

($99.5 \pm 51.8 \text{ mm}^2$ vs $86.9 \pm 46.2 \text{ mm}^2$). Neither degree nor duration of instability correlated with lesion size. Having CLAI was associated with an increase in ossicle and osteophyte lesions and with syndesmosis widening (all $P < .04$).

Compared with their preoperative scores, clinical outcomes (VAS and AOFAS) were improved for both groups at the last follow-up; however, there was no significant difference in clinical outcomes between the groups at the preoperative stage or at the last follow-up. Significantly more patients with CLAI were considered treatment failures (AOFAS score < 80 ; $P = .034$). Scores on the FAOS were similar for the 2 groups, except for the Sports/Recreation subscale, which was significantly worse ($P = .005$) for patients with instability.

These results support earlier studies showing an increase in chondral lesions at the tip of the medial malleolus [Sugimoto K et al. *J Bone Joint Surg Am.* 2009]. Importantly, they also provide data indicating increased clinical failure among these patients and inferior performance in sports and recreational activities.

No Additional Benefit With Compressive Cryotherapy After Arthroscopic Shoulder Surgery

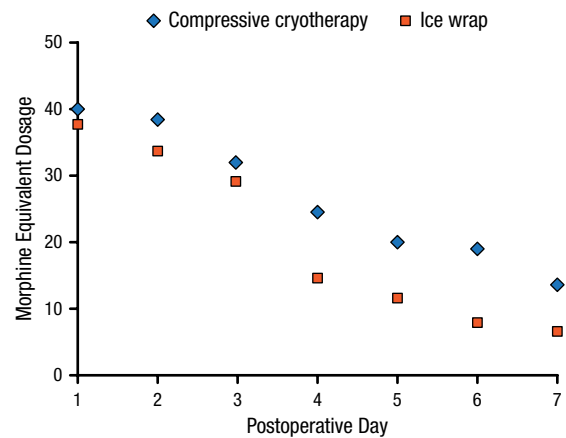
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Compressive cryotherapy did not reduce postoperative pain compared with standard cryotherapy in patients who underwent arthroscopic rotator cuff repair (RCR) or subacromial decompression (SAD). Matthew J. Kraeutler, BS, CU Sports Medicine, Boulder, Colorado, USA, presented data from the Compression and Cold Therapy on the Post-Operative Shoulder trial [NCT00703729].

Pain control after RCR and SAD remains a problem. Previous studies have shown reduction in pain with use of cryotherapy in patients following RCR or arthroscopic SAD. In total knee arthroplasty, anterior cruciate ligament reconstruction, and wrist arthroscopy, compressive cryotherapy was demonstrated to improve postoperative pain scores. The purpose of this trial was to evaluate the effect of compressive cryotherapy on postoperative pain in patients following arthroscopic RCR or SAD.

In the prospective, open-label trial, 46 patients undergoing RCR or SAD were randomly assigned to receive

Figure 1. Effect of Compressive Cryotherapy vs Cryotherapy Alone on Morphine Equivalent Units



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compressive cryotherapy ($n = 25$) or cryotherapy alone ($n = 21$) for the first postoperative week. Patients randomized to the compressive cryotherapy group used an inflatable shoulder sleeve with an electric pump that filled the sleeve with compressed air and ice water, whereas the cryotherapy-alone group used a standard ACE wrap with ice. Patient-reported pain levels were assessed twice daily with a diary that included a visual analog score, and pain medications were documented and dosages were converted to morphine equivalent dosage.

There was no significant difference in average or worst pain among patients who were treated with compressive cryotherapy or cryotherapy alone during the study period. Similarly, there was no significant difference in morphine equivalent dosage over the 7 days after operation among the 2 arms (Figure 1). In addition, there was no difference in pain between the compressive cryotherapy and cryotherapy-alone groups.

In conclusion, compressive cryotherapy did not reduce postoperative pain after RCR or SAD compared with standard cryotherapy. The results of this study suggest that compressive cryotherapy could not be recommended over standard therapy for the reduction of pain after RCR or SAD. Further studies are needed to evaluate the cost-effectiveness of compressive cryotherapy compared with traditional cryotherapy.