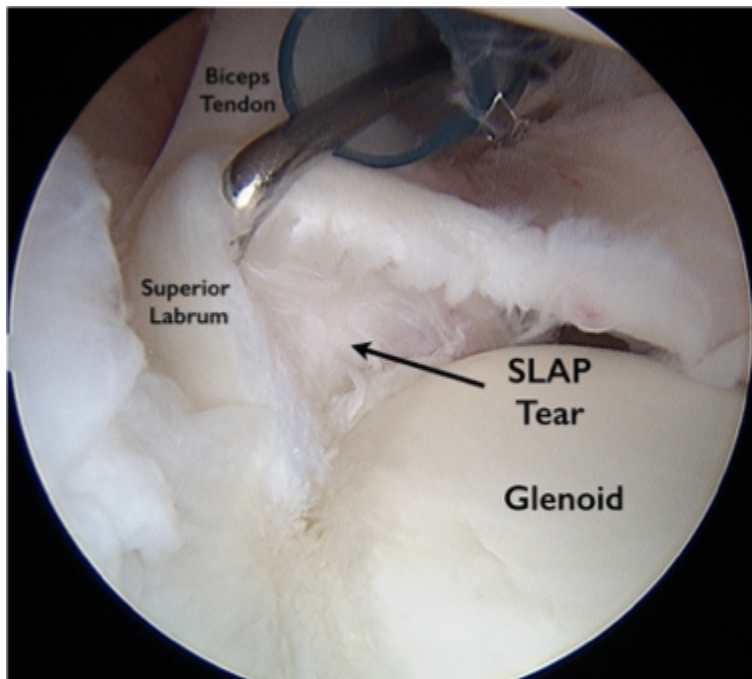


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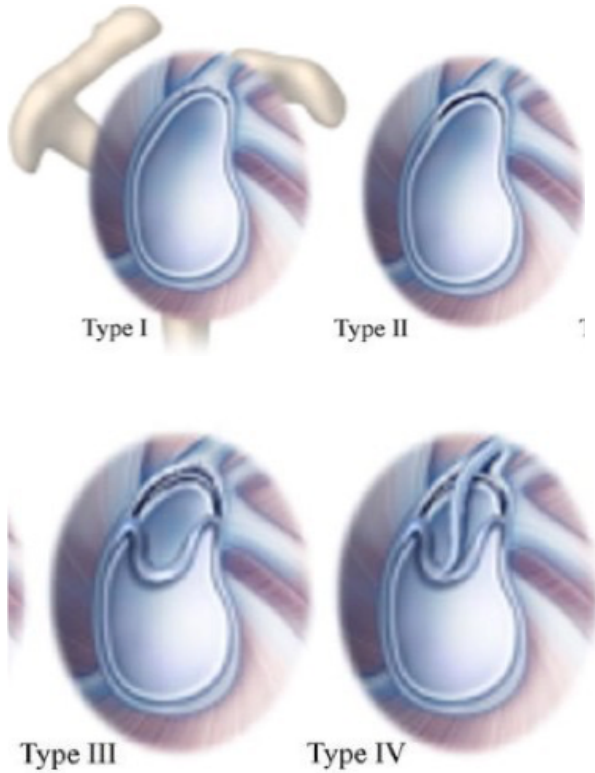
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SLAP Tears w/ Dr. Jazrawi Podcast Notes



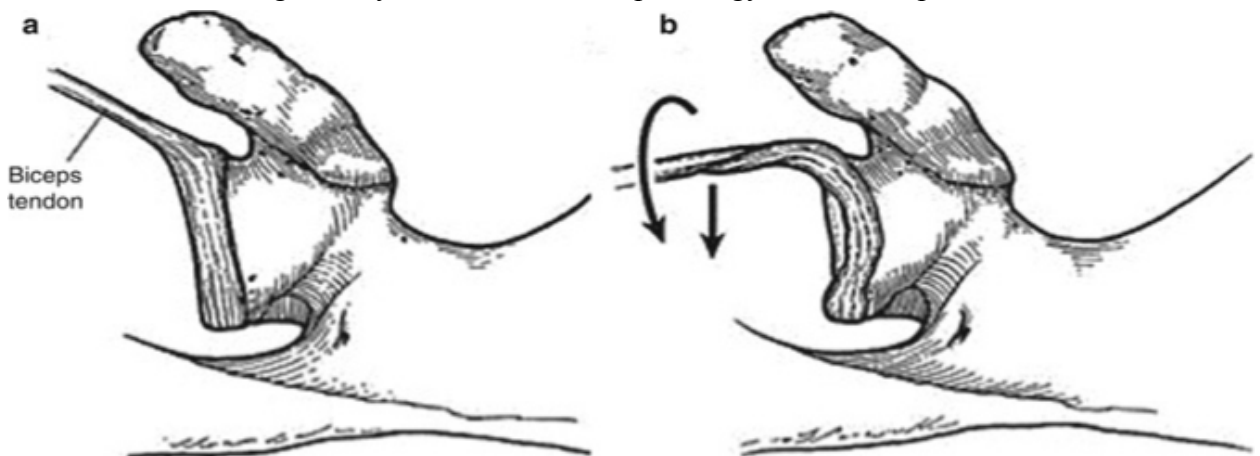
SLAP tear classification

- Type I-: superior labrum + biceps anchor fraying
- Type II- Detachment of superior labrum + biceps
- Type III- bucket handle tear w/ displacement of superior labrum, but with continued attachment of the biceps anchor to the superior glenoid
- Type IV- lesions w/ detachment of the superior labrum and biceps anchor with extension of the tear into the biceps tendon
- + additional types
- Type V- anteroinferior labral tear that extends into the superior labrum
- Type VI - biceps tendon avulsion with associated unstable flap tear of labrum
- Type VII -extend laterally inferior to the middle glenohumeral ligament
- Type VIII- tears have posterior extension.



Mechanism

- Traumatic or degenerative
- Traumatic- traction on overhead or abducted arm is MC mechanism or compression from fall on outstretched arm
- Throwers- high risk
 - Peel back mechanism- abduction + ER shoulder- puts torsional force on PS labrum and biceps anchor> causes detachment of anchor + SLAP tear
 - Overuse sx- generally don't cause labral pathology- careful w/ positive MRI



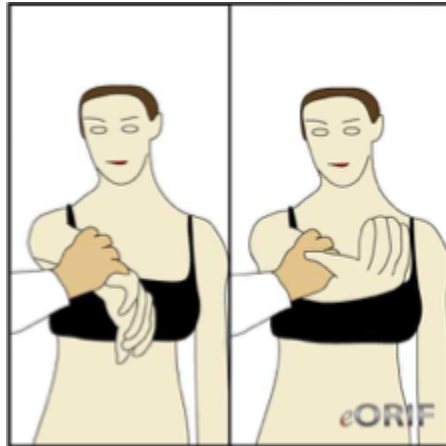
Symptoms

- Posterior shoulder pain w/ overhead activities

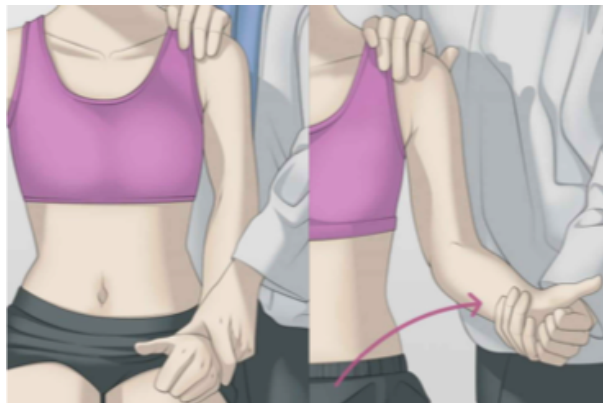
- Unstable flap- mechanical popping, catching, or grinding
- Often associated w/ other conditions

PE:

- Challenging, difficult. No sensitive/specific test
- Combination of findings may not improve results
- O'Briens active compression test
 - Shoulder @ 90 flexion, IR + adduction
 - Positive is pain w/ IR relieved by ER



- Speed, Yergason



Imaging

- Xray
 - AP/ grashey/ axillary lateral/ scap Y
- MRI
 - Closed MRI w/ magnet of 1.5T gives necessary detail
 - Results remain highly variable. Non-specific in identifying SLAP lesions
 - Paralabral cyst- pathognomonic of a labral tear> extension into spinoglenoid notch can cause SS nerve entrapment
 - Diagnostic arthroscopy may be the only definitive way to dx SLAP shoulder lesions

- During ATS- granulation tissue- high specificity for SLAP lesion

Decision making factors

- 1st treatment is non-op, unless spinoglenoid notch cyst w/ sx of suprascapular nerve compression

Operative tx options

- Debridement
 - High failure rate in athletic population
 - Studies show- improved outcomes w/ debridement w/ RCR v repair (type II)
 - Appropriate from some type I and III lesions
- Biceps tenodesis
 - Older lower demand patients, or for type IV SLAP lesion
 - BT, tenotomy, debridement- all options rather than slap repair
 - Proximal or distal open are techniques used
 - Subpec Btenodesis in young high demand and tenotomy on low demand or >40
- SLAP repair
 - Indications:
 - Younger patients w/ a symptomatic SLAP lesion
 - Type II slap tear w/ mechanical sx
 - Type II- fail non op w/ hx and PE
 - spinoglenoid notch cyst compressing SS nerve
 - Relative indications:
 - Type III and IV w/ large bucket handle tear w/ adequate vasc supply
 - Technique- suture anchor repair
 - Anchor placement
 - anterior to biceps- shown to decrease shoulder ER- which may not be good for overhead athlete
 - Suture-
 - bioabsorbable or non-absorbable? Knot squeaking?
 - Knot v Knotless anchors?
 - Some technical advantage w/ knotless, but may lead to decreased load to gap formation at

SLAP repair tips:

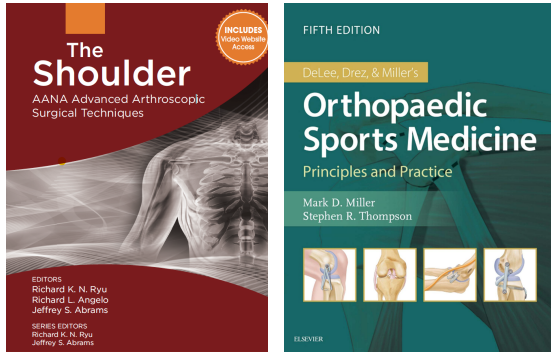
- Mua under anesthesia?
- Determining pathologic tear v physiologic?
- Use of labral tape?
- Degree of anchor insertion?

Post-op

- Cryo + sling x 4weeks
- 2 weeks postop- AA and PROM exercises

- Strengthening at 6 weeks
- RTP 4mo

Sources:



Abbot AE, Li X, Busconi BD: Arthroscopic treatment of concomitant superior labral anterior posterior (SLAP) lesions and rotator cuff tears in patients over the age of 45 years. Am J Sports Med 2009; 37: pp. 1358-1362.

Oh JH, Lee YH, Kim SH, et. al.: Comparison of treatments for superior labrum-biceps complex lesions with concomitant rotator cuff repair: a prospective, randomized, comparative analysis of debridement, biceps tenotomy, and biceps tenodesis. Arthroscopy 2016; 32: pp. 958-967.