SHOULDER

Advanced

Nerve decompressions around the shoulder

Chair: Freek Hollman, VieCuri medical center, the Netherlands

This ICL will provide knowledge on nerve related conditions around the shoulder which we are dealing with in our daily shoulder practice. How can we recognize and treat them appropriately?

Endoscopic brachial plexus release for neurogenic thoracic outlet syndrome.
Jose Garcia, Brazil

Suprascapular nerve release in the presence of massive retracted rotator cuff tears.
Ashish Gupta, Australia

Different levels of compression on the supra scapular nerve. When and where to release it?
Roman Brzoska, Poland

Nerve decompression around the scapula
Bassem Elhassan, USA

Advanced

Open and arthroscopic management of complex shoulder instability in the high demand athlete

Chair: Brian Waterman, Atrium Health Wake Forest Baptist, USA

In this ICL, we will present the primary evaluation of uni-, bi-, and multi-directional shoulder instability, high yield physical examination findings, and radiographic findings that guide clinical and surgical management. Through a case-based format and interactive panel discussion, we will discuss the roles for arthroscopic capsulolabral repair, remplissage, open Bankart repair, arthroscopic and open Latarjet, bone block augmentation, and dynamic anterior stabilization.

The lost art of the physical examination and radiographic evaluation of the unstable shoulder
Brian Waterman, USA

Arthroscopic & open soft tissue stabilization: don't overlook the classic bankart repair!
Philipp Moroder, Switzerland

The gold standard IS the latarjet procedure: open vs. arthroscopic, screws vs. buttons… you decide!
Ruth Delaney, Ireland

Free bone blocks ARE the future: distal tibia, scapular spine, clavicle, & more
Stephen Parada, USA

Advanced

Optimizing internal rotation recovery after reverse total shoulder arthroplasty

Chair: Philippe Collin, AHP Paris, France

Part 1: Patient-Related Factors
Part 2: Implant-Related Factors
Part 3: Overall Patient Morphology
Part 4: Outcome Evaluation and Reporting

How to report internal rotation after RSA
Alexandre Laederman, Switzerland

Retroversion, inlay/onlay, sphere size, does the implant matter?
Calvo Calvo, Spain

Does the general morphology has an impact
Philipp Moroder, Germany

Importance of subscapularis
Philippe Collin, France

Advanced

Optimizing rotator cuff healing in challenging rotator cuff tears in 2025

Chair: Robert Tashjian, University of Utah, USA

Failure of rotator cuff repair healing occurs on average in 25% of cases of rotator cuff repair. Various factors are associated with inferior healing including older age, worse muscle, larger tear size and retraction and patient factors including osteoporosis, hyperlipidemia and smoking. Improved healing has been shown to result in better functional outcomes, specifically strength, after repair. Various surgical techniques can be implemented to improve rotator cuff healing including various repair constructs and biologic augments including cellular (platelet rich plasma, stem cells) and structural (grafts) augmentations. Various studies have evaluated the impact of cellular augmentations with varying reports of success. Biologic only grafts (onlay and interposition) have been described in animal models to improve the histologic properties of repairs with limited clinical data supporting indications. Structural grafts, both synthetic and allograft, have been utilized to improved tendon healing which in certain cases have proven successful although current indications are unclear given the added time and cost of augmentation. Understanding a strategy to implement each of these biologic options based upon patient demographic and anatomic factors will be critical to optimize clinical success without needlessly increase surgical morbidity or cost.

The basics of how to optimize rotator cuff healing utilizing standard repair
Robert Tashjian, USA

Cellular biologic options to augment rotator cuff repairs: What are the current options, what the data shows we should be using, when we should be using them, why and what is the future?
Matthias Zumstein, MD, Switzerland

Biologic only augmentations for repairs – put it on top or between the tendon and bone – does this work and who we should be using them on
Miguel Ruiz-Iban, MD, Spain

Structural grafts (allograft and synthetic) to augment the rotator cuff – How to we do it and is it worth it?
Surena Namdari, USA

Understanding subscapularis tendon tears: from anatomy to complex reconstruction

Advanced

Chair: Maria Valencia Mora, Hospital Fundación Jiménez Díaz, Spain

Subscapularis is the most fascinating tendon of the rotator cuff. The ICL will highlight the importance of the anatomy in order to achieve an accurate and safe repair. We will discuss controversies in surgical versus conservative treatment for partial tears and define the best technique when surgical treatment is decided. Lastly, a closing remark on new trends in tendon transfers for non-reparable tears.

Anatomy, innervation and surgical considerations for subscapularis repair, describe muscle and footprint characteristics, innervation, anatomical relations, function of each part.
Maria Valencia, Spain

Partial tears of the subscapularis, rationale and decision making. Controversies in diagnosis MRI, IA; relation with PLB pathology, when should we repair a partial tear?
Joaquín Sánchez-Sotelo, USA

How to manage subscapularis tears and to achieve a perfect repair? Manage of isolated tears, differences in treatment when it is associated to supraspinatus tear, single versus double row, from the front or from the back? Releases when retracted...
Markus Scheibel, Switzerland

Tendon transfers for irreparable subscapularis tears. It is necessary to repair them? what happens if we do not? it is worth a tendon transfer? Which one to choose, old an new trends in tendon transfer for subscapularis reconstruction.
Philippe Valenti, France

Management of adults with a displaced unstable fracture of the distal clavicle: does it have to be patient specific?

Basic

Chair: Harvinder Pal Singh, University of Leicester, UK

This ICL will discuss why displaced distal clavicle fracture are uncommon but complex fractures and need a patient specific decision making. It will also discuss the ongoing DIDACT UK national trial on distal clavicle fractures and the ScandDiLaC (Scandinavian RCT on Displaced Lateral Clavicle Fractures) trial that is starting in the coming year. It will also discuss the various surgical approaches to management of these fractures.

What is a displaced distal clavicle fracture and why is it complex?
Harvinder Pal Singh, UK

Nonoperative management of Distal clavicle fractures: does it work?
Olof Wolf, Sweden

Management distal clavicle fractures with Coracoclavicular (open/arthroscopic) fixation only.
Jamie A. Nicholson, Scotland

Management of distal clavicle fractures with plate fixation.
Maxim Vanderstappen, Belgium

Pearls and pitfalls for a successful anatomical shoulder arthroplasty

Basic

Chair: Olivier Verborgt, AZ Monica Antwerp, Belgium

It is intended to be a basic ICL including all key topics of aTSA, but also the most cutting edge technologies. The purpose is that upon completion of this ICL, participants will be able to 1) understand the precise indications for anatomical shoulder arthroplasty, 2) to follow the key steps to plan preoperatively the procedure, 3) to carry out a perfect surgical technique aimed to obtain optimal clinical results and 4) also to address possible complications.

Clinical considerations in anatomic shoulder arthroplasty. Who is a perfect candidate for an aTSA, and do they exist? Physical examination: muscle and tendon function evaluation. How does cuff function or range of motion affect your decision-making process? Does age or previous surgery affect how you approach the case?
Gabor Skalizcki, Hungary

Preoperative planning and surgical technique for aTSA. What are your considerations when planning an aTSA arthroplasty (cuff, glenoid,...)? Diagnostic studies and planning software: how to increase my OR efficiency and improve my clinical results. Surgical approach. Subscapularis management. Tips on exposure. Optimizing implant position. Which mistakes should be avoided when performing a aTSA?
Patric Raiss, Germany

Modern anatomical prosthetic designs and technology: are we getting better ?. Options for anatomical humeral replacement (stem, stemless, convertible systems) and glenoid replacement (all poly, metal backed, hybrid...) – the use of augmented glenoid components. The role of PSI, mixed reality and robotics in aTSA.
Tjarco Alta, The Netherlands

Failures of aTSA: Why and how I manage them ? Etiology of complications after aTSA surgical options when they occur – is there still a place for aTSA in revisions or is revision to RSA best?
Marc-Olivier Gauci, France

The myths of proximal humeral fractures: an evidence-based approach

Basic

Chair: Joan Miquel, Hospital Parc Taulí, Spain

As shoulder surgeons, we feel tempted to assume recommendations made by colleagues or opinion leaders. These statements become myths in orthopedic knowledge commonly contradicted by the best available evidence. The objective of the ICL is to share an evidence-based approach in different areas of proximal humerus fractures. From the prevalence of fracture patterns to overtreatment, the ICL will cover hot topics for this prevalent injury.

Displaced fractures of the proximal humerus: horses or zebras?
Stig Brorson, Denmark

The evidence-base for anatomical reconstruction of the proximal humerus
Anti P Launonen, Finland

Overtreating proximal humeral fractures; even if we do conservative
Carlos Torrens, Spain

Can systematic reviews lead to decision-making for patients with PHF in 2025?
Joan Miquel, Spain

Revision radial head prosthesis; work-up and treatment

Advanced

Chair: Denise Eygendaal, Erasmus university hospital, The Netherlands

Failure of radial head prosthesis (rhp) is frequently encountered as the implant survival is 60 % at 6 years. in this ICL the work up and treatment algorithm is given. the learning objectives are: after this ICL the participant will know the most common complications of a rhp resulting in revision of the rhp. He/she will know what the work-up is towards revision and finally tips and trics are give for the surgical technique of reviision of a rhp.

Incidence and reason of revision of RHP
Lars Adolfson, Sweden

What to do if a rhp needs revision? Work-up
Denise Eygendaal, The Netherlands

Tips and trics for revisoin of radial head arthroplasty
Roger Van Riet, Belgium

Alternatives for revision or radial head arthroplasty
Raul Barco, Spain

Elbow is sports

Basic

Chair: Paolo Arrigoni, ASST Gaetano Pini, CTO, Italy

In this session, we explore the impact of different sports on elbow health. In boxing, the elbow is susceptible to epicondylitis and contusions. In tennis and racket sports, players often experience tennis elbow and tendinopathies. Javelin throwers are at risk of overuse injuries and strains, while in contact sports, common elbow injuries include contusions, fractures, and sprains. We'll introduce innovative concepts based on recent literature to provide the most up-to-date insights.

Elbow in boxing
Dani Rotman, Israel

Elbow in tennis and racket sports
Paolo Arrigoni, Italy

Elbow in javelin throw
Michel Van de Bekerom, The Netherlands

Elbow in contact sports
JoiDeep Phadnis, UK

The stiff and unstable elbow

Basic

Chair: Alessandra Colozza, Ospedale degli Infermi - Faenza, Italy

The entity of “stiff and unstable” elbow is not well known and discussed up to now. There are many open questions about the current topic:
• Is stiffness a consequence of elbow instability?
• If heterotopic ossifications (HO) englobe ligaments, do we proceed with HO excision and reconstruction in one stage or two stages?
• How we address the ulnohumeral joint if there’s an arthropathy?
• What’s the postop protocol in this patient’s category? Do we privilege motion or stability?
The aim of the ICL is go deep in this topic analyzing the possible spectrum of presentation of “stiff and unstable elbow” and the consequent surgical solutions.

What if ulno humeral joint is incongruent?
Przemyslaw Lubiatowski, Poland

What if radio humeral joint is incongruent?
Adam Watts, UK

What if ligaments are ossified?
Pierre Mansat, France

What if the elbow is stiff and unstable?
Jagwant Singh, UK

Tendon tears around the elbow

Basic

Chair: Kerem Bilsel, Acibadem Fulya Hospital, Turkey

Tendon tears around the elbow joint represent a significant clinical concern, particularly among athletes and individuals engaging in repetitive arm activities. This ICL reviews the primary tendons involved, specifically the biceps brachii, triceps brachii, and common flexor and extensor tendons. It discusses the etiology of these injuries, highlighting factors such as acute trauma, chronic overuse, and degenerative changes associated with aging. The clinical presentation typically includes pain, swelling, and a reduced range of motion, which can severely impact functional capabilities. Diagnostic approaches, including physical examination and imaging modalities such as MRI and ultrasound, are examined for their role in confirming the diagnosis. Treatment options range from conservative management, including rest and rehabilitation, to surgical interventions for complete tears or persistent symptoms. Understanding the mechanisms of tendon injuries around the elbow joint is crucial for developing effective treatment strategies and optimizing surgical protocols.

Distal biceps rupture (partial tear)
Pieter Caekebeke, Belgium

Distal biceps rupture (complete tear)
Ata Can Atalar, Turkey

Distal triceps rupture
Sebastian Siebenlist, Germany

The role of tendon tears in elbow dislocation
Shawn O’ Driscoll, USA