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Arthroscopic Latarjet yields better union and prevention of instability compared to arthroscopic bony Bankart repair in shoulders with recurrent anterior instability: a systematic review

Anselme Billaud, Laurent Baverel, Pierre Metais, Floris van Rooij, Ankitha Kumble, Guillaume Villatte, Edouard Dejour, Geoffroy Nourissat

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1 **Title:** Arthroscopic Latarjet yields better union and prevention of instability compared to
2 arthroscopic bankart repairs in shoulders with recurrent anterior instability: a systematic
3 review

4 **Abstract**

5 **Purpose:** To determine whether arthroscopic Latarjet procedure arthroscopic Latarjet or
6 arthroscopic bony Bankart repair arthroscopic bony Bankart repair provide better outcomes in
7 terms of rates of recurrent instability, non-union and complications, as well as clinical scores
8 and range of motion.

9 **Methods:** An electronic literature search was performed using PubMed, Embase®, and
10 Cochrane databases, applying the following keywords: “Arthroscopic bony bankart” OR
11 “Arthroscopic osseous bankart” AND “Arthroscopic Latarjet” OR “Arthroscopic coracoid
12 Bone block”.

13 **Results:** The systematic search returned 1,465 records, of which 29 were included
14 (arthroscopic bony Bankart repair, n=16; arthroscopic Latarjet, n=13). 37 datasets were
15 included for data extraction, on 1483 shoulders. Compared to arthroscopic Latarjet,
16 arthroscopic bony Bankart repair had significantly higher instability rates (0.14; CI, 0.10–
17 0.18; vs 0.04; CI, 0.02–0.06), significantly lower union rates (0.63; CI, 0.28–0.91 vs 0.98; CI,
18 0.93–1.00), and significantly lower pain on VAS (0.42; CI, 0.17–0.67 vs 1.17; CI, 0.96–
19 1.38). There were no significant differences in preoperative glenoid bone loss, follow-up,
20 complication rate, ROWE score, ASES score, external rotation, and anterior forward
21 elevation between arthroscopic Latarjet and arthroscopic bony Bankart repair.

22 **Conclusion:** Compared to arthroscopic Latarjet, arthroscopic bony Bankart repair results in
23 significantly (i) higher rates of recurrent instability (14% vs 4%), (ii) lower union rates (63%
24 vs 98%), but (iii) slightly lower pain on VAS (0.45 vs 1.17). There were no differences in
25 complication rates, clinical scores, or postoperative ranges of motion.

26 **Level of Evidence:** Level IV

27 **Keywords:** Arthroscopic Latarjet procedure, bony Bankart procedure, anterior instability,
28 outcomes

29 **Introduction**

30 Anterior shoulder instability often requires surgical treatment, particularly in young athletes
31 who wish to resume sports [3,46,50]. The most common surgical treatments involve either
32 labral or capsular repair in shoulders with no glenoid defects [34,51], or bone-block
33 procedures in shoulders with glenoid defects [13,26,35]. The Latarjet technique is among the
34 most popular bone-block procedures, as it proved effective at preventing recurrent
35 dislocations [1,2,12,21,25,27,39] whether performed as an open or an arthroscopic procedure
36 [15,33]. The Latarjet technique is however technically demanding and therefore has a
37 considerable learning curve and requires alteration of native scapular anatomy [5,9,15].

38

39 More recently, arthroscopic bony Bankart repair arthroscopic bony Bankart repair[49] was
40 introduced as a less invasive alternative to arthroscopic Latarjet, to treat anterior shoulder
41 instability with traumatic glenoid defects, where the bone fragment is still present and could
42 be sutured back onto the glenoid [4]. While arthroscopic bony Bankart repair demonstrated
43 satisfactory bone union rates, it is associated with higher rates of recurrent instability
44 compared to arthroscopic Latarjet [6,39,52,54], and may be insufficient to treat shoulders
45 with irreparable ligamentous damage, attritional glenoid bone loss, or major bone
46 deficiencies [15].

47

48 There is no consensus on the optimal treatment for recurrent anterior shoulder instability with
49 traumatic glenoid defects. Therefore, the purpose of this study is to determine whether
50 arthroscopic Latarjet or arthroscopic bony Bankart repair provide better outcomes for this
51 population in terms of rates of recurrent instability, non-union and complications, as well as
52 clinical scores and range of motion.

53 **Materials and Methods**

54 The protocol for this systematic review was submitted to PROSPERO prior to
55 commencement (registration number BLINDED) and conforms to the principles outlined in
56 the handbook of the Cochrane Collaboration [19], along with the guidelines established by
57 the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) [37].

58

59 *Search strategy*

60 The authors conducted a structured electronic literature search on 06 July 2022 using the
61 PubMed, Embase®, and Cochrane Central Register of Controlled Trials databases, applying
62 the following keywords: “Arthroscopic bony bankart” OR “Arthroscopic osseous bankart”
63 AND “Arthroscopic Latarjet” OR “Arthroscopic coracoid Bone block”. The full search
64 strategy is presented in Appendix I. The search was limited to articles published between
65 2002 and 2022. After removal of duplicate records, each of two researchers (BLINDED)
66 screened the titles and abstracts to determine the suitability for the review using the following
67 predefined eligibility criteria:

68

69 *Inclusion criteria*

- 70 - Comparative or non-comparative studies on patients with recurrent anterior shoulder
71 instability that underwent either primary arthroscopic Latarjet or primary arthroscopic
72 bony Bankart repair with or without adjuvant procedures
- 73 - Studies that measured preoperative glenoid bone loss using computed tomography
74 (CT) scans
- 75 - Studies that report pre- and post-operative clinical outcomes in terms of, recurrence of
76 instability, non-union, complication rates, range of motion, or clinical scores

77

78 *Exclusion criteria:*

- 79 - Narrative or systematic reviews, case reports, expert opinions, editorials, letters to
80 editors, computer simulations, cadaver or laboratory studies
- 81 - Studies published in languages other than English, French, German, Italian, Spanish,
82 and Dutch to avoid translation errors.

83

84 *Study selection*

85 Studies that met the eligibility criteria during title and abstract screening underwent full-text
86 screening by two researchers (BLINDED) and any disagreement was first discussed between
87 the researchers, and if required, a third researcher (BLINDED) resolved any disagreement.
88 The reference lists of studies for full text review were searched, and an expert (BLINDED)
89 was consulted to identify further relevant studies that may not have been captured by the
90 database searches.

91

92 *Data extraction and quality assessment*

93 Data extraction was performed by two researchers (BLINDED) independently and their
94 results were compared to ensure accuracy. Where there was disagreement in the documented
95 value, the true value was ascertained by simultaneous review of the data in question by both
96 researchers. The following information was extracted from the included studies; author(s),
97 journal, year of publication, level of evidence, country where study was performed, conflicts
98 of interest and funding declaration. Furthermore, the following clinical data was extracted:
99 type of surgery, subgroup size, sex, age, preoperative glenoid bone loss, union rates (instead
100 of non-union rates which were inconsistently defined and reported), recurrent instability rates
101 (defined as recurrence of subluxation and/or dislocation), post-operative complication rates,

102 range of motion (ROM; ER1, arm at 0° of abduction; ER2, arm at 90° of abduction; AFE,
103 anterior forward elevation), clinical scores, and pain on VAS scale.

104

105 Methodological quality of the eligible studies was assessed by two researchers (BLINDED)
106 according to the Joanna Briggs Institute (JBI) checklist, to appraise the reporting quality (10
107 items). Where there was disagreement between the researchers, consensus was achieved by
108 discussion and review.

109

110 *Statistical analysis*

111 When available in the original articles, outcomes were tabulated: continuous outcomes were
112 reported as means, standard deviations, and ranges, while categorical outcomes were reported
113 as proportions. Pooled estimates were calculated if mean and standard deviations were
114 available for least 3 studies reported. When the standard deviation was not reported, the range
115 was used to calculate standard deviation using a method outlined by Hozo et al.[22].
116 Heterogeneity was evaluated by visual inspection of forest plots and using the I^2 statistic and
117 its connected χ^2 test, to provide a measure of the degree of inconsistency across studies.
118 Pooled estimates of raw means and their 95% confidence interval (CI) were calculated using
119 a random-effects model framework. Pooled estimates of proportions and their 95%
120 confidence intervals (CI) were calculated via Freeman-Tukey double arcsine transformation
121 using inverse-variance weighting within a random-effects model framework. P-values <0.05
122 were considered statistically significant. Statistical analyses were performed using R version
123 4.1.3 (R Foundation for Statistical Computing, Vienna, Austria) using the meta package.

124 **Results**

125 The systematic search returned 1,465 records, of which 563 were duplicates, leaving 902 for
126 title and abstract screening (Figure 1). A total of 786 studies were excluded by examining
127 their titles and/or abstracts because: 500 were not relevant, 223 were editorials/conference
128 proceedings etc., 29 were reviews, 17 were published before 2002, and 17 were published in
129 languages other than those defined in the exclusion criteria. A further 87 studies were
130 excluded after full-text review. This left 29 eligible studies,[1,7,8,11,14,16-18,23,24,29-
131 32,38,40-45,47,48,53,55-59] of which 16 assessed arthroscopic bony Bankart repair, 13
132 assessed arthroscopic Latarjet (Table 1 and 2). All studies reported preoperative glenoid bone
133 loss: 21 reported mean preoperative glenoid bone loss, of which 4 created subgroups of
134 glenoid bone loss and reported the mean loss of each subgroup, while 8 used a threshold of
135 glenoid bone loss as a part of their inclusion criteria. Of the 29 eligible studies, 37 datasets
136 were included for data extraction, with a total of 1,483 shoulders (arthroscopic bony Bankart
137 repair, n=874; AL, n=609) (Table 3 and 4). Of the 37 included datasets, 12 datasets reported
138 on concomitant Hill-Sachs (arthroscopic bony Bankart repair, n=7 and arthroscopic Latarjet,
139 n=5) lesions.

140

141 *Quality assessment*

142 Of the 29 eligible studies, 2 were prospective and 27 were retrospective. Of the 29 studies, 3
143 did not report criteria for inclusion and 2 did not specify the presenting sites demographic
144 information. Furthermore, it was unclear in 4 studies whether the study had complete
145 inclusion of participants. Overall, all included studies had good to excellent scores according
146 to the JBI checklist (Table 5).

147

148 *Preoperative glenoid bone loss*

149 Of the 37 included datasets, preoperative glenoid bone loss was reported as part of their
150 inclusion criteria in 7 and was reported as a mean in 26 datasets (arthroscopic bony Bankart
151 repair, n=19; arthroscopic Latarjet, n=7). There was no significant difference in mean
152 preoperative glenoid bone loss between shoulders treated by arthroscopic bony Bankart repair
153 (17.6%; CI, 13.7–21.6; $I^2=99\%$) or arthroscopic Latarjet (18.9%; CI, 13.5–24.3; $I^2=98\%$)
154 (Figure 2).

155

156 *Follow-up*

157 Of the 37 included datasets, mean follow-up was reported in 24 (arthroscopic bony Bankart
158 repair, n=13; arthroscopic Latarjet, n=11). There was no significant difference in mean
159 follow-up between shoulders treated by arthroscopic bony Bankart repair (49.3 months; CI,
160 27.9–70.8; $I^2=100\%$) or arthroscopic Latarjet (29 months; CI, 20.7– 37.3; $I^2=99\%$).

161

162 *Recurrent instability*

163 Of the 37 included datasets, rates of recurrent instability were reported in 19 (arthroscopic
164 bony Bankart repair, n=13; arthroscopic Latarjet, n=6). There was a statistically significant
165 higher rate of instability following arthroscopic bony Bankart repair (0.14; CI, 0.10–0.18;
166 $I^2=49\%$) compared to arthroscopic Latarjet (0.04; CI, 0.02–0.06; $I^2=0\%$) (Figure 3).

167

168 *Union*

169 Of the 37 included datasets, union was reported in 14 (arthroscopic bony Bankart repair, n=5;
170 arthroscopic Latarjet, n=9). All studies assessed union using postoperative CT scans, and
171 there was a statistically significant lower union rate following arthroscopic bony Bankart
172 repair (0.63; CI, 0.28–0.91; $I^2=96\%$) compared to arthroscopic Latarjet (0.98; CI, 0.93–1.00;
173 $I^2=70\%$) (Figure 4).

174

175 *Postoperative complications*

176 Of the 37 included datasets, complication rates were reported in 15 (arthroscopic bony
177 Bankart repair, n=3; arthroscopic Latarjet, n=12), of which 3 reported rates instead of
178 absolute values [23,57]. There was no statistical difference in complication rate following
179 arthroscopic bony Bankart repair (0.01; CI, 0.00–0.07; $I^2=0\%$) compared to arthroscopic
180 Latarjet (0.03; CI, 0.00–0.06; $I^2=47\%$) (Figure 5).

181

182 *Clinical scores*

183 There were no significant differences between arthroscopic bony Bankart repair and
184 arthroscopic Latarjet, in terms of ROWE score (92.78 vs 92.47), and ASES score (94.26 vs
185 92.16). However, arthroscopic bony Bankart repair demonstrated significantly lower pain on
186 VAS (0.42) compared to arthroscopic Latarjet (1.17; $p<0.01$).

187

188 *Range of motion*

189 There were no significant differences between arthroscopic bony Bankart repair and
190 arthroscopic Latarjet, in terms of ER1 (59.5° vs 57.26°), and AFE (167.93° vs 170.90°).

191 **Discussion**

192 The most important findings of this meta-analysis are that, compared to arthroscopic Latarjet,
193 arthroscopic bony Bankart repair results in significantly (i) higher rates of recurrent
194 instability (14% vs 4%), (ii) lower union rates (63% vs 98%), but (iii) slightly lower pain on
195 VAS (0.45 vs 1.17). There were however no significant differences in complication rates,
196 clinical scores, or postoperative ranges of motion. The null hypothesis that the two
197 procedures would result in comparable outcomes is therefore refuted. The clinical relevance
198 of these findings is that, while arthroscopic bony Bankart repair demonstrated comparable
199 clinical scores to arthroscopic Latarjet, the latter might be more suitable in patients prone to
200 recurrent instability or non-union. It is worth noting, however, that the present meta-analysis
201 did not account for the surgeon experience and learning curves, which should also be
202 considered when choosing the surgical technique.

203

204 The present systematic review included studies that had good to excellent scores according to
205 the JBI checklist. A previous systematic review by Longo et al.[36] compared outcomes of all
206 surgical treatments for traumatic anterior glenohumeral instability with glenoid and/or
207 humeral bony defects. Longo et al.[36] found that shoulders with glenoid bone loss <25%
208 were most frequently treated with arthroscopic Bankart repair (50%) or arthroscopic bony
209 Bankart repair (32%), while shoulders with glenoid bone loss >25% were most frequently
210 managed by open reconstruction with bone graft (37%), arthroscopic Bristow procedure
211 (26%), or open Latarjet procedure (OLP) (22%). The present meta-analysis found no
212 significant difference in mean preoperative glenoid bone loss between shoulders treated with
213 arthroscopic bony Bankart repair (17.6%; CI, 13.7–21.6) versus arthroscopic Latarjet (18.9%;
214 CI, 13.5–24.3). However, it remains unclear whether the choice of procedure should be based
215 on the extent of glenoid bone loss, or rather on the size of the remaining bone fragment

216 present that could be sutured back onto the glenoid. It is worth noting that arthroscopic bony
217 Bankart repair may be insufficient to treat shoulders with irreparable ligamentous damage,
218 attritional glenoid bone loss, or major bone deficiencies [15], where bone block procedures
219 may be the only treatment option. A recent systematic review by Hurley et al.[28] compared
220 outcomes of ABR alone versus ABR with remplissage versus OLP, to treat anterior shoulder
221 instability in patients with concomitant Hill-Sachs lesions. Hurley et al.[28] found higher
222 rates of recurrent instability following ABR alone (16.8%) compared to OLP (7.0%) and
223 ABR with remplissage (3.2%). A study by Horinek et al. [20] compared OLP with ABR with
224 remplissage, for anterior shoulder instability and found no difference in terms of clinical
225 scores, return to sport, and satisfaction. In the present meta-analysis, only one study
226 performed arthroscopic bony Bankart repair with remplissage (in 11 of 312 patients) [47] but
227 did not report the outcomes of this subgroup. Furthermore, out of the 29 included studies in
228 the present meta-analysis, Hill-Sachs lesions were reported in 15 studies, and their prevalence
229 ranged from 24% to 100%. It was not possible to perform a subgroup analysis of the
230 outcomes of this pathology as the type of Hill-Sachs lesion was not consistently reported,
231 which could affect the rate of recurrent instability [10,36].

232

233 The results of the present meta-analysis should be interpreted with the following limitations
234 in mind. All included studies were case series, although the level of quality was good to fair.
235 Furthermore, the thresholds of glenoid bone loss reported were heterogenous across studies
236 which makes it difficult to determine whether the choice for arthroscopic bony Bankart repair
237 or arthroscopic Latarjet should be based on the extent of preoperative glenoid bone loss. This
238 meta-analysis did not evaluate Hill-Sachs lesions which could have affected recurrent
239 instability rates [10,36] as the specific lesions were not consistently reported. Additionally,
240 there is need for a more standardised method of reporting outcomes as a great number of

241 different clinical scores were reported, making it difficult to quantitatively compare studies.
242 Finally, it is worth noting that, while there was no statistically significant difference in
243 follow-up between the two techniques, the mean follow-up for arthroscopic bony Bankart
244 repair was almost 2 years longer than for arthroscopic Latarjet, which could introduce bias in
245 the comparisons.

246

247 *Conclusion*

248 This systematic review and meta-analysis found that, compared to arthroscopic Latarjet,
249 arthroscopic bony Bankart repair results in significantly (i) higher rates of recurrent
250 instability (14% vs 4%), (ii) lower union rates (63% vs 98%), but (iii) slightly lower pain on
251 VAS (0.45 vs 1.17). There were however no significant differences in complication rates,
252 clinical scores, or postoperative ranges of motion.

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454
- 455

456 **Figure legend**

457 **Figure 1:** Flowchart of study inclusion

458 **Figure 2:** Forest plot on glenoid defect size

459 **Figure 4:** Forest plot on recurrent instability

460 **Figure 5:** Forest plot on union

461 **Figure 6:** Forest plot on postoperative complications

462

463 **Supplementary material:**

464 **Figure 1:** Forest plot on follow-up

465 **Figure 2:** Forest plot on ROWE score

466 **Figure 3:** Forest plot on ASES score

467 **Figure 4:** Forest plot on pain on VAS

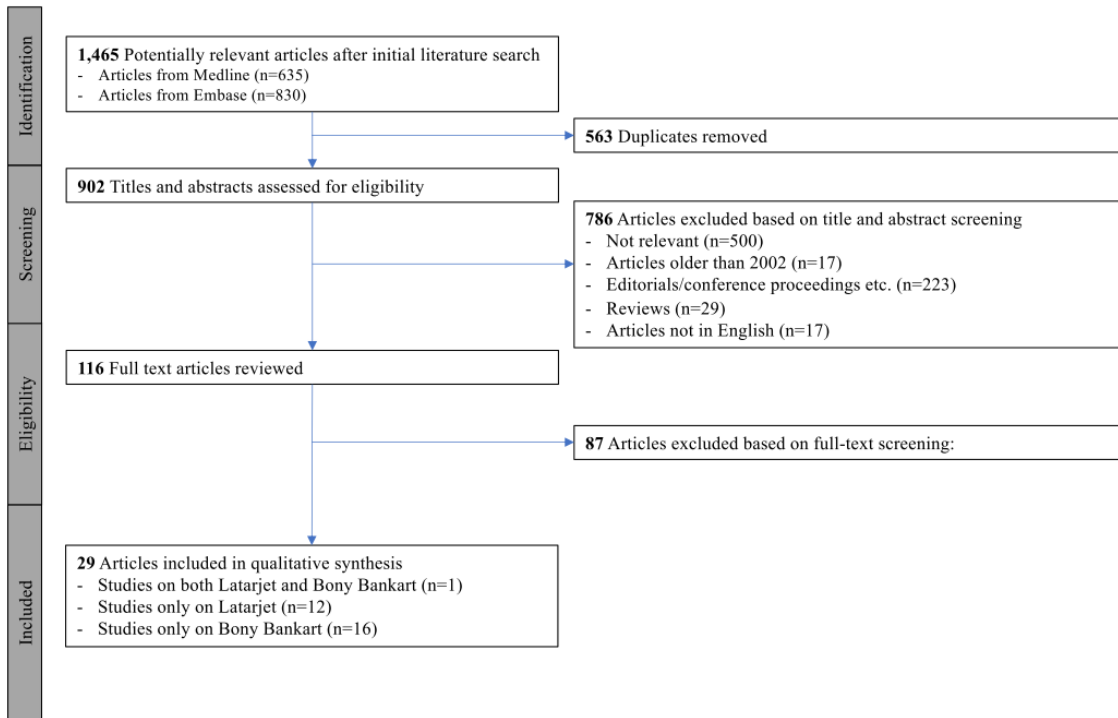
468 **Figure 5:** Forest plot on external rotation 1

469 **Figure 6:** Forest plot on active forward elevation

470 **Appendix 1: Search strategy**

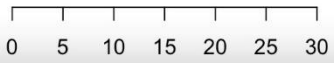
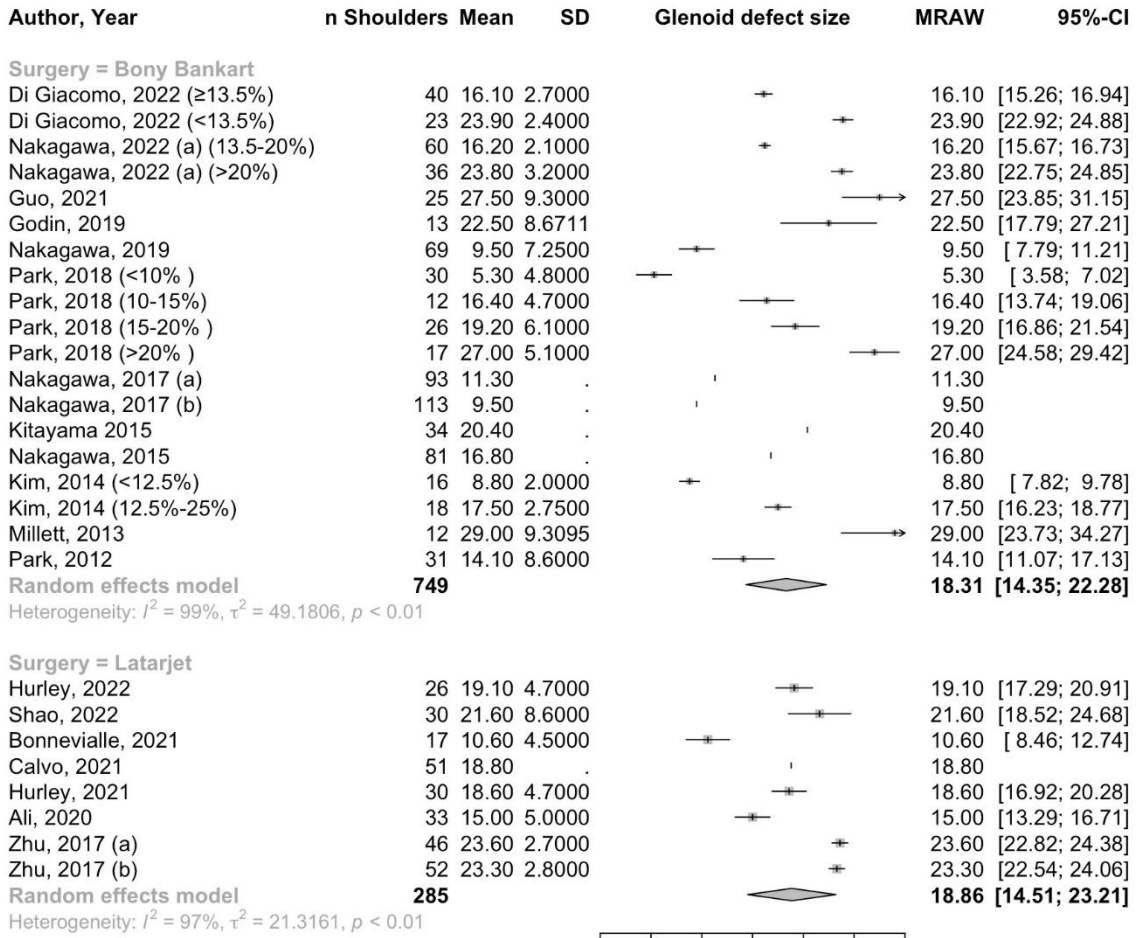
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472 **F1**



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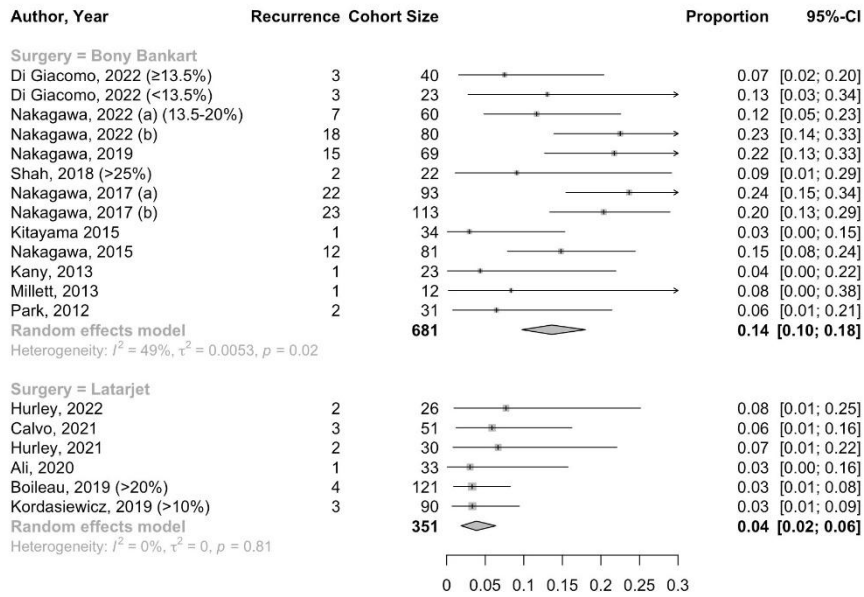
474 **F2**



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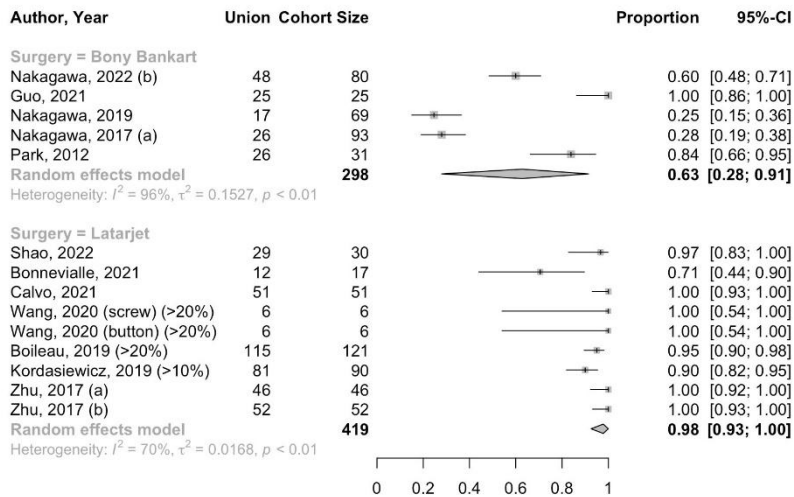
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477 **F3**



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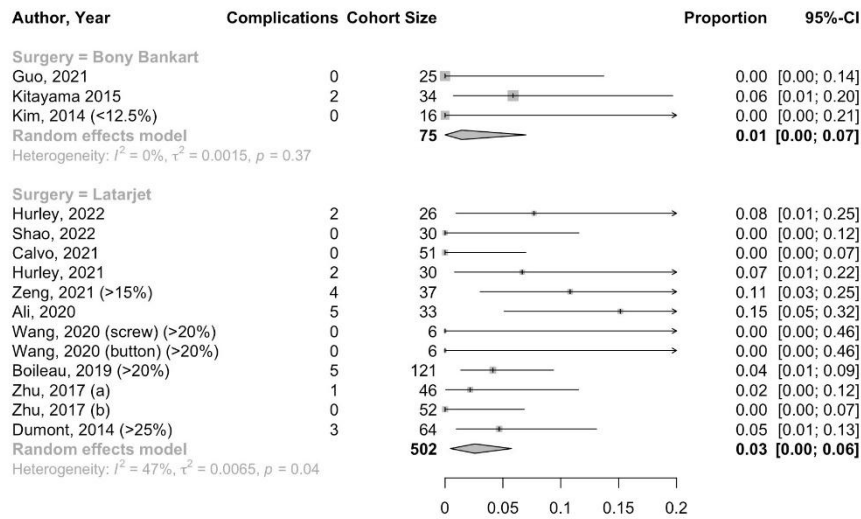
479 **F4**



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482 **F5**



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485 **T1**

Table 1: Study characteristics of the studies on arthroscopic Latarjet

Year	Author	Journals	Declare COIs	Have COI	Declare funding	Have funding	Level of evidence	Country
Latarjet								
2022	Hurley	Arthrosc Sports Med Rehabil	Y	Y	Y	Y	III	USA
2022	Shao	Arthroscopy	Y	N	Y	Y	IV	China
2021	Bonnevalle	AJSM	Y	Y	N	NR	III	France
2021	Calvo	AJSM	Y	Y	N	NR	IV	Spain
2021	Hurley	Arthrosc Sports Med Rehabil	Y	Y	N	NR		USA
2021	Zeng	BMC Musculoskeletal Disorders	Y	N	Y	Y		China
2020	Ali	Arthroscopy	Y	N	N	NR	III	Turkey
2020	Wang	Orthop. Surgery	Y	N	Y	N		China
2019	Boileau	Arthroscopy	Y	Y	N	NR	IV	France
2019	Kordasiewicz	KSSTA	Y	N	Y	N		Poland
2017 (a)	Zhu	AJSM	Y	N	Y	Y	IV	China
2017 (b)	Zhu	Arthroscopy	Y	Y	Y	N	III	China
2014	Dumont	AJSM	Y	Y	N	NR	IV	France

486

487 **T2**

Table 2: Study characteristics of studies on arthroscopic bony Bankart repair

Year	Author	Journals	Declare COIs	Have COI	Declare funding	Have funding	Level of evidence	Country
Bankart								
2022	Di Giacomo	AJSM	Y	Y	Y	Y	III	Italy and USA
2022 (a)	Nakagawa	AJSM	Y	N	N	NR	IV	Japan
2022 (b)	Nakagawa	Arthroscopy	Y	N	N	NR	III	Japan
2021	Guo	OJSM	N	NR	N	NR	IV	China
2019	Godin	AJSM	Y	Y	Y	Y	IV	USA
2019	Nakagawa	OJSM	Y	N	N	NR	III	Japan
2018	Park	AJSM	Y	Y	Y	Y	III	Korea
2018	Shah	Shoulder and Elbow	Y	N	Y	N		UK
2017 (a)	Nakagawa	AJSM	Y	N	N	NR	III	Japan
2017 (b)	Nakagawa	OJSM	Y	N	N	NR	III	Japan
2015	Kitayama	JBJS-Am	Y	N	Y	N	IV	Japan
2015	Nakagawa	AJSM	Y	N	N	N	III	Japan
2014	Kim	AJSM	Y	Y	N	NR	IV	Korea
2013	Kany	Tech Should Surg	Y	N	N	NR		India/France
2013	Millett	AJSM	Y	Y	Y	Y	IV	USA
2012	Park	Arthroscopy	Y	N	N	NR	IV	South Korea

488

489 **T3**

Table 3: Patient demographics of studies on arthroscopic Latarjet

Studies			Patient demographics												
Year	Author	Subgroups	Number of shoulders	Men (%)	Women (%)	Age (mean)	±SD	Mean follow-up (months)	±SD	(Range)	BMI (mean)	±SD	Smoking (%)	Dominant (%)	Hill-Sachs lesions (%)
Latarjet															
2022	Hurley		26	81%	19%	32 ±13		52		(24 – 90)					100%
2022	Shao		30	70%	30%	27 ±6		38 ±3						80%	100%
2021	Bonnevialle		17	82%	18%	22 ±5							23%	47%	59%
2021	Calvo		51	94%	6%	30 ±8								55%	
2021	Hurley		30	83%	17%	32 ±12		46							100%
2021	Zeng		37	100%	0%	25 ±5		13		(8 – 22)					
2020	Ali		33	88%	12%	30 ±7		30		(24 – 50)				55%	24%
2020	Wang	screw	6	100%	0%	23 ±6		25		(10 – 53)	23.4 ±2				
		button	6	100%	0%	23 ±5					24.9 ±5				
2019	Boileau		121	79%	21%	27		26		(24 – 27)			31%	65%	
2019	Kordasiewicz		90	89%	11%	26 ±6		24 ±7		(13 – 50)				61%	
2017(a)	Zhu		46	78%	22%	32 ±10								83%	
2017 (b)	Zhu		52	81%	19%	32 ±10		28		(24 – 42)				69%	
2014	Dumont		64	86%	14%	29		76							

490

Table 4: Patient demographics of studies on arthroscopic bony Bankart repair

Studies			Patient demographics										
Year	Author	Subgroups	Number of shoulders	Men (%)	Women (%)	Age (mean)	±SD	(Range)	Mean follow-up (months)	±SD	(Range)	Dominant (%)	Hill-Sachs lesions (%)
Bankart													
2022	Di Giacomo	≥13.5%	40	100%	0%	26		(19 – 35)	60		(58 – 68)		
		<13.5%	23	100%	0%	26		(19 – 35)	60				
2022 (a)	Nakagawa	Overall	96	89%	11%				29				
		13.5% to ≥20%	60	85%	15%	24 ±10							
2022 (b)	Nakagawa	>20%	36	94%	6%	22 ±7							
		Overall	80						29 ±11		(24 – 67)		16%
		<13.5%	38			18 ±3		(14 – 26)					
		≥13.5%	42			19 ±4		(14 – 29)					
2021	Guo		25	72%	28%	43 ±15			41		(24 – 60)		
2019	Godin		13	100%	0%	40			81		(61 – 108)	39%	100%
2019	Nakagawa		69	100%	0%	18		(14 – 27)			(24)		15%
2018	Park*	Overall	85	91%	9%	26 ±10						71%	
		<10%	30										
		10-15%	12										
		15-20%	26										
		>20%	17										
2018	Shah	(>25%)	22	95%	5%	30		(17 – 66)	28		(24 – 35)	45%	
2017 (a)	Nakagawa		93	100%	0%	17		(14 – 27)					62%
2017 (b)	Nakagawa		113	89%	11%	18							100%
2015	Kitayama		34	91%	9%	24		(15 – 34)	74				
2015	Nakagawa		81	90%	10%	23		(14 – 69)					
2014	Kim	<12.5%	16	100%	0%	25		(17 – 41)	34			75%	
		12.5%-25%	18	89%	11%	32		(19 – 43)	35			61%	
2013	Kany		26	88%	12%	27		(15 – 39)					74%
2013	Millett		15	87%	13%	44		(24 – 70)	32		(24 – 53)	47%	90%
2012	Park		31	94%	6%	23		(15 – 55)	31		(13 – 51)		

*11 of 223 shoulders has additional remplissage due to engaged Hill-Sachs lesions

