

References

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**Author Reply to
"Regarding 'Editorial
Commentary: Thank You,
Thank You, Thank
You...for Demonstrating
Histologic Evidence of
Shoulder Bicipital Tunnel
Disease in the Absence of
Magnetic Resonance
Imaging Findings'"**



We appreciate the interest and comments from Saithna and Jordan regarding our recent study¹ and the corresponding editorial comments by Taylor.² We would like to thank them for documenting further studies that also add to our understanding and management approach in patients with chronic long head of the biceps tendon pathology.

Regarding the ability to fully visualize the extra-articular tendon arthroscopically, multiple studies have been published recently.³⁻¹⁰ Whereas Bhatia et al.³ and Saithna et al.⁴ have reported techniques to evaluate the tendon arthroscopically, there have been other studies documenting the limitations of diagnostic arthroscopy.⁵⁻⁸ Sheean et al.⁹ showed improved visualization of the bicipital groove (zone 1) with the aid of a 70° arthroscope, but zone 2 and zone 3 (subpectoral region) remained poorly visualized. Therefore, there may remain more distal "hidden" lesions⁵ that go unrecognized with routine arthroscopy with either a 30° or 70° arthroscope.

We believe our recent study provides data that support our clinical thought, which is that there may often be pathology present further distal than the groove itself (past zone 1 and into zone 2). In addition, as Saithna and Jordan stated in their letter and as supported by our study results, even if you can perform a thorough intraoperative evaluation of the tendon, macroscopic changes in the long head of the biceps tendon do not always correlate with preoperative symptoms or imaging. In conclusion, I think we all agree that a thorough preoperative evaluation, inclusive of the history, appropriate physical examination maneuvers,¹⁰ and diagnostic imaging to evaluate concomitant pathologies, should all be considered, but the decision to perform a tenotomy or tenodesis should be made preoperatively to avoid potentially false-negative diagnostic arthroscopic findings.

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Regarding "Arthroscopic Superior Capsular Reconstruction With Acellular Dermal Allograft for the Treatment of Massive Irreparable Rotator Cuff Tears"



I wish to thank and congratulate Pennington et al.¹ for their article titled "Arthroscopic Superior Capsular Reconstruction With Acellular Dermal Allograft for the Treatment of Massive Irreparable Rotator Cuff Tears: Short-Term Clinical Outcomes and Radiographic Parameters of Superior Capsule Distance." In this article, the authors published their short-term clinical and radiographic outcome following superior capsular reconstruction. There is, however, an inconsistency in this article that I believe is important to address.

In the Methods section of the article, the authors state the following: "Postoperative advance imaging with MRI [magnetic resonance imaging] was only performed on those patients who expressed dissatisfaction with

their level of pain, or who had insufficient functional improvement in terms of strength and range of motion."¹ The issue is that in the Results section under the Failure subheading, it is stated: "Currently, we are obtaining advanced imaging of all of our patients to evaluate graft incorporation; however, we have had 3 radiographically revealed graft failures on MRI in patients reporting dissatisfaction."¹ The following is further stated in the same section: "These patients represent a failure rate of 4.5% (4/88 shoulders). All 3 radiographic failures we observed occurred at the greater tuberosity of the humerus attachment site."¹

Thus, in the Methods section, the authors report that MRI was only obtained in "patients with dissatisfaction," whereas in the Results section, readers may be left with an impression that MRI was obtained in all patients to evaluate graft incorporation. I believe that it is very important for this to be clarified, because it is stated that there were "3 radiographic failures." What is important is 3 of how many patients? If it is 3 of the 4 dissatisfied patients (if only the dissatisfied patients had postoperative MRI), then the radiographically MRI failures rates may have been much higher if all patients (satisfied and dissatisfied) had postoperative MRIs, as we know from previous publications in which all patients were scanned that patients have significant improvement in their outcome scores despite a high rate of incomplete healing with postoperative superior capsular reconstruction.² If all patients had postoperative MRI leading to a radiological MRI failure rate of 3 in 88 (which is extremely low), then the Methods section should be corrected. Otherwise, the Results section should be clarified so that one is not left with the impression that all patients had advanced imaging with MRI after surgery to evaluate graft incorporation.

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