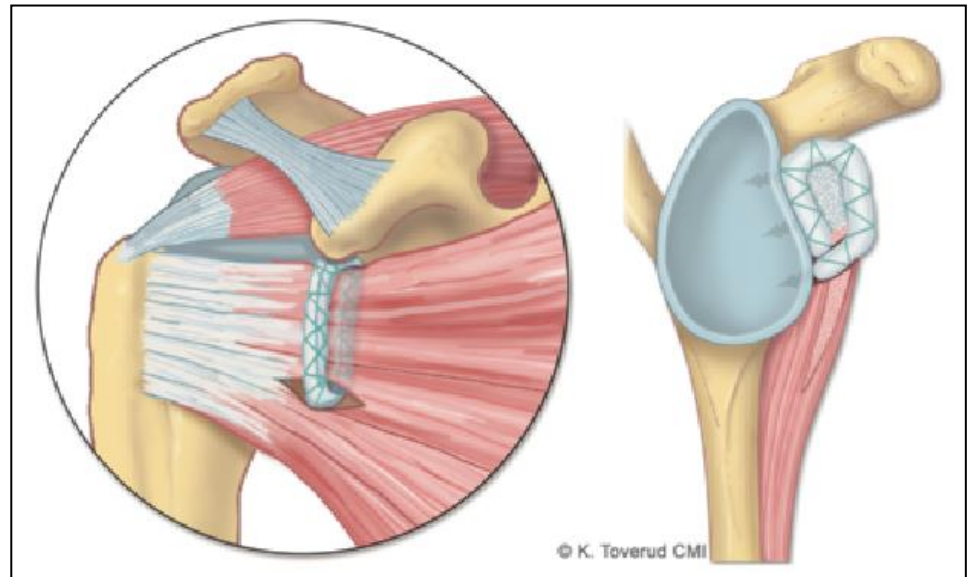
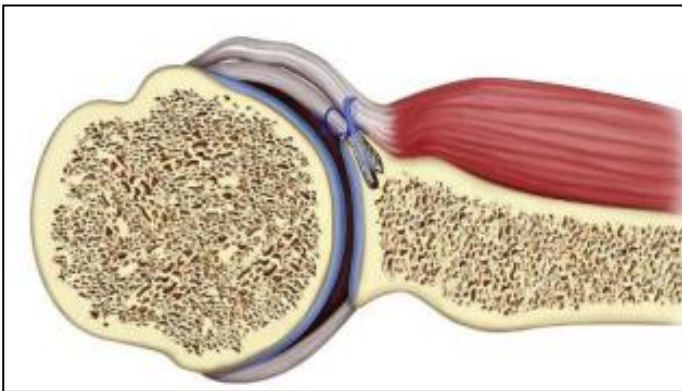
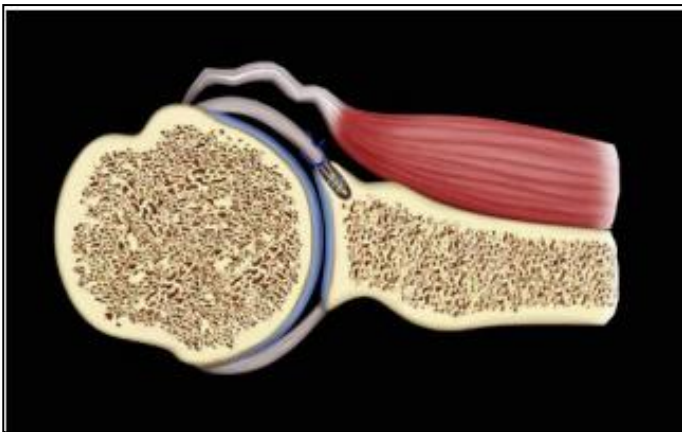
PURPOSE: To assess the short-term outcomes of the arthroscopic subscapularis augmentation (ASA) technique, consisting of a tenodesis of the upper third of the subscapularis tendon and a Bankart repair, and its effect on shoulder external rotation.

METHODS: Patients selected for this study were involved in contact sports, with a history of traumatic recurrent shoulder dislocations and a minimum of 2-year follow-up. Inclusion criteria were patients with glenoid bone loss (GBL) ranging from 5% to 25%, anterior capsular deficiency, and Hill-Sachs lesion who underwent ASA technique. Exclusion criteria were GBL >25%, multidirectional instability, preexisting osteoarthritis, and overhead sports activities. Visual analog scale (VAS) scale for pain, Rowe score, and American

IX CONGRESSO NAZIONALE DMSA

ZONA GRIGIA Bone loss < 20-25% ????

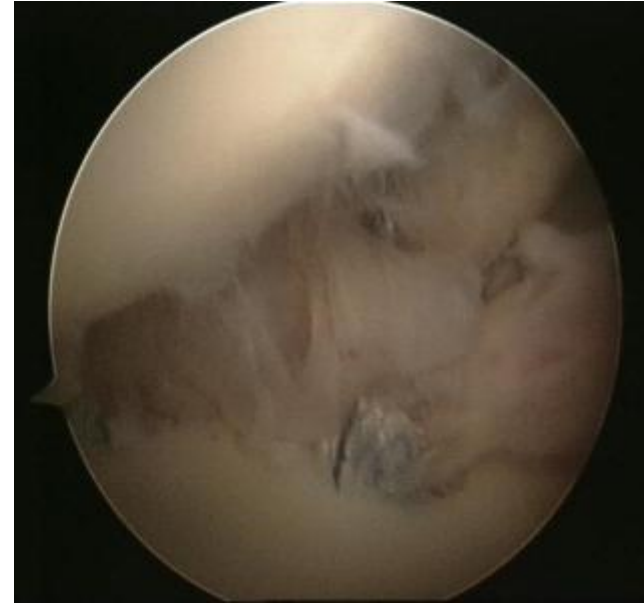
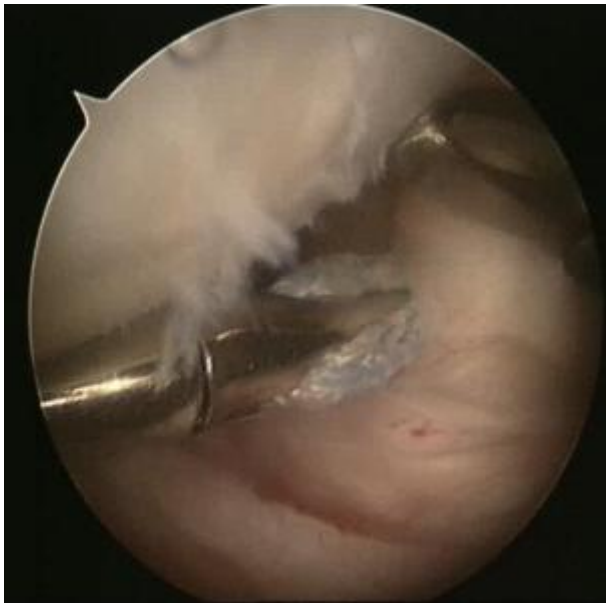
TECNICA ASA ASSOCIATA ALLA CAPSULOPLASTICA



IX CONGRESSO NAZIONALE DMSA

ZONA GRIGIA Bone loss < 20-25% ????

TECNICA ASA ASSOCIATA ALLA CAPSULOPLASTICA



IX CONGRESSO NAZIONALE DMSA

ZNA GRIGIA Bone loss < 20-25% ????

TECNICA ASA ASSOCIATA ALLA CAPSULOPLASTICA

Musculoskelet Surg. 2017 Apr;101(1):75-83. doi: 10.1007/s12306-016-0446-8. Epub 2016 Dec 21.

Arthroscopic Bankart repair associated with subscapularis augmentation (ASA) versus open Latarjet to treat recurrent anterior shoulder instability with moderate glenoid bone loss: clinical comparison of two series.

Russo R¹, Della Rotonda G², Cautiero F¹, Ciccarelli M¹, Maiotti M², Massoni C³, Di Pietto F⁴, Zappia M⁵.

⊕ Author information

Abstract

PURPOSE: The treatment of chronic anterior shoulder instability with glenoid bone loss is still debated. The purpose of this study is to compare short-term results of two techniques treating chronic shoulder instability with moderate glenoid bone loss: bone block according to open Latarjet-Patte procedure and arthroscopic Bankart repair in association with subscapularis augmentation.

METHODS: Ninety-one patients with moderate anterior glenoid bone loss underwent from 2011 to 2015. From these patients, two groups of 20 individuals each have been selected. The groups were homogeneous in terms of age, gender, dominance and glenoid bone loss. In group A, an open Latarjet procedure has been performed, and in group B, an arthroscopic Bankart repair associated with subscapularis augmentation has been performed. The mean follow-up in group A was 21 months (20-39 months), while in group B was 20 months (15-36 months). QuickDash score, Constant and Rowe shoulder scores, were used for evaluations of results.

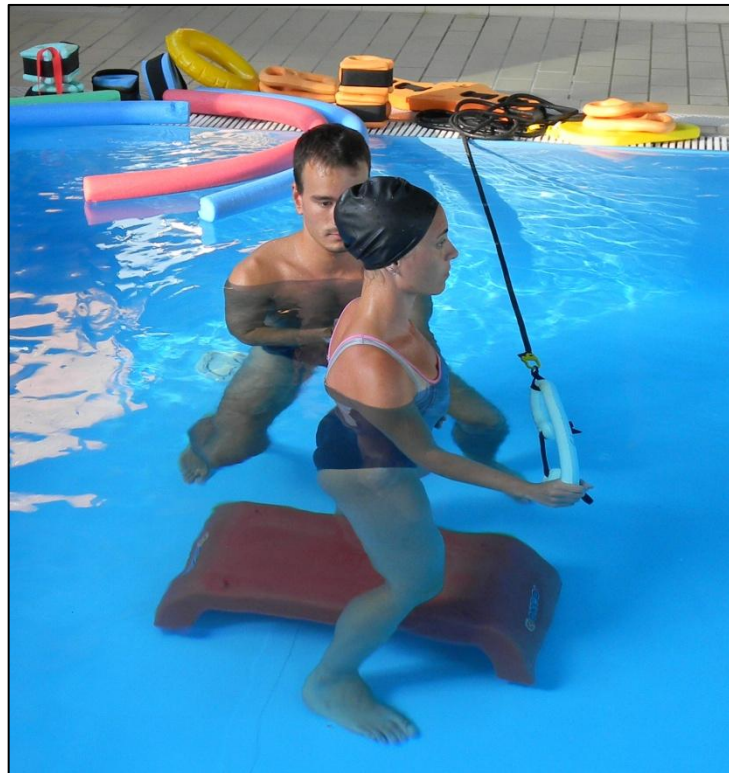
RESULTS: The mean preoperative rate of QuickDash score was 3.6 for group A and 4.0 for group B; Rowe Score was 50.0 for group A and 50.0 for group B. Preoperative mean Constant score was 56.2 for Latarjet-Patte and 55.2 for Bankart plus ASA. Postoperative mean QuickDash score was in group A 1.8 and 1.7 in group B; Rowe Score was 89.8 and 91.6; Constant Score was 93.3 and 93.8. No complications related to surgery have been observed for both procedures. Not statistically significant difference was reported between the two groups ($p > .05$). Postoperatively, the mean deficit of external rotation in ER1 was -9° in group A and -8° in group B; In ER2, the mean deficit was -5° in both groups ($p = .0942$).

CONCLUSIONS: Arthroscopic subscapularis augmentation of Bankart repair is an effective procedure for the treatment of recurrent anterior shoulder instability with glenoid bone loss without any significant difference in comparison with the well-known open Latarjet procedure.

IX CONGRESSO NAZIONALE DMSA

FISIOTERAPIA???

STESSI PROTOCOLLI PER TUTTI GLI INTERVENTI



IX CONGRESSO NAZIONALE DMSA

IGREDIENTI PER UN BUON RISULTATO

- Indicazione corretta
- Intervento chirurgico eseguito con tecnica rigorosa e precisa
- Post/op rigoroso e preciso



IX CONGRESSO NAZIONALE DMSA

GRAZIE (team & school)



Abbiamo lasciato 1 mm di lasco mediale....



MARIO



ALBERTO

MICHELE

GIANPIETRO

SILVIO

alberto.residori@gmail.com