searched the American Board of Orthopaedic Surgery Part II database to evaluate changes in treatment over time and to identify available outcomes and associated complications arthroscopic repair of SLAP lesions. The ABOS Part II database was searched for all SLAP lesions (ICD-9 codes 840.7) and SLAP repairs (CPT codes 29807) for the years 2003 through 2008. Utilization was analyzed by geographic region, and compared with regard to complications and outcomes as self-reported by candidates during the online application process. Incidence rates were also obtained based on applicant subspecialty declaration.

Results: There were 4,975 SLAP repairs, representing 9.4% of all applicants shoulder cases. Mean follow-up was 8.9 weeks due to the time-limited case collection period. 78.4% were male and 21.6% of patients were female. The rate of repair increased over the study period to 10.1% by 2008. Mean age of male patients was 36.4 years (S.D.=13.0) with a maximum of 85 years of age. Mean age of female patients was 40.9 (S.D.=14.0), with a maximum of 88 years of age. Pain was reported as absent in only 26.3% of patients at follow-up, and function as normal in only 13.1%. 40.1% of applicants self-reported their patients to have an excellent result. The self-reported complication rate was 4.4%. Declared sports medicine specialists had a higher percentage of SLAP repairs than general orthopedists, 12.4% versus 9.2%.

Conclusions: The percentage of Part II Candidates cases that are SLAP repairs is three times the published incidence supported by the current literature for subspecialty referral practice. It might be anticipated that this rate should be even lower for general orthopedists. Especially worrisome is the rate of repair in middle-aged and elderly patients. This incidence of repair is associated with a significant rate of complications and poor outcomes. Focusing on educating young orthopedists to recognize pathologic SLAP lesions from incidental degeneration of the labrum may bring the rate of SLAP repair down to the incidence rates reflected in the literature, and hopefully decrease the complication rate and improve the outcome of arthroscopic SLAP repair.

Glenohumeral Joint Pathology Associated with High-Grade Acromioclavicular Joint Separations (SS-20) *Evan Lederman, M.D., Matthew Nugent, M.D., Thomas Carter, M.D., Anikar Chhabra, M.D.*

Introduction: Arthroscopy of the shoulder is not routinely preformed during reconstruction of the acromioclavicular joint (ACJ). During an open ACJ reconstructive procedure, failure to recognize and address glenohumeral joint (GHJ) pathology can adversely affect outcomes. There is no consensus in the literature regarding the need for concomitant GHJ arthroscopy during the time of ACJ reconstruction. The objective is to determine the need for routine GHJ arthroscopy with open ACJ reconstruction procedures by retrospectively identifying the incidence and type of GHJ pathology in patients undergoing ACJ reconstruction and to determine if pre-operative MRI's are sufficient to preclude routine GHJ arthroscopy during these procedures.

Methods: 61 consecutive patients had arthroscopic evaluation of the GHJ concomitant with ACJ reconstruction surgery. ACJ injuries were graded using Rockwood's classification. Preoperative MRI's were reviewed when available. Diagnostic arthroscopy of the GHJ was performed in the beach chair position prior to open surgical treatment. If additional pathology was found, it was addressed surgically at that time.

Results: Of the 61 patients, there were 37 type III injuries, 16 type IV injuries and 7 type V injuries. There was also one type II with an associated distal clavicle fracture, and three isolated distal clavicle fractures. There were 55 males and 6 females. Average age at the time of surgery was 37.7 years. Time to surgery from date of injury was 8 days to 51 months (average 9.9 months). 17 patients had early surgery (within 6 weeks) and 44 were delayed (after 6 weeks). 11 of the patients had pre-operative MRI scans. 46% (28 patients) had GHJ pathology. There were 22 labral tears (36%) and eight rotator cuff tears (13%). There were 11 SLAP I lesions, 7 SLAP II lesions and 4 other labral tears. Two patients (3%) had instability requiring capsulolabral repair. 46% of patients with Type III ACJ injuries, 31% with Type IV lesions, and 86% of Type V injuries had associated GHJ pathology. 100% of the rotator cuff tears and 43% of the labral tears with pre-operative MRI's were detected.

Conclusion: In patients requiring ACJ reconstruction surgery for traumatic ACJ separations, diagnostic arthroscopy of the GHJ may be warranted due to the high incidence of associated pathology. Pre-operative MRI's do not preclude concomitant GHJ arthroscopy.

Subcoracoid Impingement: Factors associated with the size and location of the Coracohumeral Interval (SS-21) *R. Timothy Greene, M.D., Marilee P Horan, M.P.H., Peter J. Millett, M.D. M.Sc.*

Introduction: A narrowing of the subcoracoid space may lead to mechanical conflicts that result in injury to the rotator cuff, biceps, and biceps pulley. The coracohumeral interval (CHI) is associated with age and gender but has not been standardized to size and anatomic location. The purpose of this study therefore was to determine clinical and anatomic factors associated with the size and location of the CHI.