

# Editorial Commentary: Augmented Bankart Could Be the Right Option for Subcritical Bone Loss



Alexandre Lädermann, M.D.

**Abstract:** The suitable treatment for recurrent anterior shoulder instability with subcritical glenoid bone loss remains controversial. Although the Latarjet procedure is one of the most successful surgery for shoulder instability, it has been associated with potential complications in my patients with limited bone loss and poor soft-tissue conditions, which motivated me to further investigate Bankart augmentation techniques. A myriad of them have been devised and proposed for this specific group of patients; however, there are no sufficient clinical data reported in the literature to support one of them particularly or clarify in which situation they should be used. Further comparative and prospective studies are therefore needed to build an evidence-based decision tree to help us treating our patients and better match their expectations. That said, current literature and my experience have resulted in a shift in my treatment paradigm undertaken 3 years ago to augmented Bankart in case of subcritical glenoid bone loss.

See related article on page 706

I started my career as a shoulder surgeon doing a fellowship with Gilles Walch in 2007. During this training, Dr. Walch taught me the “best French surgery ever”: The Latarjet procedure. The latter is an exception in the shoulder field, being among the few surgeries that has almost never failed since more than 75 years. Once back home, I began to propose such stabilization to my patients in a routine manner, with excellent clinical outcomes.<sup>1,2</sup> Nonetheless, this surgery is technically challenging and prone to recurrences of instability or other complications,<sup>3-5</sup> especially in my patients with limited glenoid bone loss and poor soft-tissue conditions (e.g., hyperlaxity or inherent capsule deficiency). Since my goal is not to reproduce their original anatomy (that previously failed), I consequently devised for this specific type of patients a new Bankart augmentation technique involving the long head of the biceps.<sup>6</sup>

Currently, a myriad of Bankart augmentation methods exists, including capsular shift,<sup>7</sup> remplissage,<sup>8,9</sup> dynamic anterior stabilization,<sup>6,10</sup> closing rotator interval,<sup>11,12</sup> a split subscapularis tendon flap,<sup>13</sup> a reconstruction of the inferior glenohumeral ligament,<sup>14</sup> etc. All these different techniques have several pros and cons, making it difficult to decide which one to use in clinical practice. It is furthermore essential to consider patients’ lifestyles in the decision making to better match their expectations in terms of return to sport or daily physical activities. We are therefore left to grapple with a dilemma: which one for which situation? Do they all have a place in a decision tree?

In their article entitled “Arthroscopic Bankart Repair With Remplissage in Comparison to Bone Block Augmentation for Anterior Shoulder Instability With Subcritical Bone Loss: A Systematic Review,”<sup>8</sup> Gouveia, Abidi, Shamsnoon, Gohal, Madden, Degen, Leroux, Alolabi, and Khan found that both Bankart with remplissage and Latarjet are effective treatment options. Their findings consolidate my shift in treatment paradigm undertaken 3 years ago to augmented Bankart in case of subcritical glenoid bone loss. As expected, the main limitations of their systematic review stem from the quality and quantity of evidence available on the topic. Gouveia et al. inspire a call to action. Clinical and surgical observations must therefore continue to spur further high-level prospective and comparative researches. Otherwise, adequate

University of Geneva

The author reports the following potential conflicts of interest or sources of funding: consultant for Wright, Arthrex, and Medacta (money paid to FORE); receives payment for lectures including service on speakers bureaus (money paid to FORE); receives payment for development of educational presentations (money paid to FORE); and receives travel, accommodations, and meeting expenses unrelated to activities listed (money paid to FORE). He received royalties from Wright. Full ICMJE author disclosure forms are available for this article online, as [supplementary material](#).

© 2020 by the Arthroscopy Association of North America  
0749-8063/201693/\$36.00

<https://doi.org/10.1016/j.arthro.2020.10.027>

indications for these various stabilization techniques will remain obscure.

### References

1. Cunningham G, Benchouk S, Kherad O, Lädermann A. Comparison of arthroscopic and open Latarjet with a learning curve analysis. *Knee Surg Sports Traumatol Arthrosc* 2016;24:540-545.
2. Lädermann A, Lubbeke A, Stern R, Cunningham G, Bellotti V, Gazielly DF. Risk factors for dislocation arthropathy after Latarjet procedure: A long-term study. *Int Orthop* 2013;37:1093-1098.
3. Lädermann A, Denard PJ, Arrigoni P, Narbona P, Burkhart SS, Barth J. Level of the subscapularis split during arthroscopic latarjet. *Arthroscopy* 2017;33:2120-2124.
4. Lädermann A, Denard PJ, Burkhart SS. Injury of the suprascapular nerve during latarjet procedure: An anatomic study. *Arthroscopy* 2012;28:316-321.
5. Lädermann A, Denard PJ, Tirefort J, et al. Does surgery for instability of the shoulder truly stabilize the glenohumeral joint? A prospective comparative cohort study. *Medicine (Baltimore)* 2016;95:e4369.
6. Collin P, Lädermann A. Dynamic anterior stabilization using the long head of the biceps for anteroinferior glenohumeral instability. *Arthrosc Tech* 2018;7:e39-e44.
7. Ahmed I, Ashton F, Robinson CM. Arthroscopic Bankart repair and capsular shift for recurrent anterior shoulder instability: Functional outcomes and identification of risk factors for recurrence. *J Bone Joint Surg Am* 2012;94:1308-1315.
8. Gouveia K, Abidi SK, Shamssoon S, et al. Arthroscopic Bankart repair with remplissage in comparison to bone block augmentation for anterior shoulder instability with bipolar bone loss: A systematic review. *Arthroscopy* 2021;37:706-717.
9. Lee YJ, Kim C, Kim SJ, Yoon TH, Cho JY, Chun YM. Does an "off-track" Hill-Sachs lesion that is misclassified as "non-engaging" affect outcomes from Bankart repair alone compared with Bankart repair combined with remplissage? *Arthroscopy* 2021;37:450-456.
10. Mehl J, Otto A, Imhoff FB, et al. Dynamic anterior shoulder stabilization with the long head of the biceps tendon: A biomechanical study. *Am J Sports Med* 2019;47:1441-1450.
11. Chiang ER, Wang JP, Wang ST, Ma HL, Liu CL, Chen TH. Arthroscopic posteroinferior capsular plication and rotator interval closure after Bankart repair in patients with traumatic anterior glenohumeral instability—A minimum follow-up of 5 years. *Injury* 2010;41:1075-1078.
12. Kim SH, Ha KI, Kim YM. Arthroscopic revision Bankart repair: A prospective outcome study. *Arthroscopy* 2002;18:469-482.
13. Denard PJ, Narbona P, Lädermann A, Burkhart SS. Bankart augmentation for capsulolabral deficiency using a split subscapularis tendon flap. *Arthroscopy* 2011;27:1135-1141.
14. Arenas-Miquelez A, Karargyris O, Zumstein M. All-arthroscopic, 270 degrees reconstruction of the inferior glenohumeral ligament with palmaris longus autograft. *Arthrosc Tech* 2019;8:e1145-e1151.