Re: 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.

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Dear Editor,

We read the editorial comment by Dr Taylor with great interest [1] and we agree that the recent publication from Nuelle et al. [2] entitled ‘Radiologic and Histologic Evaluation of the Proximal Bicep Pathology in Patients With Chronic Biceps Tendinopathy Undergoing Open Subpectoral Biceps Tenodesis’ furthers the notion that the decision to perform surgery for long head of the biceps tendon (LHBT) pathology should not rely exclusively on imaging, or indeed on the macroscopic appearance of the tendon intra-operatively.

Our clinical experience mirrors the observations made by Nuelle et al, that in patients with chronic LHB tendinopathy, who undergo open subpectoral tenodesis, pre-operative MRI and intraoperative assessment often do not show significant abnormalities. However, we do not agree with the statement by Dr Taylor that “direct visualisation of the bicipital tunnel is not possible”. Previously Bhatia et al. [3] reported the ability to perform biceps tenoscopy to visualise the intra-articular and intertubercular regions of the tendon. We have also demonstrated that biceps tenoscopy can be successful in allowing full visualisation of the extra-articular LHB [4]. However, because of our experience, confirmed by Nuelle et al, that macroscopic appearances of the LHBT don’t correlate with symptoms, we do not advocate biceps tenoscopy routinely. Instead, we agree that the decision on LHB management should be made pre-operatively.

However, pre-operative assessment of LHB pathology has its challenges. In 2015 we reported that the sensitivity and specificity data reported for many imaging studies and physical examination tests was invalid because of the reliance on arthroscopy as the gold standard [5]. We have previously advocated that arthroscopy should no longer be considered the gold
standard because several authors, including ourselves, have demonstrated that standard
arthroscopic techniques fail to adequately visualise the LHBT. In our systematic review we
reported that the visualisation of the overall tendon length in these studies varied between
only 34% to 48%. Therefore a “normal” arthroscopy does not exclude pathology. This is
further evidenced by Gilmer et al. and Murthi et al. who have reported that arthroscopic
assessment missed LHBT pathology in between 33% and 51% of cases when compared
to open assessment [6, 7]. Although the “3-Pack” examination advocated by Dr Taylor [8]
has the advantage of sensitivity and specificity data derived from visualisation from the
subdeltoid arthroscopic portal, which provides greater visualisation of the overall tendon
length compared to standard posterior portal viewing, it still remains a limitation that the
macroscopic appearances of the tendon do not necessarily correlate with patient symptoms.

In closing we would like to state that we agree with Dr Taylor [1] with respect to the message
that the decision to perform tenotomy or tenodesis should be made pre-operatively. In our
opinion this should be based on the patients’ symptoms and by holding an appropriate index
of suspicion for pathology based on the presence of concomitant pathologies. We do not
discredit physical examination tests and imaging modalities because important roles have
been defined for each but we do feel that the limitations of each must be highlighted and
clearly understood in order to avoid the high rate of missed diagnoses of LHBT pathology.
We also feel that it is particularly important to emphasise that a “normal” arthroscopy, even
with advanced arthroscopic techniques such as biceps tenoscopy, does not exclude important
symptomatic pathology because macroscopic changes are not always present.
References


of the Biceps-Labrum Complex and the Bicipital Tunnel: A Prospective Study.


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