**ABSTRACT**

Massive rotator cuff tears, involving the posterosuperior rotator cuff, remain difficult to treat particularly in the younger population. Fatty infiltration of the muscle, excessive chronic tendon retraction, and degeneration are the main irreversible factors predisposing to high failure rates of direct repair. There are many techniques for Superior Capsular Reconstruction (SCR) mainly using allograft. However low accessibility to the dermal grafts in many countries led the authors to use and suggest autograft of the fascia lata as another option for the reconstruction of the superior capsule of the shoulder. These techniques are reliable options for irreparable lesions of the rotator cuff.

**Key words:** Rotator cuff; Shoulder pain; Tendon injuries; Superior capsular reconstruction

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**INTRODUCTION**

Massive rotator cuff tears, involving the posterosuperior rotator cuff, remain difficult to treat particularly in the younger population. With an arthroscopic, or open approach, rotator cuff repair is possible in the majority of cases and functional outcomes are improved. The term “irreparable” has been used with different meanings in the past. For example, the term was frequently used when partial repair of the rotator cuff was performed[1].

More recently, a subtle change in meaning was adopted. The term “irreparable” began to be used to describe a rotator cuff that was either (1) predicted to be irreparable based on preoperative characteristics; or (2) predicted to have a poor outcome from rotator cuff surgery, regardless of the possibility of achieving current intraoperative repair[2].

Fatty infiltration of the muscle, excessive chronic tendon retraction, and degeneration are the main irreversible factors predisposing to high failure rates of direct repair. Some authors say that the term irreparable should only be applied intraoperatively[1].

Hanada et al first described a “superior capsular reconstruction” of the glenohumeral joint as a revision operation in a paraplegic patient with an irreparable supraspinatus tendon tear[3,4]. During a postoperative follow-up, 1.2 years after the surgery, pain persisted as well loss of function. Muscle strength and endurance deteriorated to “fair”. In summary, the overall result was unsatisfactory[3].

During cadaveric studies of patch graft surgery, for irreparable rotator cuff tears, Mihata et al discovered that the graft should be attached.
Rotator cuff strength is assessed initially by testing the resisted external rotation (to detect tears of the supraspinatus, infraspinatus, and teres minor). A positive Homblower’s Test and Lag Sign indicate involvement of the supraspinatus, infraspinatus, and teres minor. In addition, subscapularis function is tested by means of the Bear Hug, Belly Press, and Lift-Off Tests.

**SURGICAL TECHNIQUES**

These techniques require an experienced surgeon and surgical team, in addition to the appropriate (sometimes considerable) time needed to complete the procedure. Preparation of the joint, before beginning the reconstruction of the upper capsule, is of the utmost importance.

Acromioplasty can be performed to improve visualization of the subacromial space, but some authors preserve the coracoacromial ligament in massive cuff surgery.

Biceps tenotomy for elderly and tenodesis of the biceps for the younger patients can be performed according to the surgeon’s preference.

Partial cuff repair is almost always possible and should be performed routinely to improve the forward range of motion, and avoid possible suprascapular nerve compression.

The subscapularis tendon should be sutured in the minor tubercle, according to the surgeon’s technical preference, as it plays an important role in the static and dynamic stability of the shoulder. Without a functional subscapularis suture, the reconstruction of the upper capsule may fail.

Release of the teres minor and infraspinatus should be done to cover as much area as possible during the repair. The posterior interval slide technique is a viable option to improve tendon mobility. Good postero-lateral coverage improves the prognosis of external rotation in the postoperative period, since the upper capsule will be the stabilizer that will make the fulcrum of the glenohumeral joint, while the remaining tendons move the joint.

Exposure of the glenoid should be extensive, with removal of all tissue from the supraglenoidal tubercle for easy identification of future anchor location.

Mihata et al. inserted the anchors into the superior glenoid at the 10 to 11 o’clock and 11 to 12 o’clock positions on the glenoid of the right shoulder (or the 1 to 2 o’clock and 12 to 1 o’clock positions of the left shoulder).

The Nevasier Portal and accessory portals anterior and posterolateral should be used when necessary. Angle placement of the anchor is critical, as there must be no invasion of the joint. If the distance between the anchors is greater than 35 mm a third anchor may be used.

The major tuberosity of the humerus is prepared by removing all remaining tissue leaving a propitious and scarified bone area.

A milimetered probe is used to measure the anteroposterior distance to the glenoid, the anteriorposterior distance to the great tuber, and the medial lateral distances. A made-to-measure graft is then fashioned based on these specific measurements.

To provide tissue for fixation, 5 mm is added to the medial, anterior, and posterior dimensions and 15 mm is added to the lateral dimension, to account for the rotator cuff footprint.

A vertical skin incision is made, over the lateral thigh and around the greater trochanter of the femur. A section of fascia lata 2 to 3 times the size of the superior capsular defect is harvested, after which a graft 6 to 8 mm thick is fashioned by folding the fascia Lata twice or thrice as necessary.

The glenoid anchor wires should be arranged on the graft before the latter is transported through the cannula in the lateral portal and guided to its location in the glenoid. There are successful several variations of this strategy, which depend on the choice of glenoid an-
the size of the graft.

Insertion of the graft into the joint is the most challenging part of the procedure (Figure 3). Several technical tips can help to prevent complications[1].

The sutures in the medial row of the greater tuberosity are crossed over the graft and secured with 2 additional lateral suture anchors in a transosseous-equivalent style repair (Figure 4). This is done with 20° to 30° of arm abduction. Mihata, however, in his original paper references the use of 45° of abduction[3].

The important concept to note is that, the graft should not be placed with laxity.

The graft is then sutured to the infraspinatus using 2 or 3 sutures in a simple fashion. This a not an optional step[1,6,21].

Reconstruction of the upper capsule using the LHBT, consists of preserving the previously integrated bicipital insertion, evaluating the viability of the remaining LHBT with no excessive tendinitis or partial tears.

Repairable partial and/or full infraspinatus and subscapularis tendin tears must be reconstructed to ensure the stabilizing force couple in the transverse plane[9].

A 5.5 mm suture anchor is inserted approximately in the middle of the greater tuberosity (just behind the bicipital groove). The surgeon then passes all sutures through the intact LHBT, performing a “lasso-loop” configuration[8]. (Figure 5).

After this, tenotomy with or without tenodesis is performed on the biceps distal to the suture. Sutures are then pulled and tied by placing the tendon in the desired position.

Side-to-side fixation of the infraspinatus and subscapularis with the LHBT is performed.

Postoperative radiographs should show down-migration of the humeral head after procedure[7].

**POSTOPERATIVE PROTOCOL**

The use of an abduction pillow, for 4 weeks after the reconstruction surgery, is recommended. After the immobilization period, passive and active-assisted exercises were initiated.

Eight weeks after surgery, patients begin to perform exercises in order to strengthen the rotator cuff and scapula stabilizers with the as-
sistance of physical therapists\(^6\).

Active overhead motion strengthening exercises are not advised in the period up to four months after surgery. Thus allowing adequate time for allograft incorporation and cuff healing. High-demand activities are restricted for 1 year after surgery\(^5\).

Hirahara et al\(^6\) use musculoskeletal ultrasound to evaluate the dermal allograft. Subsequently showing that the graft is incorporated into the patient’s body and transformed into host tissue. Vascularization was found using a Doppler 4-8 months after surgery, thus proving incorporation of the tissue.

**CONCLUSION**

The SCR technique has shown very good functional and biomechanical results. In the body of this article, several technical options are described using either a Dermal graft or less expensive alternatives such as fascia lata and LHB. As surgeons become more familiar with the SCR technique, the use of this surgery, as an option for irreparable lesions of the rotator cuff, will significantly increase.

**REFERENCES**


