

# The Effect of Total Shoulder Arthroplasty on Glenohumeral Kinematics during Activities of Daily Living (ADLs)

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**INTRODUCTION:** Glenohumeral osteoarthritis (GOA) has been implicated with significant pain and disability when performing activities of daily living (ADLs). Total shoulder arthroplasty (TSA) reliably assists in restoring shoulder range of motion (ROM), but current subjective outcome metrics to assess ROM such as ASES may not provide enough objective data for clinicians to assess basic function or disability when performing ADLs. Furthermore, there is no consensus within the literature as to how objectively track a patient's restoration of ROM or ability to perform ADLs after TSA. Therefore, the purpose of this study is to objectively track restoration of shoulder ROM and ability to perform ADLs after TSA using motion capture system.

**METHODS:** 26 patients who underwent TSA for GOA performed multiple ADLs including hygiene, drinking, overhead reach and hairbrush (Figure 1) tasks using both the surgical and asymptomatic upper extremity (control) for direct comparison pre-operatively and up to three months post-operatively. Patients underwent a standard post-operative physical therapy protocol. A motion capture system used eight infra-red cameras (Vicon, Oxford, UK) sampling at 100 Hz to capture both a patient's peak shoulder angle and total degrees of ROM achieved during ADLs. Shoulder flexion, adduction, and rotation were all employed to provide three planes of motion for 3D motion capture. Unadjusted descriptives were compared using Kruskal-Wallis and chi-squared tests for continuous and categorical variables, respectively (Stata 16.1, StataCorp, CollegeStation, TX).

## RESULTS:

Demographic and patient reported outcome scores are reported in Table One. Patients demonstrated significant pre-operative ROM deficits and lower peak kinematic angles while performing ADLs in the diseased extremity compared to controls ( $p < 0.05$ , Table 2). By 3 months, though statistically significant ( $p < 0.05$ ), patients were clinically within 5 degrees of ROM in all three planes for hygiene and drinking tasks. Overhead reach remained significantly limited at 3 months (flexion  $78.02^\circ$  vs  $103.75^\circ$ ,  $p < 0.001$ ; adduction  $31.98^\circ$  vs  $46.89^\circ$ ,  $p < 0.001$ ); rotation  $42.69^\circ$  vs  $71.13^\circ$ ,  $p < 0.001$ ). Overall patients demonstrated significant improvements in at least two planes during ADL performance compared to pre-operative values ( $p < 0.05$ ).

Though peak kinematic angle was restored for hair brushing at 3 months, patients still demonstrated some deficits in all planes for the remaining ADLs (Table 3). Flexion during overhead reach ( $67.64^\circ$  vs  $80.44^\circ$ ,  $p = 0.005$ ), and rotation during hygiene ( $19.30^\circ$  vs  $36.99^\circ$ ,  $p < 0.001$ ) were the most notable, though other planes for these tasks were within  $10^\circ$  to the asymptomatic side. Except for flexion, adduction ( $14.19^\circ$  vs  $10.04^\circ$ ,  $p < 0.001$ ) and rotation ( $21.58^\circ$  vs  $19.30^\circ$ ,  $p < 0.001$ ) during hygiene did not recover to pre-operative values.

## DISCUSSION AND CONCLUSION:

Our findings provide objective evidence that TSA for GOA significantly reduces multi-plane disability that hampers performance of ADLs with the use a motion capture system. Apart from overhead reach, patients demonstrated sufficient ROM to perform self-hygiene, drinking, and hairbrush tasks using the operative extremity three months after surgery. Patients can expect restoration of peak kinematic angle to pre-operative values at 3 months for almost all tasks but may require more time to achieve comparable results to their asymptomatic side. Our objective measurements coincided with subjective reported functional improvement and reduced pain post-operatively. Not only do our findings help clinicians possibly council patients on post-operative expectations, but use of motion capture provides a more efficient and cost-effective mean of tracking a patient's post-surgical recovery and ability to perform ADLs.

Figure 1: Demonstration of ADLs. A: Overhead reach. B: Drinking. C: Hairbrushing. D: Hygiene.

Table 1. Demographics and Patient Reported Outcomes. \*  $p < 0.050$ , †  $p < 0.010$ , ‡  $p < 0.001$ ; PROMIS: Patient-Reported Outcomes Measurement Information System. SD = Standard Deviation.

Table 2. Shoulder Total Kinematic Degrees of Range of Motion During Four ADL Tasks. \*  $p < 0.050$  (orange), †  $p < 0.010$  (yellow), ‡  $p < 0.001$  (green). Values reported as Mean (Standard Deviation).

Table 3. Shoulder Kinematic Peak Angle During Four ADL Tasks. \*  $p < 0.050$  (orange), †  $p < 0.010$  (yellow), ‡  $p < 0.001$  (green). Values reported as Mean (Standard Deviation).

