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The rate and predictors of healing of repaired lesser tuberosity osteotomy in reverse total shoulder arthroplasty

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**A R T I C L E   I N F O**

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Level of evidence: Level III; Retrospective Cohort Comparison; Prognosis Study

**Background:** Evidence is building that a functional subscapularis improves function—specifically internal rotation tasks—following reverse total shoulder arthroplasty (rTSA). However, the optimal method for subscapularis repair during rTSA remains unknown with variable healing rates reported. This study aims to investigate the rate of and predictors for healing a lesser tuberosity osteotomy (LTO) following rTSA.

**Methods:** Following local institutional review board approval, patients with at least one-year follow-up for rTSA managed with an LTO and subsequent repair between March, 2017 and March, 2020 were retrospectively identified. Shoulders were selected for LTO repair based upon preoperative imaging and intraoperative assessment of subscapularis quality. All patients were implanted with a system consisting of a 150° or 155° (constrained) humeral neck-shaft angle and 2.5 to 4.5 millimeters (mm) of glenoid lateralization (Trabecular Metal Reverse Shoulder System; Zimmer Biomet, Warsaw, IN, USA). At a minimum of six months, radiographs were reviewed for an assessment of LTO healing by three independent reviewers. Healing was classified as displaced, fibrous union, or ossified union. For assessing predictors, the repair was considered intact if the LTO fragment was not displaced (fibrous union or ossified union).

**Results:** Sixty-five rTSA with LTO repair were performed in 64 patients. These patients had an average age of 67.2 years (range, 31-81) and 36 (55.4%; 36/65) were female. At an average follow-up of 15.2 months (range, 8-38), 50 cases (76.9%; 50/65) were classified as having an ossified union. The radiographic healing could not be assessed in a single case. Of the 14 cases without ossification, 8 (12.3%; 8/65) were displaced and 6 (9.2%; 6/65) were combined fibular liner height predicted LTO displacement (odds ratio = 1.4 [95% confidence interval = 1.1-1.8]; P = .01). Humeral loosening was not found in any cases following LTO.

**Conclusion:** This analysis demonstrates that radiographic healing of LTO repair is more favorable than published rates of healing after subscapularis tenotomy or peel in the setting of rTSA. Subscapularis management with LTO provides the ability to monitor repair integrity with plain radiographs and a predictable radiographic healing rate. The integrity of subscapularis repair may be influenced by the use of thicker humeral liners. Further investigation is needed to determine the functional impact of a healed subscapularis following rTSA.

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subscapularis in the setting of rTSA, however, remains poorly understood. Given the altered joint position and glenohumeral kinematics of rTSA compared to anatomic total shoulder arthroplasty, there are theoretical concerns regarding subscapularis healing potential. Some have questioned whether effective healing occurs with soft tissue subscapularis repair techniques in the setting of rTSA.\(^5\) Using an rTSA system with a lateralized glenoid and medialized humerus, Collin et al reported a 52% healing rate on ultrasound following repair of a subscapularis tenotomy.\(^4\) Importantly, these authors reported improved functional internal rotation in patients with a healed subscapularis repair. Given the potential influence of subscapularis integrity on functional outcomes following rTSA, further studies are needed to determine the method of repair that maximizes healing. LTO for subscapularis management and repair provides theoretical advantages of subscapularis integrity following rTSA. This study aims to (a) quantify the healing rate and (b) determine predictors of healing for this unique approach. It is hypothesized that in the setting of rTSA, LTO repair will provide a superior healing rate compared to other subscapularis management techniques, and that meaningful predictors of LTO healing will be identified.

**Methods**

Following local institutional review board approval, a retrospective analysis was undertaken. All patients undergoing primary rTSA with a repaired LTO by one of two shoulder and elbow fellowship-trained surgeons at a single academic institution between 2017 and 2020 with an identical rTSA implant were identified. Patients undergoing rTSA for fracture or revision arthroplasty were excluded. Minimum follow-up for inclusion was 6 months with plain radiographs that included an anteroposterior, Grashey, lateral, and 6 (6/65; 9%) were displaced LTO, 50 (50/65; 77% of entire cohort) had bony union and 6 (6/65; 9%) were fibrous union. In this early follow-up period, there was no evidence of stem subsidence or humeral loosening in any cases. Interobserver reliability for determination of LTO healing was substantial with kappa value of 0.74 (substantial agreement), both for full classification and for dichotomous healed versus not healed (displaced). In 55 cases (84.6%; 55/65), all three reviewers independently agreed. In the remaining cases, 2 of the 3 reviewers agreed during the independent review.

When comparing healed versus non-healed (displaced) LTO, there was no difference in the age (67.1 vs. 67.6 years; \(P = .89\)). Male patients were more likely to develop an LTO nonunion (24.1%; 7/29) compared to females (2.8%; 1/35; \(P = .02\); Fig. 3). Females were more likely to develop a non-displaced fibrous union (14.3%; 5/35) than males (3.4%; 1/29; \(P = .02\)). Patients with an LTO nonunion had a thicker humeral liner (mean 6.75 mm; standard deviation (SD) = 4.7) compared to those with an intact LTO repair (mean 2.0 mm; SD = 2.4; \(P < .001\)). No statistically significant difference was noted between males (3.1 mm; SD = 4.0) and females (2.0 mm; SD = 2.2; \(P = .07\)) for humeral liner thickness. On multivariate logistic regression, overall liner height was the only significant predictor of LTO displacement with a 1 mm increase in liner height associated with a 40% increase in the odds for LTO displacement (odds ratio = 1.4 [95% confidence interval = 1.1-1.9]; \(P = .01\)).
Figure 1 Intraoperative photographs detailing (a) saw placement for lesser tuberosity osteotomy, (b) completed lesser tuberosity osteotomy, (c) placement for drill tunnels lateral to the bicipital groove, (d) heavy-braided sutures passed through the drill tunnels around the stem, (e) impacted stem with secured sutures, and (f) repaired lesser tuberosity osteotomy.

Figure 2 Examples of radiographic (a) ossified union, (b) fibrous nonunion, and (c) displaced nonunion following LTO repair in the setting of rTSA. LTO, lesser tuberosity osteotomy; rTSA, reverse total shoulder arthroplasty.
Receiver operating characteristic analysis (area under the curve = 0.74) demonstrated a sensitivity and specificity of radiographic failure for LTO healing of 85.7% and 55.6%, respectively, for a liner thickness of 4.5 millimeters or greater.

**Discussion**

Subscapularis repair during rTSA remains a controversial topic with theoretical but poorly defined advantages. Some authors suggest improved internal rotation and decreased risk for instability with subscapularis repair, while others have highlighted the poor healing rate of subscapularis repair with tenotomy or peel. This study aimed to understand the radiographic healing rate of traditional LTO repair using a single rTSA system with a valgus humeral stem and slight lateral glenoid offset. Only 12.3% of repaired LTO in this rTSA cohort were displaced at the latest follow-up. Furthermore, over three-quarters of the cohort achieved an ossified union of the LTO.

The healing rates reported in this study are substantially higher than healing following rTSA with other methods of subscapularis management. Using a Grammont-style implant, de Boer et al found that only 40% of selectively repaired subscapularis tenotomies were intact on ultrasound at a minimum of 12 months. They were unable to detect a difference in functional scores based upon subscapularis repair or postrepair integrity. Similarly, Collin et al found a marginal healing rate (52.6%) for patients undergoing rTSA with a Grammont style implant with lateralized placement of the glenoid component via bone-graft and selective subscapularis tenotomy repair. While they also noted no difference in patient-reported outcome measures, they did find that patients with an intact subscapularis demonstrated significantly greater internal rotation with no loss of external rotation. In contrast, Erickson et al reported an 83.3% healing rate on ultrasound of a double row subscapularis peel repair following rTSA with a 135° humeral neck-shaft angle. They also did not note a difference in patient-reported outcomes of range of motion based upon postoperative subscapularis integrity. Lastly, Dedy et al reported on the subscapularis integrity of a cohort of patients treated with mixed subscapularis management techniques (48% LTO) and a mix of Grammont style implants. They found that 77% of cases had a subscapularis in continuity. However, a majority of the cohort had a subscapularis that was mildly (33%) or severely (31%) attenuated. In their analysis, subscapularis integrity did not appear to impact patient-reported outcomes but did influence achievable internal rotation.

In addition to finding a high incidence of healing, this study identified that at-risk repairs may be predictable. Multivariate
analysis demonstrated that polyethylene liner thickness is independently associated with LTO displacement. The majority of displaced LTO nonunions in this cohort occurred in males. However, men trended toward having an increased liner thickness. The humeral implant used in this study is characterized by a valgus neck-shaft angle, leading to relatively greater distalization with increasing liner thickness compared to a system with a varus humeral implant. Increasing the humeral liner thickness may place greater strain on the repair and ultimately lead to early failure. Conceptually, this may explain the variability in previous reports of subscapularis healing.14,17 with higher healing rates associated with systems utilizing humeral implants with more varus neck-shaft angles.7 Decreasing tension through smaller humeral liners in a Grammont-style system may improve LTO union rates without compromising prosthetic stability, as prior literature suggests improved stability with subscapularis repair.

The findings of this analysis must be interpreted in light of its limitations. First, this is a retrospective analysis with many confounding variables that cannot easily be controlled for, including surgeon bias toward which patients were considered for subscapularis repair, and variable indications for surgery. This complicates the assessment of predictors for displacement following LTO repair. Given the selective use of subscapularis repair, findings of this study would have limited applicability to shoulders with advanced subscapularis damage and/or contracture. All repairs in this study were performed in a similar technique using the same humeral stem and a consistent range of glenoid offset. In the presence of reasonable subscapularis tissue quality, this method of repair produces consistent healing results. The goal of this study was to report radiographic rates of LTO union. Ossific or fibrous union of an LTO repair does not necessarily dictate a healthy and functional subscapularis tendon, and we cannot make conclusions about association of healing with clinical function. In this analysis, there was no utilization of ultrasound or computed tomography to further confirm subscapularis integrity. Other analyses have demonstrated some clinical improvement with subscapularis repair and subsequent integrity. While we note a suspected improvement in subscapularis integrity with an LTO repair in this setting, we make no effort to correlate this with clinical outcomes. We report that humeral liner thickness has a significant impact on LTO displacement. However, we did not account for the humeral stem placement or any further radiographic parameters that may dictate humeral liner thickness. Although this was a single implant system and single repair technique, findings of radiographic union may not be reproducible in systems with greater lateralization and/or varus humeral neck-shaft angles. Finally, given the retrospective nature of this study, we did not precisely control for the size or dimension of the LTO fragment. Bony surface area for healing could have a potential influence of healing rates following LTO repair. Despite this potential flaw, we were able to discern the position of the LTO in all but one case and were able to demonstrate a consistent rate of LTO healing across a nonuniform range of LTO sizes in this cohort.

**Conclusion**

In conclusion, subscapularis repair through a lesser tuberosity osteotomy has a high rate of radiographic healing compared to other repair constructs described. Furthermore, repair of the subscapularis with an LTO in the setting of rTSA allows for reproducible radiographic monitoring of the repair integrity with plain radiographs. Consideration should be given to minimizing humeral liner thickness when attempting to repair the subscapularis with a more valgus humeral stem. More research is needed to truly understand the impact of a repaired and functional subscapularis on functional outcomes following rTSA.

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