≪심포지움 I (Shoulder Instability) 09:45~09:55≫

Arthroscopic Labral Repair / Capsular Plication with the Mini-Revo Anchor

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The arthroscopic treatment of shoulder instability has progressed rapidly over the last decade. The traditional open labral repair and capsular plication are well-treated procedures with excellent results. The evolution of these procedures arthroscopically has been aided by surgical technique and instrumentation. The arthroscopic techniques that closely mimic the open techniques have the best result. Labral pathology at the superior glenoid and the anterior inferior glenoid, Bankart, can be sucessfully treated with the mini-Revo anchor

Both superior and enterior inferior labral repairs are performed with the arthroscope in the standard posterior portal and we anterior operative portals. Both anterior portals are established from outside in with a spinal needle for direction. The anterior superior portal is established to enter the glenohumeral joint inthe rotator cuff interval at the biceps tendons. The anterior inferior portal in esablished to enter the the geglenohumeral joint at the superior margin of the subscapularis muscle Exernally, this should be lateral to the coracoid

For the superior labral repair and frayed soft tissue is removed with an arthroscopic shaver beneath the labral tear. The superior glenoid rim and neck are then decorticatod with a small round bur. The mini-Rove guide and drill bit are placed in the anterior superior portal and at approximately the 1 O'clock position in the right shoulder and the 11 o'clock position in the left shoulder, a pilot hole is driled. This is filled with a mini-Revo screw and attached #2 nonabaorbable braided suture. These two stands are then taken out the anterior interior portal A 45° Curved suture hook for the right shoulder or a 45° curved left suture hook for the left shoulder, is placed through the anterior superior cannula, piercing the inferior aspect of the lobral the anterior superior cannula and taken out the anterior inferior cannula. One limb of the #2 nonabsorbable suture is placed in this suture shuttle and this is then used to pass the nonabsorbable suture through the labral tear. Once this is completed, the second suture which is not through the tissue is taken out the anterior superior cannula. Using a loop handle knot pusher, a Rove knot is tied. securing the superior labrum to the superior glanoid rim. The sutures are then cut and the labral tear is probed to assure adaquate fixation.

Repair of anterior inferior labral tears, Bankart, are carried out in much the same fashion as a repair of the superior labrum. The labral tear is mobilized because many times this has retracted medially along the glenoid neck. Once the labral tear is mobilized the glenoid rim and neck are decorticeted with a small bur. Next two or

three pilot holes are drilled with the mini-Revo guide and drill bit on the edge of the articular surface of the glenoid rim. The first is placed as far inferiorly as poassible. This is carried out through the anterior interior portal. All pilot holes are filled with mini-Revo screws and atteched #2 nonabsorbable braided suture. Each pair is taken out the anterior superior cannula and a as French red rubber catheter laber tear capsular plication is carred out with either a modified . Casperi Suture punch or a 45° curved suture hook. The suture passer is advanced into the joint from the anterior inferior portal. A grasper is used to pull this and out the anterior superior cannula, making sure the other and remains outside the anterior interior portal. Then in sequential fashion from inferior to superior each of the #2 braided sutures are pulled through the uraviously grasped labrum and capsule and out of the anterior interior cannula. Once this is completed a horizontal mattress suture is tied using a loop handled knot pusher securing the labrum to the glenoid rim and plicating the capsule. The sutures are cut, the labral tear and capsular plication 13 that tested with a probe for secure fixation.
Postoperativaly a sling in worn for only one day and physical therapy is started on postoperative day one with aggressive passive motion in flexion and elavation. External rotation to more than, 10-15° is delayed until postoperative week three. A full return to sports can be expected in as early as four months.