

Editorial Commentary: To Cyst or Not to Cyst: Shoulder SLAP Lesions With Concomitant Spinoglenoid Notch Ganglion Cysts



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Abstract: When a patient presents with shoulder pain and the workup reveals a spinoglenoid notch cyst, it is presumed by most to be related to an intra-articular SLAP tear. When managing this condition cyst excision has been advocated to alleviate suprascapular nerve pressure and also perhaps minimize recurrence assuming that the SLAP has also been treated. Cyst excision can endanger the suprascapular nerve and takes additional operating room time. The question is whether repairing the SLAP and therefore removing the starting point for the cyst would be adequate as the only surgical management. My preference is to leave the operating room with some indication that the pressure on the suprascapular nerve has been dealt with by at least decompressing the cyst. But on the basis of recent published experience, we may need to re-evaluate this.

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Systematic reviews often leave the reader a bit cold because they point out that there is limited to no information to guide treatment of a particular problem. It is nice to have a systematic review that can address a reasonable question and then help answer, rather than reinforce how much we do not know or that more research is needed. The systematic review “Arthroscopic Management of SLAP Lesions With Concomitant Spinoglenoid Notch Ganglion Cysts: A Systematic Review Comparing Repair Alone to Repair With Decompression” by Schroeder, Bedeir, Schumaier, Desai, and Grawe¹ tackles the question of whether a spinoglenoid notch cyst needs to be opened or removed at the time of shoulder arthroscopy with SLAP repair, or just have the SLAP tear addressed. It is presumed in most of these situations that there is accompanying SLAP tear and that a sort of one-way valve exists that is the etiology for the cyst. Some of these patients present with neurologic compromise to the suprascapular nerve, and therefore the question comes up whether we should treat nerve

issues by managing the cyst more directly. Recent studies have indicated that perhaps just taking care of the SLAP would be adequate, and thus this systematic review was done in trying to answer this question.²⁻⁴ We even have a comparative study with reasonable numbers of patients to help us form a treatment opinion.²

One issue is that in the review it gets a bit vague with the description of exactly what is done to the cyst. For example, the authors include a study by Youm et al.⁴ in the group without cyst decompression. However, Youm et al. state that “...gelatinous material was seen to extrude in 8 of 10....” It could be a matter of debate when the SLAP is opened, debrided, and repaired if the cyst may actually be somewhat decompressed. In this situation, we may be getting an indirect treatment of the cyst, even though we are not purposefully windowing or doing a more medial dissection to take the cyst out. If the cyst is perhaps inadvertently opened by SLAP preparation, it may technically be decompressed even if the surgeon is not directly attempting to do so.

Based on the findings in this review, it does seem that the data would reasonably support that windowing the capsule or opening the medial dissection to directly see and decompress the cyst would not be needed. It would seem that here the review separates itself from many we see published and could actually affect how we manage a particular condition when it presents. Clearly, this is a reasonably uncommon problem, and so the total number of patients managed is fairly small and one can make all

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the criticisms of inadequate numbers and data to make a firm conclusive statement. One can also certainly envision that there may be exceptions to the general treatment of cysts that could be considered given a size, location, or acute denervation in findings that might push one in a unique case to be a little more aggressive to eliminate the cyst to treat the nerve. At the end of the day with the typical case of a spinoglenoid notch cyst with SLAP tear, Schroeder et al. have given us a sound basis for primarily just doing SLAP repair to treat the patient's problem.

References

1. Schroeder AJ, Bedeir YH, Schumaier AP, Desai VS, Grawe BM. Arthroscopic Management of SLAP Lesions With Concomitant Spinoglenoid Notch Ganglion Cysts: A Systematic Review Comparing Repair Alone to Repair With Decompression. *Arthroscopy* 2018;34:2247-2253.
2. Kim DS, Park HK, Park JH, Yoon WS. Ganglion cyst of the spinoglenoid notch: Comparison between SLAP repair alone and SLAP repair with cyst decompression. *J Shoulder Elbow Surg* 2012;21:1456-1463.
3. Schroder CP, Skare O, Stiris M, Gjengedal E, Upppheim G, Brox JI. Treatment of labral tears with associated spinoglenoid cysts without cyst decompression. *J Bone Joint Surg* 2008;90:523-530.
4. Youm T, Matthews PV, El Attrache NS. Treatment of patients with spinoglenoid cysts associated with superior labral tears without cyst aspiration, debridement, or excision. *Arthroscopy* 2006;22:548-552.