

## **Bankart Repair Open or Arthroscopic?**

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- Introduction  
Controversial and evolving area  
Know who is giving the information to judge bias in presentation
- Bankart Lesion Definition  
Bankart 1938: "No one who has ever seen this typical lesion exposed at operation could possibly doubt that the only rational treatment is to reattach the glenoid ligament to the bone from which it has been torn."  
Lintner SA, Speer KA: >85% patient with dislocation have a bankart lesion  
Baker CL, Uribe JW, Whitman C: AJSM 1990: 100% Bankart lesion  
Norlin R: Arthroscopy 1993: 100% Bankart lesion  
Taylor DC, Arciero RA: AJSM 1997: 97% Bankart lesion, 82% Hill Sachs lesion, 9% SLAP, 3% Capsular tear

**Anterior dislocation causes an avulsion of the anterior-inferior insertion of the capsulolabral complex of the glenoid. To compromise shoulder stability, the "essential lesion" must be associated to other stabilizing structures.**

- Open Repair Literature  
Rowe 1978  
Dislocators and subluxators treated through Capsulorrhaphy: 96.5% success  
Thomas and Matsen, 1989  
Dislocators treated with Bankart repair through drill holes: 97% success  
Bigliani 1994  
Dislocators treated with capsular shift and labral repair: 92% success  
Return by throwing athletes 67%  
Altcheck 1991  
T-plasty modification of capsular shift: 95% success  
Summary of open shift  
Effective recurrence <10%  
Good results in many surgeons hands  
Complications  
Stiffness  
Subscapularis problems  
Nerve injury  
Recurrence of instability
- Arthroscopic Literature  
Johnson 1993

Arthroscopic Staple Capsulorrhaphy: 11% redislocation (others 16-44%)

ER loss of ten degrees

Staple removal in 10% No longer recommended

Caspari 1997

Transglenoid Suture Capsulorrhaphy: 16.6% overall instability

**Younger patients higher recurrence (28% redislocation in <20 years)**

**Bankart lesion 27% redislocation, No Bankart lesion 6% redislocation**

**Best result by the pioneers of this technique**

Arthroscopic Suture Repair

Most popular current technique,

7-33% recurrence rates

Summary of Arthroscopic repair

Best in skilled hands only (>10 cases per years)

Pioneers reported better results than followers

Potential advantages

Anatomic repair

Avoid subscapularis problems

Faster recovery

Cosmesis?

Problems

Recurrence of instability (10-20%)

Advances Arthroscopic skills needed

Nerve injury

### **MOST SURGEONS WILL ACHIEVE HIGHER SUCCESS WITH OPEN STABILIZATIONS.**

- Indications for surgical intervention

Recurrent anterior instability supported by history, physical examination and radiographs that fails to respond to activity modification and physiotherapy

Activity limiting apprehension

First time Dislocators?

High performance athlete

Overhead worker

Military

Immobilization does not restore anatomy

Continues activity likely to result in dislocation

Recurrence of dislocation of athlete in two consecutive season will end career

Recurrence rates

Overall 50% 10 year follow-up (Hovelius)

Athletes 80%

Cadets 90%

Adolescents approach 100%

- Indications for Open Repair

## **ANY PATHOLOGIC LESION**

- Indications for Arthroscopic Repair
  - Traumatic anterior dislocation
  - Bankart lesion without rim defects
  - Few recurrences
  - Non-dominant arm
  - Non-collision sport activities
  - Capsular laxity equal to opposite shoulder
  
- Contraindications for Arthroscopic repair
  - Contact Athlete
  - History of multiple dislocations
  - Anterior instability no Bankart lesion
  - Poor tissues
  - Pathologic ligamentous laxity
  
- My personal approach
  - Clinical Indications
    - Absolute indications sparse
    - Allows inspection of intra-articular pathology
    - Easier to handle superior labral pathology
    - Combined rotator cuff and labral pathology
    - Any case that I feel I can achieve the same result
  - Surgeon driven
    - Interest in learning and applying Arthroscopic skills
    - Assess psychology of patient
    - Assess dynamics of practice
  - Technology driven
    - Instrumentation and techniques continue to evolve

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