Prevalence of subscapularis tear is ranged from 25-49% in arthroscopic surgery, higher than reported in open surgery which is reported less than 10%. 90% of subscapularis tear is combined with supraspinatus tear.

Subscapularis has a large footprint on the lesser tuberosity. It is a strong internal rotator and anterior stabiliser of the gleno-humeral joint. Subscapularis also works as bicep tendon stabiliser and provides balance dynamic coupling force in the transverse plane to the gleno-humeral joint.

The pathogenesis of subscapularis tear includes the degenerative wear, subcoracoid impingement, micro-vascularity impairment and acute traumatic force. The mechanism of traumatic injury is the external rotation force with the arm in hyperextension and abduction. The clinical presentations are pain, weakness in internal rotation and bicep tendon instability. There are several clinical tests to detect the present of subscapularis tear. The radiograph is useful when there is anterior subluxation of glenohumeral joint. The ultrasound with dynamic image is high sensitivity but operator dependant. MRI with contrast is gold standard in diagnose the tear pattern and associated pathology such as supraspinatus tear, muscle atrophy, bony injury and bicep instability. Treatment for subscapularis tear includes analgesic, physical therapy and lifestyle modification. The indications for surgery are acute traumatic injury, persistent pain and weakness and failed non operative treatment. A subscapularis repair can be done with single row, double row or suture bridge method. The overall outcome of subscapularis repair is good in term of pain relief and functional improvement. Bicep tendon instability can be addressed with tenodesis or tenotomy.

The prevalence of subscapularis tear is more common than we thought and the clinical tests are still evolving but with varies specificity and sensitivity. Arthroscopic repair is a feasible technique and gives a overall good result.