KEY PROCEDURES

ARTHROSCOPIC SURGICAL STABILIZATION OF GLENOHUMERAL DISLOCATIONS WITH CLAVICULAR GRAFT AND REMPLISSAGE

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Published outcomes of this procedure can be found at: *Ann Joint.* 2017;2:77, *Arthrosc Tech.* 2014 Aug;3(4):e475-81, and *J Shoulder Elbow Surg.* 2016 Jun;25(6):960-6.

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Abstract

Surgical repair of the unstable shoulder begins with reattachment of the detached capsulolabral complex. The degree of damage to the glenohumeral articulation can be variable and is often related to the degree of trauma, duration of dislocation, and the number of instability events. There have been many surgical procedures proposed for the treatment of shoulder instability in the athlete, ranging from soft-tissue repair to coracoid transfer or the addition of a bone graft. The arthroscope provides an opportunity to visualize and repair the injured structures, returning the shoulder to maximal range of motion and permitting functional improvement.

Indications for arthroscopic anterior stabilization include a first-time dislocation, patients with apprehension following dislocation, and recurrent dislocation and subluxation prior to creating advanced bone loss. If there is advanced bone loss, an augmented repair or a procedure other than arthroscopic stabilization has been recommended. Mobilization of the anterior capsule and fixation to recreate the proper anterior tension will limit translation and potential recurrence of instability.

The steps of the arthroscopic anterior stabilization include:

1. Perform examination under anesthesia to identify the directions and degree of humeral translation relative to the glenoid.
2. Position the patient with the shoulder 30° abducted and 20° flexed.
3. Create proper portals, including a posterior viewing portal, dual anterior portals, and accessory portals for suture anchor placement.
4. Perform a diagnostic arthroscopy to determine the damaged structures and how they relate to shoulder positions that may invite future dislocations.
5. Perform capsule and labrum mobilization to permit anatomic relocation of the injured ligament.
6. Place a series of suture anchors along the anterior and inferior glenoid margin.

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7. Utilize suture hooks to retrieve the sutures placed through the capsule to advance the capsule superiorly to the glenoid margin.
8. Assess glenoid deficiency and place an autograft anterior to the damaged glenoid rim in selected cases.
9. Tenodes the posterior capsule and infraspinatus to a large Hill-Sachs lesion on the posterosuperior aspect of the humeral head in selected cases.
10. Repair additional labral structures superiorly and posteriorly if they contribute to glenohumeral instability.

The anticipated outcome is a return to sport and high-demand activities. Bracing is available, but the internal repair is the most reliable technique to protect the glenohumeral articulation. Additional techniques can be implemented when added trauma has resulted in severe bone loss of the glenoid, humeral head, or anterior capsular structures. A return to high-risk activities can be anticipated in 4 to 7 months.

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