

Arthroscopic management of a lateral glenohumeral ligament rupture in two dogs. A comment

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Dear Sir,

I would like to commend Mr. Pettitt and Prof. Innes on their interesting case report detailing the arthroscopic management of lateral glenohumeral ligament (LGHL) ruptures in two dogs (1). I would like to make a few comments and ask some questions on the cases and their management.

Firstly, the cases were initially investigated from a standard lateral portal and subsequently surgery was performed using a hanging limb and craniomedial portal. Have the authors changed their standard examination technique in light of this? Is it possible that previous cases investigated from a lateral portal have had pathology missed but have recovered despite incomplete diagnosis?

Secondly, both cases were Labrador Retrievers and there was not any speculation regarding the cause of injury. McKee and others (2) described infraspinatus bursal pathology in 13 Labradors. Is it possible that the lesions seen in these two cases were early cases of infraspinatus bursitis with resulting impingement of the lateral capsule and subsequent rupture, similar to the

mechanism of injury in people with superior labral anterior posterior (SLAP) tears?

Thirdly, both cases were initially treated conservatively, consisting of exercise restriction for six weeks. Do the authors feel that a more aggressive physiotherapy regime, including underwater treadmill and proprioceptive retraining, may have been more beneficial? A small, unpublished case series that I saw of LGHL tears responded poorly to physiotherapy in contrast to medial glenohumeral ligament (MGHL) and subscapularis tears, which, in my experience, respond well to physiotherapy.

Fourthly, neither case had a sling nor hobble applied post-operatively, which may have resulted in the approximated tissues becoming separated through normal limb use. Is it possible that debridement of the tear alone may have resolved the lameness as reported by Andrews and others (3) in human patients with SLAP tears.

Finally, I would like to comment on the surgical technique. Suture anchors were used and arthroscopic knots tied in both cases. I have used a 2.9 mm Pushlock (Arthrex, Naples, FL, USA) in an Alaskan Malamute with a similar injury. This is a knotless suture anchor system which obviates the need for knot tying equipment, which is large and cumbersome. The absence of the knot also means that the repair is completely

flush to the bone surface, reducing the potential risk of knot impingement within the joint. I used two lateral portals in exactly the same manner as described in the case report but I used larger 5.5 mm Crystal Cannulas (Arthrex). Recently, I trialled a new cannula system on a cadaver (Staffordshire Bull Terrier) which appeared to solve the problem of the cannula dislodging. The cannula is called a Passport (Arthrex) and is a soft malleable cannula with flanges either side. It also includes a dam so that whilst it is not being used fluid is not lost from the joint. It is relatively easy to place and once in it does not fall out. It is also large enough so that all of the shuttling can be performed through the one cannula.

References

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