Therapy of intraarticular lesions and elimination of structural risk factors for those suffering from clinical manifest anterosuperior impingement (ASI) of the shoulder. This includes as a maximum version the arthroscopic repair of supraspinatus (SST) and subscapularis tendon (SCT) tears with subsequent subpectoral tenodesis of the long head of the biceps tendon (LBT) and arthroscopic coracoplasty. Clinical manifest anterosuperior impingement of the shoulder with anterior shoulder pain, failed conservative treatment and clear intraarticular damage in radiological imaging. This involves in detail lesions of the SST, SCT and damage to the LBT. Lack of structural intraarticular lesions or massive osteoarthritis. Persistent dysfunction of active and passive glenohumeral and scapulathoracal motion, due to neurologic deficits or stiff shoulder. A hypertrophic or deformed healed coracoid process is seen as a structural risk factor for suffering from ASI and should be addressed surgically when causing impingement. Arthroscopic tenotomy of the LBT with subsequent repair of the SST and SCT. Arthroscopic coracoplasty if indicated and subpectoral tenodesis of the long head of the biceps. No biceps activity and intermittent immobilization in sling for 6 weeks. Limitation of abduction, flexion and external rotation for 6 weeks depending on rotator cuff tendon repair. Start of sport-specific training after 3 months, over-head sports 6 months postoperatively. The
arthroscopic repair of anterosuperior rotator cuff tears provides reliable results for improvement in function, decreases in pain and improvement in shoulder scores. The overall rate of adverse events is low.