is arguable that individuals may become obese because they are persistently hypertriglyceridaemic. If they have an excessive amount of fat circulating, they probably store more of it and become more obese as a result. In relation to alcohol, if they use this as a source of material to be converted into lipid, this just adds to the situation. Secondly, it has been suggested that some of the drugs which are effective in reducing hypertriglyceridaemia, like clofibrate and its derivatives, are also uricosuric; I wonder whether you have actually attempted treatment with any of these and what results you got.

**D.R. GIBSON** We have not tried these. I think it would be true to say that workers such as Trevaks and Lovell (1965), who used Atromid to treat hyperuricaemia, found that they could not get consistent results and they certainly could not find a sustained uricosuric effect.

**References**

**Glenoidectomy: A Method of Treating the Painful Shoulder in Severe Rheumatoid Arthritis. By DENYS WAINWRIGHT (North Staffs. Hospital Centre, Orthopaedic Hospital, Hartshill, Stoke-on-Trent, Staffs)**

The painful rheumatoid shoulder can be very disabling. Inability to raise the arm from the side or put the hand round to the small of the back or the back of the head is a serious handicap and there are many cases in which successful surgical treatment of the elbow, wrist, and hand in generalized rheumatoid arthritis has been rendered virtually ineffective because the slightest movement of the shoulder was painful. Although several attempts have been made to produce an artificial shoulder, these have not been particularly successful and many complications have been described.

This is a preliminary report on six cases of severe rheumatoid arthritic change in the shoulder which have been treated by a simple glenoidectomy or excision of the glenoid together with as much of the synovial membrane as can be achieved.

The operation is performed through a posterior incision. After partial synovectomy about 1/3 of the glenoid and neck of the scapula is removed. The arm is immobilized on an abduction splint for 3 or 4 weeks. Active abduction from the horizontal position is started after 3 weeks and graduated exercises and rehabilitation are continued for several weeks.

The results so far have been encouraging and all but one of the patients are well pleased with the relief of pain. Passive shoulder movements are much increased and, although active abduction at the shoulder joint itself rarely amounts to more than 30\(^\circ\), the relief of pain enables scapular movements to be brought into play so that an active range of 60–80\(^\circ\) is possible. Rotation movements are also improved, enabling the patient to reach the back of the neck and the lower part of the back.

The procedure is reserved for severely disorganized arthritic shoulder joints associated with the intractable pain which often accompanies the slightest movement of the joint.

**Discussion**

**D.R. J. GLYN (London)** Have you inspected any of these joints subsequently. Do you know what happens in the gap?

**MR. WAINWRIGHT** No, we haven't operated on them again at all.

**D.R. J. GLYN (London)** And the longest follow-up?

**MR. WAINWRIGHT** Is 15 months. They have not deteriorated in any way.

**D.R. A. ST. J. DIXON (Bath)** What do you think is the mechanism of the relief of pain? Is it that some ligament which was previously on a stretch has been released from the stretch, or is it due to the removal of the bone itself?

**MR. WAINWRIGHT** I think that our understanding of the cause of pain in the arthritic joint is very limited, but it is common experience, in any chronically inflamed joint, that when you release the tension by removing part of the bone on one side or the other, and in particular if you remove the inflamed synovial membrane as well, the pain is considerably relieved. I think the diminution of tension contributes to relief of pain.

**D.R. A. G. MOWAT (Oxford)** We have had a little experience in the use of a Shier prosthesis which, as you know, involves the replacement of the humeral head and so is therefore a partial joint replacement. The range of motion achieved is similar to your own but then there are the complications of metal. We have found post-operatively that we have induced a partial frozen shoulder which has made it difficult to mobilize the shoulder for a month or so afterwards.

**MR. WAINWRIGHT** No. Our joints have remained very loose. The most impressive thing has been the painless range of passive movement. I think that if you put a prosthesis in you recreate the tension. On the whole, until we can devise a proper total replacement, there is not much point in persevering with an arthroplasty which replaces one side or the other of the joint.

**D.R. A. G. S. HILL (Stoke Mandeville)** Returning to this question of pain, I wonder whether there is not a particular type of pain in arthritis which goes with eburnation and sclerosis of bone and exposure of bone to direct pressure without any cartilage intervening. Perhaps you are relieving pain by removing that situation, just as Dr. Mowat and his colleagues have relieved the pain by putting a MacIntosh plate into the knee.

**MR. WAINWRIGHT** When you expose the joint, and it is a very good exposure from the back which is very much easier than the front, you have an excellent view of the joint; the amount of destruction of cartilage is quite extraordinary in these very badly affected rheumatoid joints. The bone of the humeral head is very moth-eaten and is lying totally exposed to a rather moth-eaten glenoid.
D Wainwright

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