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be used to decompress a spinoglenoid notch cyst at the base of the scapular spine. To decompress the suprascapular nerve at the suprascapular notch, a shaver through the posterior portal removes the soft tissue on the acromion and distal clavicle to expose the coracoclavicular ligaments. The medial border of the conoid ligament is identified and followed to its coracoid attachment. The supraspinatus muscle is retracted with a blunt trocar placed through an accessory Neviaser portal. The transverse scapular ligament, which courses inferior to the suprascapular artery, is sectioned with arthroscopic scissors, and the suprascapular nerve is decompressed.
Arthroscopic Decompression of the Suprascapular Nerve at the Spinoglenoid Notch and Suprascapular Notch through the Subacromial Space

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Abstract

Suprascapular nerve entrapment can cause disabling shoulder pain. Suprascapular nerve release is often performed for compression neuropathy and to release pressure on the nerve associated with arthroscopic labral repair. This report describes a novel all-arthroscopic technique for decompression of the suprascapular nerve at the suprascapular notch or spinoglenoid notch through a subacromial approach. Through the subacromial space, spinoglenoid notch cysts can be visualized between the supraspinatus and infraspinatus at the base of the scapular spine. While viewing the subacromial space through the lateral portal, a shaver through the posterior portal can be used to decompress a spinoglenoid notch cyst at the base of the scapular spine. To decompress the suprascapular nerve at the suprascapular notch, a shaver through the posterior portal removes the soft tissue on the acromion and distal clavicle to expose the coracoclavicular ligaments. The medial border of the conoid ligament is identified and followed to its coracoid attachment. The supraspinatus muscle is retracted with a blunt trocar placed through an accessory Neviser portal. The transverse scapular ligament, which courses inferior to the suprascapular artery, is sectioned with arthroscopic scissors, and the suprascapular nerve is decompressed.

Key Words: Arthroscopy—Suprascapular nerve—Transverse scapular ligament—suprascapular notch—Rotator cuff—Shoulder
INTRODUCTION

Suprascapular nerve (SSN) entrapment is a cause of delocalized shoulder pain and weakness. Suprascapular neuropathy is infrequent, causing only 1-2% of diagnoses for shoulder pain. It occurs at either the suprascapular notch, resulting in weakness and atrophy of both the infraspinatus and the supraspinatus, or at the spinoglenoid notch, resulting in only infraspinatus weakness. Constraint of the nerve is commonly caused by its course through the suprascapular notch under the transverse scapular ligament or through the spinoglenoid notch under the spinoglenoid ligament, as well as compression by supraglenoid and paralabral cysts. Although conservative treatment such as physical therapy can be recommended for SSN entrapment, it is commonly only successful in cases of overuse and not in cases of nerve compression or space-occupying lesions, which require surgery for pain relief. While pain relief after surgery has been consistent, the return of muscle strength and shoulder function is less predictable.

The literature reports the advantages of the arthroscopic techniques over the traditional open procedure for SSN decompression. Similar to other reported arthroscopic techniques to decompress the SSN at the suprascapular notch, our technique relies on a subacromial approach and direct visualization of the relevant anatomy of the coracoclavicular ligaments, suprascapular neurovascular structures and the transverse scapular ligament. In contrast to other described techniques of arthroscopic suprascapular nerve decompression at the spinoglenoid notch, our surgical technique describes SSN decompression through the subacromial space.
technique allows direct visualization of the medial neck of the glenoid and helps avoid complications of iatrogenic SSN nerve injury from overly-aggressive medial capsule dissection through the glenohumeral joint. With a thorough understanding of shoulder anatomy, the orthopedic surgeon should be able to identify the spinoglenoid notch and the suprascapular notch in the subacromial space, and decompress the SSN without injury to the nerve or surrounding structures. The purpose of the present article is to provide our surgical technique to safely and successfully decompress the SSN at the suprascapular notch or the spinoglenoid notch through the glenohumeral joint and subacromial space.

SURGICAL TECHNIQUE

Patient Positioning

We prefer to place the patient in the beach chair position, but patients may be positioned in lateral decubitus in cases of concomitant superior labral anterior posterior (SLAP) repair. After standard preparation and draping, the acromion, distal clavicle, and coracoid process, and course of the suprascapular nerve are outlined with a marking pen. (Figure 1) A posterior portal is created approximately 3 cm inferior and in line with the posterolateral acromion. The 30 degree arthroscope is inserted through this portal and diagnostic glenohumeral arthroscopy is performed. An initial anterior portal is created high in the rotator interval with an outside-in technique after localization with an 18 gauge spinal needle. Hemostasis is critical to visualization during the procedure and can be enhanced by maintaining adequate pump arthroscopic pump pressure (approximately 50mm Hg) and relative hypotensive anesthesia (systolic BP about 100mm Hg).
Spinoglenoid Notch

In cases of a SLAP lesion that requires repair, the spinoglenoid notch is accessed through the glenohumeral joint. The authors recommend repairing the SLAP lesion before performing the paralabral cyst decompression. Once the SLAP repair is complete, the arthroscope is placed in the anterior portal. The posterior superior capsular release is performed with mechanical shaver between 9 and 12 o’clock, and debridement should be clearly away from the posterior band of the inferior glenohumeral ligament complex. The raphe between supraspinatus and infraspinatus is identified and followed medially. At this point, the prominence of the cyst can be seen directly on the scapula. (Figure 2)

The cyst is decompressed with the mechanical shaver and synovial fluid emanating from the cavity is visible. The mechanical shaver is used to remove part of the cyst wall to limit the possibility of recurrence. The decompression is complete when no additional cystic wall remnants or fluid can be detected. (Figure 3)

If inspection of the glenohumeral joint does not reveal a capsule or labral tear, the spinoglenoid notch cyst is decompressed from the subacromial space. The arthroscopic instrumentation is then placed in the subacromial space using the posterior portal and a lateral portal. All soft tissue is removed from the undersurface of the acromion and the bursal surface of the rotator cuff. At this point, the arthroscope is directed posteriorly and medially to identify the separate muscle bellies of the supraspinatus and the infraspinatus. The scapular spine is visualized and demarcates the medial boundary of the dissection. (Figure 4) A probe can be used to palpate the posterior aspect of the glenoid which
defines the anterior boundary, and the cyst can sometimes be localized between the
scapular spine and the posterior glenoid. The mechanical shaver is used to debride the
soft tissue and further expose the spinoglenoid notch cyst. (Figure 54) The mechanical
shaver is advanced from anterior to posterior but must be done with caution to avoid
injury to the suprascapular nerve. The tip of the mechanical shaver can be used to
intermittently palpate the cyst. The suprascapular nerve is located at the base of the
scapular spine, and therefore, the mechanical shaver should not be used near the spine. If
the cyst is not palpable, the mechanical shaver can be carefully advanced until cyst fluid
is visible.

Suprascapular Notch

In order to decompress the suprascapular nerve at the suprascapular notch, the
arthroscope is placed in the lateral portal, and the shaver is introduced via the posterior
portal. The dissection proceeds medial to the acromioclavicular joint to allow
identification of the coracoclavicular (CC) ligaments. The posterior aspect of the CC
ligaments is dissected, and the conoid ligament is identified medially along with the
anterior border of the supraspinatus muscle. Again, care must be taken during the
dissection to maintain continuous hemostasis. Once the anterior edge of the
supraspinatus is adequately visualized, an accessory portal is created about 2cm medial to
a standard Neviser portal, anterior to the scapular spine. This portal is created under
spinal needle localization, and a blunt trocar is introduced. The trocar is then used for
further blunt dissection and for posterior retraction of the supraspinatus muscle belly.
Using the shaver via the posterior portal and blunt dissection with the trocar, the base of the conoid ligament is identified. The base marks the lateral insertion of the Transverse Scapular Ligament (TSL) which can now be identified running approximately perpendicular to the CC ligaments. (Figure 6) Using the blunt trocar, the suprascapular nerve can (SSN) can be identified and protected during sectioning of the ligament. (Figure 7) The artery is generally visualized running superior to the TSL in most cases, and care should be taken during dissection in this area to avoid excessive bleeding which may impair visualization. However, we are unaware of any significant sequela if the artery is inadvertently injured during the dissection, and bleeding can generally be controlled with the radiofrequency coagulation. A second Neviaser portal is created under spinal needle localization to allow access to the TSL. This portal is placed in a standard Neviaser position at the junction of the scapular spine and posterior aspect of the AC joint. Under direct visualization, an arthroscopic scissors or punch is then used to section the ligament while retracting the SSN with the blunt trocar. Rarely, there are cases in which the transverse ligament is ossified, and a quarter inch osteotomy can be used to resect the ossified ligament. (Figure 8)

DISCUSSION

With the introduction of new arthroscopic techniques to release the TSL, a thorough understanding of the anatomy of the SSN is important to provide for safe, reproducible decompression techniques. The SSN originates from the upper trunk of the brachial plexus with contributions from C4, C5, and C6 nerve roots. The SSN courses deep to the omohyoid and trapezius muscles before traveling to the suprascapular notch with the
suprascapular artery. At the suprascapular notch, the SSN passes underneath the TSL and provides two motor branches to the supraspinatus whereas the suprascapular artery courses over the TSL. The nerve then passes deep to the supraspinatus, through the spinoglenoid notch, and terminates in the muscle belly of the infraspinatus. (Figure 1)

At the spinoglenoid notch the SSN can be constrained by the inferior transverse suprascapular ligament or by a ganglion cyst. At the suprascapular notch, the SSN faces entrapment by the transverse scapular ligament and the shape of the notch itself. Six different classifications of suprascapular notch anatomy were originally defined by Rengachary, et al. (1979). (Figure 9) The type I notch is defined as lacking a discrete notch. Type II is a wide “V”-shaped notch, while type III is a wide “U”-shaped notch. Types IV and V are a narrower “V”-shaped notch and a “U”-shaped notch with partial ossification of the transverse suprascapular ligament, respectively. Finally, the type VI notch is defined as a completely ossified transverse suprascapular ligament. The type VI notch, which occurs approximately 4-12.5% of the time in cases of SSN entrapment, is composed of a calcified ligament that reduces the space for the SSN within the notch, thus compressing and aggravating the nerve. While the other types of notches involve ligament release and potential burring of the notch to widen the path for the SSN, the type VI notch provides the added complication of the ossified ligament. In the present article, the authors prefer to use an osteotome to resect the ossified transverse scapular ligament, but other authors have described using a Kerrison rongeur.
Traditionally, SSN entrapment is treated with an open decompression at both the spinoglenoid and the suprascapular notch. A posterior incision is used to expose the scapular spine and then the spinoglenoid ligament at the spinoglenoid notch.\(^{14}\) The suprascapular notch decompression procedure involves either an incision along the scapular spine or a muscle splitting technique in which the trapezius is split in line with the muscle fibers, localizing the nerve for release.\(^{10,14}\) More recently, an arthroscopic approach for both spinoglenoid and suprascapular notch decompression is favored. Most commonly, decompressions of ganglion cysts occur at the spinoglenoid notch, where landmarks such as the acromioclavicular joint, conoid ligament, and coracoid process can be used to locate the SSN without endangering the spinal accessory nerve at the suprascapular notch.\(^{5,14-10}\) Open dissections of cadavers after arthroscopic SSN decompressions reveal that no nerve or arterial damage is inflicted by this procedure.\(^{17,42}\) Although the arthroscopic procedure is technically difficult, it has been shown to be safe, reproducible, and favorable over the open technique.\(^{5,9,10,12,17,18,204,5,6,8,12,11,14}\)

To begin, the arthroscopic technique makes it easier to identify and distinguish the SSN nerve from the nearby artery and ligament due to the magnification of the arthroscope.\(^{5,10,4-6}\) This procedure also makes it possible to assess other comorbid injuries such as labral tears.\(^{9,20,4-16}\) Simultaneously decompressing the SSN and fixing a labral tear, which is not possible in the open technique, has been shown to reduce recurrence of nerve entrapment.\(^{9,30,4-16}\) Finally, the less invasive arthroscopy does not involve detaching or splitting the trapezius muscle, which results in less pain for the patient.\(^{106}\) This allows the patient to start rehabilitation sooner and thus recover faster.\(^{11}\)
The arthroscopic technique has been reported to have equal success in relieving pain and returning muscle strength shoulder function as the open technique. In comparison to other described techniques of arthroscopic decompression of the SSN, our technique offers varied risks and benefits. With our technique, the spinoglenoid notch cyst can be directly visualized through the subacromial space and dissection of the capsule along the medial neck of the glenoid can be avoided. In contrast to other reports, we prefer to decompress the spinoglenoid notch cyst after repair of a SLAP lesion. Decompression of the cyst through torn labrum exposes the labrum and SSN to additional risk as inadequate visualization of the medial neck of the glenoid and overlying SSN can lead to iatrogenic injury. Through direct visualization of the cyst through the subacromial space, the spinoglenoid cyst can be carefully decompressed. With concomitant rotator cuff tear, our technique provides the surgeon with a facile method to visualize and decompress the cyst through the same portals that can be used to repair the rotator cuff. With this technique, however, the arthroscopist must be able to identify the raphe between the supraspinatus and infraspinatus to locate the spinoglenoid notch without injuring the rotator cuff muscle bellies. A thorough diagnostic arthroscopy must be performed prior to performing our described method of spinoglenoid notch cyst decompression to rule out concomitant SLAP tear. Our preferred method for release of the TSL is similar to other reported techniques that rely on visualization of the CC ligaments through the subacromial space. For decompression of the SSN at the suprascapular notch, we recommend careful retraction of the fat pad and suprascapular artery with blunt trocars inserted through...
separate Neviaser portals. To release an ossified TSL, we prefer to use an osteotome whereas other described techniques report the use of kerrison rongeurs or burrs.\textsuperscript{1,10}

The present surgical technique should enable the orthopedic surgeon to identify the SSN at both the suprascapular notch and the spinoglenoid notch via the subacromial space. Arthroscopic decompression of the SSN at the spinoglenoid notch has been described through the glenohumeral joint with a posterior and superior capsulotomy. The authors prefer this approach in cases requiring a simultaneous SLAP repair. In cases without an obvious tear in the labrum or capsule, the authors prefer to decompress the paralabral cyst at the spinoglenoid notch through the subacromial space so that the cystic fluid may drain into the subacromial space should fluid continue to collect. The subacromial approach should, in theory, decrease the possibility of recurrence, but clinical follow-up comparing these two techniques need to be performed to determine the likelihood of recurrence.

Conclusions

Compression of the SSN at the transverse scapular notch or spinoglenoid notch has important clinical implications of supraspinatus and infraspinatus atrophy and weakness. All-arthroscopic techniques of SSN release have been recently described and offer several advantages over the traditional open method. This report describes a simplified subacromial arthroscopic technique for decompression of the SSN at the suprascapular notch and spinoglenoid notch while providing the surgeon with a facile, effective method to concomitantly evaluate and treat comorbid shoulder pathology.
REFERENCES


Figure Legends

Figure 1: Right shoulder of patient in lateral decubitus position. Note drawn landmarks including A) coracoid, B) clavicle, C) scapular spine, D) suprascapular notch, E) course of SSN marked with dotted line.

Figure 2: Left shoulder, beach chair position; arthroscopic visualization of the spinoglenoid cyst through the glenohumeral joint. The arthroscope is placed in the anterior portal and the mechanical shaver is placed through the posterior portal.

Figure 3: Left shoulder, beach chair position; arthroscopic visualization of the cystic wall remnants after debridement of the spinoglenoid cyst with a shaver placed through the posterior portal.

Figure 4: Left shoulder, beach chair position; arthroscopic visualization of the spinoglenoid cyst in a typical location at the base of the scapular spine.

Figure 5: Left shoulder, beach chair position; arthroscopic visualization of the spinoglenoid cyst cavity after debridement through the subacromial space. The arthroscope is placed into the subacromial space through the lateral portal and the space between the supraspinatus and infraspinatus is visualized.

Figure 6: Right shoulder, lateral view; arthroscopic visualization of the transverse scapular ligament through the lateral portal.

Figure 7: Right shoulder, lateral view; arthroscopic visualization of the suprascapular artery running superior to the suprascapular nerve through the lateral portal.

Figure 8: Right shoulder, beach chair position; debridement of an ossified transverse scapular ligament with an osteotome.

Figure 9. Suprascapular Notch. Rengachary et al described six types of suprascapular notch, including Type I: depression (8%), Type II: shallow V-shaped (31%), Type III: U-
shaped (48%), Type IV: deep V-shaped (3%), Type V: Type III with partial ossification of the ligament (6%), Type VI: complete ossification of ligament.
Table Legends

337 Table 1: Advantages and Risks of Our SSN Decompression Technique
340 Table 2: Surgical Pearls and Complications to Avoid During SSN Decompression
References


Figure(s) in separate file(s)
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Scapular spine

Cyst wall remnants
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<tr>
<th>Advantages</th>
<th>Risks</th>
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<tr>
<td>Direct visualization of spinoglenoid notch</td>
<td>Requires identification of the raphe between supraspinatus and infraspinatus</td>
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<tr>
<td>Does not require 70° scope</td>
<td>Missed SLAP tear</td>
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<td>No need for accessory posterolateral portal</td>
<td>Over aggressive use of osteotome for ossified TSL</td>
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<td>Performed through subacromial space to allow decreased operative time</td>
<td>Injury to the muscle bellies of the supraspinatus or infraspinatus</td>
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<td>Decreased chance of inadvertent injury to the medial capsule and labrum compared to glenohumeral approach</td>
<td>The cyst cavity may not always be visualized depending on its chronicity</td>
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<td>Use of dual Neviser portals allows direct approach to dissection of deep surface of CC ligaments and SSN</td>
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<tr>
<td>Surgical Tips/Pearls</td>
<td>Complications to Avoid</td>
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<tr>
<td>Rule out concomitant glenohumeral pathology with diagnostic scope</td>
<td>Incomplete cyst wall decompression</td>
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<td>Repair SLAP tear prior to cyst decompression</td>
<td>Failure to diagnose concomitant SLAP tear</td>
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<td>Use 30° scope</td>
<td>Over aggressive use of osteotome for bony TSL</td>
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<td>Identify raphe between supraspinatus and infraspinatus</td>
<td>Failure to located CC ligaments prior to visualization of the TSL</td>
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<td>Use blunt trocar to retract infraspinatus and avoid injury to SSN branch to infraspinatus</td>
<td>Injury to SSN from aggressive medial capsular dissection</td>
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<td>Visualize the SSN as it courses under the TSL</td>
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<td>Identify and debride entire cyst wall</td>
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<td>Keep pump pressure high to decrease bleeding</td>
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<td>Use blunt trocar to retract suprascapular artery</td>
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