

Assessing the Effectiveness of Arthroscopic Capsular Repair in Elite Baseball Players: Letter to the Editor

Dear Editor:

We read with pleasure the article by Uffmann et al² titled “Return to Sport After Arthroscopic Capsular Repair in Elite Baseball Players” and would like to provide commentary on aspects of the study design that may have affected its main findings. We hope that these insights may guide further research and improvement to arthroscopic capsular repair.

The purpose of this study was to find the outcomes and the return-to-sport (RTS) rates for elite baseball players after arthroscopic capsular repair. The authors included 11 patients from 2012 to 2019 who were diagnosed with a midsubstance glenohumeral capsular injury and treated with arthroscopic capsular repair. These elite baseball players had a mean age of 26.9 years and played at the major league (n = 8), minor league (n = 1), or collegiate (n = 2) level. There were 9 pitchers, 1 catcher, and 1 outfielder. After the procedure, 10 of the 11 (90.9%) players met the good or excellent criteria for RTS; 6 of the 10 met the excellent criteria, while the other 4 players met the good criteria. All the players were pleased with their outcome, reporting a high degree of satisfaction with the surgical procedure (5/5 on a Likert scale).

The length of time that athletes had played elite baseball was not mentioned, and this raises concerns of whether this would affect the RTS rates. Whether a player played for 10 years compared to someone who played for 1 year might help the readers understand the results. In general, acute lesions of the shoulder caused by sudden sport injuries, such as traumatic luxation, acromioclavicular joint disruption, traumatic tendon ruptures, labral lesions, cartilage defects, and fractures, have to be distinguished from chronic or long-standing abnormalities due to recurrent microtrauma, such as overuse bursitis and tendinitis, as well as secondary forms of impingement along with rotator cuff tears and labral lesions.¹ It would need to be assessed to see if that is a confounding variable that influenced why some players met the excellent criteria, met the good criteria, or were not able to meet either. The authors mentioned age, but it is not enough to draw conclusions about how long the patients have been playing.

The article did not specify the nonoperative treatments each patient had received. Later, it also stated that patients

who had success with nonoperative treatments had a mean Kerlan-Jobe Orthopaedic Clinic (KJOC) score of 86.7 but did not clarify what treatments they received. Thus, of the 11 patients who failed, we do not know if they all received the same nonoperative treatment because a treatment that does not work for one patient may work for another. There are multiple manual therapies including integrative manual therapy, myofascial release, muscle energy technique, and counterstrain. Also, physical therapies include stretching, strength training, endurance exercises, hot and cold packs, electrical muscle stimulation, and joint mobilization. More clarification on this would help us to understand what was done before the operative procedure.

In conclusion, the study by Uffmann et al² offers insightful data on how arthroscopic capsular repair can help patients RTS more quickly. There are various limitations that must be considered when interpreting the data, despite the study having high postoperative KJOC scores and meeting good or excellent criteria for RTS for 10 of the 11 players. These drawbacks include the length of time that athletes played elite baseball and the nonoperative treatments performed on the players to see if there was any relation to their KJOC scores and RTS rates. These restrictions cast doubt on the reproducibility and validity of the findings as well as their ability to be applied to other groups. We look forward to reading future studies that provide a more comprehensive understanding of how nonoperative treatment and length of play can affect the KJOC score and the RTS time of patients.

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The authors declared that they have no conflicts of interest in the authorship and publication of this contribution. AOSSM checks author disclosures against the Open Payments Database (OPD). AOSSM has not conducted an independent investigation on the OPD and disclaims any liability or responsibility relating thereto.

REFERENCES

1. D’Hooghe P, Waldén M, Hägglund M, Bengtsson H, Ekstrand J. Anterior ankle impingement syndrome is less frequent, but associated with a longer absence and higher re-injury rate compared to posterior syndrome: a prospective cohort study of 6754 male professional soccer players. *Knee Surg Sports Traumatol Arthrosc.* 2022;30(12):4262-4269.
2. Uffmann WJ, ElAttrache NS, Youssefzadeh K, Carbone A, Limpivasthi O. Return to sport after arthroscopic capsular repair in elite baseball players. *Orthop J Sports Med.* 2023;11(2):23259671231153142.

The Orthopaedic Journal of Sports Medicine, 11(12), 23259671231190937
 DOI: 10.1177/23259671231190937
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