

The Rotator Cuff Repair Mess

To the Editor:

I reached orthopaedic surgery led by the hand of my father, Jose M. Palomo, as well as Lorenz Böhler (*The Treatment of Fractures*) and Sir Reginald Watson-Jones (*Fractures and Joint Injuries*). Soon afterward, at the faculty of medicine, I learned about Sir John Charnley (*The Closed Treatment of Common Fractures*). Until that moment, a bony fracture meant some kind of cast and traction, as well as the dictum, “Close open fractures but don’t open the closed ones.” I had to give up that knowledge to closely and religiously follow, in a successive and exclusive way, the immovable principles of Maurice Muller (AO plates and screws), Gerhard Küntscher and Josef Ender (intra-medullary nails), R. Hamilton Russell (balanced suspension skeletal traction), Augusto Sarmiento (functional casts), Klaus Klemm and Dieter Schellman (locked nails), AO LISS plates, and nowadays, MIPO locked plates. Shall they—locked plates—remain forever or will any of the previously abandoned “obsolete” techniques return to the present time, the same way the Foucault pendulum always returns to its starting point?

It is now nearly 30 years since I started performing arthroscopic surgery of the knee, and although it has quite progressed, that development has maintained a certain predominant direction without too many bends except for extra-articular techniques and double-bundle ACL reconstruction. Shoulder arthroscopy has evolved quite differently. For rotator cuff repair, I started my training following Gary Gartsman, and so my metallic anchors went to the lateral aspect of the humerus to send their threads in an inverted mattress stitch configuration, in a single row, to push the cuff against its footprint. I then shifted to simple stitches from double-loaded metallic anchors inserted at the top of the footprint (à la Stephen Snyder) and to absorbable top and medial anchors (à la Stephen Burkhart) to configure double-everted mattress stitches brought to a second single row of PEEK anchors distal to the lateral edge of the greater tuberosity. Then came the triple-loaded metallic anchors, just to fight the SutureBridge configuration, polyester suture-based anchors, not to mention all the transosseous-equivalent constructs, which were followed by the anchorless real transosseous device. Modified Mason-Allen stitches and rip-stop constructs, as well as reconstructive tissue matrices, then came to close the loop...up to a few months ago. I have now returned, very much in the way the Foucault pendulum

does, to my starting point: following Pascal Boileau, I now prefer a lateral single row and inverted mattress stitches. I have come back to metal anchors in trans-tendinous repair of PASTA lesions and am on my way to that last step, quitting nonmetallic anchors. Moreover, I have nearly abandoned long head of the biceps tenodesis in favor of tenotomy.

I have walked along all these paths and crossed all those lines, but working in a second-level hospital as I do, my numbers do not allow me to figure out which one is the right choice to opt for. They are very different in terms of cost, procedure duration, and even surgical difficulty for ordinary surgeons like myself. All these more and more sophisticated and expensive standards have been applicable and are strongly recommended for tears ranging from small to large, but as far as massive tears are concerned, a single row of anchors even with simple stitches after some footprint medialization is deemed sufficient. In addition, there are all kinds of publications and research communications to endorse any of the aforementioned more or less sophisticated and expensive techniques. There is “evidence-based medicine” too for all those models.

What is the explanation for all this mess? I understand that there can be commercial conflicts of interest, ego conflicts of interest and personality, and unintentional bias and mistakes. I accept that there must be differences in vascularization and healing potential between in vitro and in vivo studies and, eventually, there may well be more than a single answer to a particular surgical question. However, I cannot understand why a number of outstanding surgeons, today’s Men of Research and/or Most Valuable Surgeons, cannot join to pull together (preferably in the same direction) to shed some light on this confusion. French shoulder surgeons and their multicenter studies, at least, represent an invaluable example of what should be the collective attitude and commitment.

They owe it to us ordinary arthroscopic surgeons. They certainly owe it to us in return for the constant attention we pay to their work and ideas.

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