

Editorial Commentary: The Not So Benign Nature of an Isolated SLAP Repair



Abstract: Although superior labrum anterior posterior (SLAP) repairs have a relatively high success rate, emerging evidence suggests that this is not always the case. The authors of “Subsequent Shoulder Surgery Following Isolated Arthroscopic SLAP Repair” reveal that 1 in 10 people needed additional surgery within 3 years after SLAP repair—mainly for disorders of the rotator cuff, biceps, and distal clavicle. This underscores the fact that SLAP tears rarely occur in isolation and that the initial diagnosis and management may require more than just SLAP work.

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Isolated superior labrum anterior posterior (SLAP) tears occur in 4% to 8% of shoulder injuries; however, they don't always occur in isolation and up to 72% to 88% of the time^{1,2} are accompanied by rotator cuff injuries, impingement syndrome, instability (extensive SLAP tears), and acromioclavicular disorders. Dr. Mollon and his colleagues from the NYU Hospital for Joint Disease should be congratulated for asking a focused question, applying high-level inclusion and exclusion criteria, and providing useful information about the trends of SLAP repairs and subsequent revision surgery in a contained health system.³

SLAP repairs remain a challenge, and there are increasing reports of failures after repair.^{4,5} Mollon et al.³ highlight that we still have much work to do in terms of defining what is truly a “symptomatic SLAP tear” and also how to adequately address additional relevant pathology. One concern, however, is that the authors only used *isolated* SLAP repair codes for inclusion criteria. The study assumes that the diagnosis is (1) correct, (2) includes the full spectrum of its pathology, and (3) does not describe the type of SLAP, the SLAP repair type, or any extension of the SLAP tear into the anterior or posterior labrum. Thus, from a research standpoint, these data cannot be fully extrapolated to everyone's practice; nevertheless, it certainly is what payers and insurance companies see in terms of billing and eventual revision surgery. It would be interesting to see how many patients had revision surgery that required multiple initial procedures (e.g., SLAP, labrum repair, rotator cuff

work, etc.). There surely are cases of isolated SLAP tears that are symptomatic and cause the primary limitation in patient function; however, not all SLAP tears visualized on magnetic resonance imaging or angiography are symptomatic, and the finding of a radiographic SLAP tear should be scrutinized when indicating patients for surgery.

What is interesting and likely correct is that the incidence of SLAP repair continues to decline and diagnosis should be reserved for cases with pathology clearly related to the proximal biceps.^{4,6,7} This trend to some extent could be due to patient selection in terms of sports (e.g., throwing or overhead athletes) versus those who may have sustained a traction injury (e.g., laborers, lifting).⁸ In addition, there was a trend of more biceps tenodesis cases,³⁻⁵ both from primary treatment and revision settings. This is especially true in patients older than 35 years and those with a degenerative-appearing biceps-glenoid attachment. What is clear is that our abilities to treat SLAP tears are improving. However, additional longer-term prospective, comparative studies are necessary to define optimal treatment for patients diagnosed with a SLAP injury.

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