

Abstracts From The Argentina Congress Of Shoulder Surgery.

Differences in postoperative rehabilitation after inverted prosthesis by traumatic pathology compared to degenerative disease

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The aim of this study is to present the different characteristics in rehabilitation protocols of our service after a primary inverted prosthesis (PIP) in patients with traumatic or degenerative disease pathology.

Communication between trauma and rehabilitation services is essential to optimize the results after a PIP. The surgeon knows unique aspects of pathology and surgical treatment that will be crucial in the rehabilitation process and, consequently, smooth communication between the surgeon and the rehabilitation team (specialist in physical medicine and rehabilitation and physiotherapy) is unavoidable.

There is no standard rehabilitation program to which all patients should uphold. Rehabilitation after a PIP must be strictly individualized depending on the etiology, individual patient factors such as age or comorbidity, approach, surgical technique (cemented, with ingrowth, or hybrid), and degree of stability of the tuberosities in the case of traumatic pathology or stability between humeral and glenoid components in the case of degenerative disease.

The differential components and aspects in the rehabilitation program after a PIP, according to its etiology, are shown in the following table:

Rehabilitation program (exercises)	Approach	Degenerative (Deg) etiology	Traumatic etiology
Sling		3-6 weeks	6-8 weeks
Passive	Superolateral Approach	24-48 h	
	Deltpectoral Approach	24-48 h	24-48h
	* (Deg) Subscapularis Tenotomy	3 weeks	tuberosities Stability: 3 weeks
	* (Deg) Tuberosity osteotomy	4-6week	Precarious: 6 weeks
Pendulum	(if relax properly)	Early	
Active	Superolateral Approach	2 weeks	
	Deltpectoral Approach	2 weeks	
	* (Deg) subscapularis tenotomy	6 weeks	tuberosities Stability: 6 weeks
	* (Deg) Tuberosity osteotomy	8-10 weeks	Precarious 8-10 weeks
Isometrics	Superolateral Approach	3 weeks	
	Deltpectoral Approach	3 weeks	
	* (Deg) subscapularis tenotomy	7 weeks	tuberosities Stability: 7 weeks
	* (Deg) tuberosity osteotomy	8-10 weeks	Precarious: 10-12 weeks
Active resisted	Superolateral Approach	6-8 weeks	
	Deltpectoral Approach	8-10 weeks	
	* (Deg)subscapularis tenotomy	10-12 weeks	tuberosities Stability: 12 weeks
	* (Deg) tuberosity osteotomy	12-14 weeks	Precarious14 weeks

Conflict of Interest: – NIL
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Return to sports after arthroscopic capsulolabral repair using knotless suture anchors for anterior shoulder instability in soccer players: minimum 5-year follow-up study

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Purpose: To report the return to sports and recurrence rates in competitive soccer players after arthroscopic capsulolabral repair using knotless suture anchors at a minimum of 5 years of follow-up. **Methods:** All competitive soccer players with anterior glenohumeral instability treated by arthroscopic capsulolabral repair using knotless suture anchors between 2002 and 2009 were retrospectively identified through the medical records. Inclusion criteria were: no previous surgical treatment of the involved shoulder, absence of glenoid or tuberosity fractures, absence of large Hill-Sachs or glenoid bone defect, minimum follow-up of 5 years, instability

during soccer practice or games, and failure of non-surgical treatment. The charts of included players were reviewed, and a phone call was performed in a cross-sectional manner to obtain information on: current soccer, return to soccer, recurrence of instability, shoulder function (Rowe score), and disability [Quick-Disability of the Arm, Shoulder, and Hand (DASH) score and Quick-DASH Sports/Performing Arts Module].

Results: Fifty-seven young male soccer players were finally included with a median (range) follow-up of 8 (5-10) years. Forty-nine (86 %) of the soccer players were able to return to soccer and 36 of them (73 %) at the same pre-injury level. There were 6 (10.5 %) re-dislocations in the 57 players, all of them of traumatic origin produced during soccer and other unrelated activities. The main reasons to not return to soccer were: knee injuries (two players), changes in personal life (two players), and job-related (three players). None of the players quit playing soccer because of their shoulder instability injury. The median (range) Rowe score, Quick-DASH score, and Quick-DASH sports score were 80 (25-100), 2.3 (0-12.5), and 0 (0-18.8), respectively.

Conclusions: Competitive soccer players undergoing arthroscopic capsulolabral repair with knotless suture anchors for shoulder instability without significant bone loss demonstrate excellent return to play at mid-to-long-term follow-up, with a 10.5 % chances of re-dislocating.

Conflict of Interest: – NIL
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Clavicular Blockade with local anesthesia in osteosynthesis of clavicle

Carlos Acevedo , Diogenes Rondelli .

Introduction: The local blockade of the clavicle in selected patients can provide good results in the surgical act and provide good postoperative analgesia, in addition to lower costs and offer a faster recovery, it is a quick and simple procedure .

Material and methods: A prospective study was performed in a series of 24 selected patients ASA I - II , between 19 and 42 years old, which was explained and the patients accepted the procedure and they were operated with the clavicular blockade technique with local anesthetic that was prepared in the following way: Lidocaine 2% (15ml) bupivacaine 0.5% (10ml) 20 ml of physiological saline solution 0.9%, of which is generally used 30-35 ml in the fracture focus combined with subcutaneous infiltration in the region of the

fracture. Fentanyl 100-150 micrograms was used as premedication. This way, are avoided deep punctures to prevent complications such as the pleural or vascular injuries.

Exclusion criteria topics were: ASA greater than II, the refusal of a patient, infections of the skin near the site of puncture, known hypersensitivity to local anesthetics and a time of fracture greater than 15 days. Pain tests and evaluations on the change of vital signs were conducted before the start of the surgery.

Results:

The clavicular blockade with local anesthetic was successful in 20 patients. The patients referred comfort during surgery and good postoperative analgesia, according to the visual pain scale that was evaluated during the surgery. There were no major variations in vital parameters . It should be noted that all these patients with good outcome had a broken clavicle for less than 5 days, being this a good indicator for a good block.

In 2 patients there was need for anesthetic rescue with general anesthesia, these cases had more than 10 days of fracture and 2 patients referred discomfort during the procedure.

Discussion: In the literature we found similar procedures as blockades of the brachial plexus, or supraclavicular blocks, sometimes guided by ultrasound, being this study novel when performed with a local block of the clavicle with good outcome too.

In addition to the local block of the fracture hematoma, the block is carried out in the subcutaneous area next to the fracture site covering the branches of the supraclavicular descending nerve, the superficial cervical plexus and the Brachial Plexus.

Conclusion

The blockade of clavicle with local anesthetic in selected patients ASA I-II and with a time of fracture until the osteosynthesis of less than 5 days can provide a good operative analgesia and postoperative with a fast, simple procedure with low cost.

Conclusions: Competitive soccer players undergoing arthroscopic capsulolabral repair with knotless suture anchors for shoulder instability without significant bone loss demonstrate excellent return to play at mid-to-long-term follow-up, with a 10.5 % chances of re-dislocating.

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