Systematic Review

Majority of Studies Show Similar Rates of Return to Play After Arthroscopic Bankart Repair or Latarjet Procedure: A Systematic Review

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Purpose: To systematically review the current evidence in the literature to compare return to play following arthroscopic Bankart repair versus open Latarjet procedure for the treatment of anterior shoulder instability. **Methods:** A literature search was performed based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. Comparative studies reporting return to play following arthroscopic Bankart repair versus open Latarjet procedure were included. Return to play was compared, with all statistical analysis performed using Review Manager, Version 5.3. **Results:** Nine studies with 1,242 patients (mean age: 15-30 years) were included. The rate of return to play was 61% to 94.1% among those undergoing arthroscopic Bankart repair and 72% to 96.8% in those undergoing an open Latarjet procedure. Two studies (Bessiere et al. and Zimmerman et al.) found a significant difference in favor of the Latarjet procedure ($P < .05$ for both, $I^2 = 37\%$). The rate of return to play at preinjury level was 9% to 83.8% among those undergoing arthroscopic Bankart repair and 19.4% to 80.6% in those undergoing an open Latarjet procedure, with no study finding a significant difference ($P > .05$ for all, $I^2 = 0\%$). The mean time of return to play was 5.4 to 7.3 months among those undergoing arthroscopic Bankart repair and 5.5 to 6.2 months in those undergoing an open Latarjet procedure, with no study finding a significant difference ($P > .05$ for all, $I^2 = 39\%$). **Conclusions:** Overall, the majority of studies showed no significant difference in rates of return to play or timing following arthroscopic Bankart repair or open Latarjet procedure. Furthermore, no study has found a significant difference in rate of return to play at pre-injury level, or rate of return to play among collision athletes. **Level of Evidence:** Level III, systematic review of Level I-III studies.

Anterior shoulder instability is a common clinical problem among athletic populations.[1-3] Traditionally, patients with a first-time dislocation have been managed nonoperatively.[4-6] However, primary stabilization has been shown to result in lower rates of recurrence and greater rates of return to play, which have been shown to be the most important determinants of patient satisfaction with shoulder instability.[7-10] Arthroscopic Bankart repair and the Latarjet procedure are the 2 most performed procedures for anterior shoulder instability.

Arthroscopic Bankart repair is the most commonly performed procedure worldwide for anterior shoulder instability, with high rates of return to play noted, as Memon et al. found 81% of patients returned to play at a mean of 8 months postoperatively in their systematic review.[11,12] The Latarjet procedure is indicated for patients with high risk for recurrent instability, is a nonanatomic repair that is considered more technically challenging, and is most commonly performed via an open approach.[13,14] Similarly high rates of return to play have been noted, with Hurley et al.[15] in their systematic

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review finding 89% returned to play following the Latarjet procedure at a mean of 5 months. Furthermore, there is a lack of comparative data between arthroscopic Bankart repair and Latarjet procedure in athletic populations, with previous systematic reviews not comparing rates or timing of return to play.[11,15,16]

The purpose of the current study is to systematically review the current evidence in the literature to compare return to play following arthroscopic Bankart repair versus open Latarjet procedure for the treatment of anterior shoulder instability. It was hypothesized was that there would be no difference in return to play following arthroscopic Bankart repair and open Latarjet procedures.

Methods

Study Selection

Two independent reviewers (E.H., A.P.) performed the literature search based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines and reviewed the search results, with a senior author arbitrating on any disagreement (D.T.).[17] The title and abstract were reviewed for all search results and potentially eligible studies received a full-text review. Finally, the reference lists of the included studies and literature reviews found in the initial search were manually screened for additional articles meeting the inclusion criteria.

Search Strategy

The following search terms were used in MEDLINE, EMBASE, and The Cochrane Library, databases on July 2022 as the search algorithm: (Bankart and Latarjet). No time limit was given to publication date.

Eligibility Criteria

The inclusion criteria were the following: (1) studies comparing arthroscopic Bankart repair and open Latarjet procedure (Levels I-III), (2) reporting on return to play, (3) published in a peer-reviewed journal, (4) published in English, and (5) full text of studies available. The exclusion criteria were the following: (1) case series, (2) review studies, (3) cadaver studies, (4) biomechanical studies, and (5) abstract only.

Data Extraction/Analysis

The relevant information regarding the study characteristics including the study design, the level of evidence, the methodological quality of evidence (MQOE), population, the outcome measures, and the follow-up time points were collected by 2 blinded reviewers using a predetermined data sheet, with the results compared. When required information was not available in the text, the authors were contacted. The MQOE was assessed using the Newcastle-Ottawa scale.[18] This is a 9-point scale where studies with 7-9, 5-6, 4, and 0-3 points were graded as very good, good, satisfactory, and unsatisfactory, respectively.

Outcomes Measured

The outcomes measured focused on (1) return to play, (2) return to play at preinjury level, (3) time to return to play, and (4) return to play in collision athletes.

Statistics

All statistical analysis was performed using Review Manager (RevMan [Macintosh], Version 5.3, Copenhagen: The Nordic Cochrane Centre, The Cochrane Collaboration, 2014). Results were presented as risk ratio for dichotomous outcomes and mean difference for continuous outcomes, with a 95% confidence interval. Heterogeneity between studies was quantified using the I^2 statistic.[19] A P value of $<.05$ was considered to be statistically significant.

Results

Literature Search

The initial literature search resulted in 674 total studies. After removal of duplicates, the articles were screened for inclusion and exclusion criteria, and 434 unique studies were evaluated, and 16 full texts were assessed for eligibility. Nine clinical trials with 1,242 patients were included in this review. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart is shown in Figure 1.

Study Characteristics/Patient Demographics

There was 1 randomized control study (Level of Evidence I) and 8 retrospective cohort studies (Level of Evidence II).[20-28] The mean MQOE of the studies was 7.8. Nine studies compared 771 patients treated with arthroscopic Bankart repair with 471 patients treated with the open Latarjet procedure. The majority of these patients (89.6%) were male, with an average age of 25.4 years and average follow-up time of 70 months. The baseline age, sex, and reported instability measures of patients were similar between the cohorts ($P > .05$). The study characteristics and patient demographics are shown in Table 1, and the glenohumeral bone loss is shown in Table 2.

Return to Play

Overall, return to play was reported in 8 comparative studies (1,222 patients). Two studies (Zimmerman et al.[28] and Bessiere et al.[20]) found a significant difference in favor of the Latarjet procedure ($P < .05$ for both). The rate of return to play was 61% to 94.1% among those undergoing arthroscopic Bankart repair and 72% to 96.8% in those undergoing an open Latarjet procedure. Both of the studies, which found

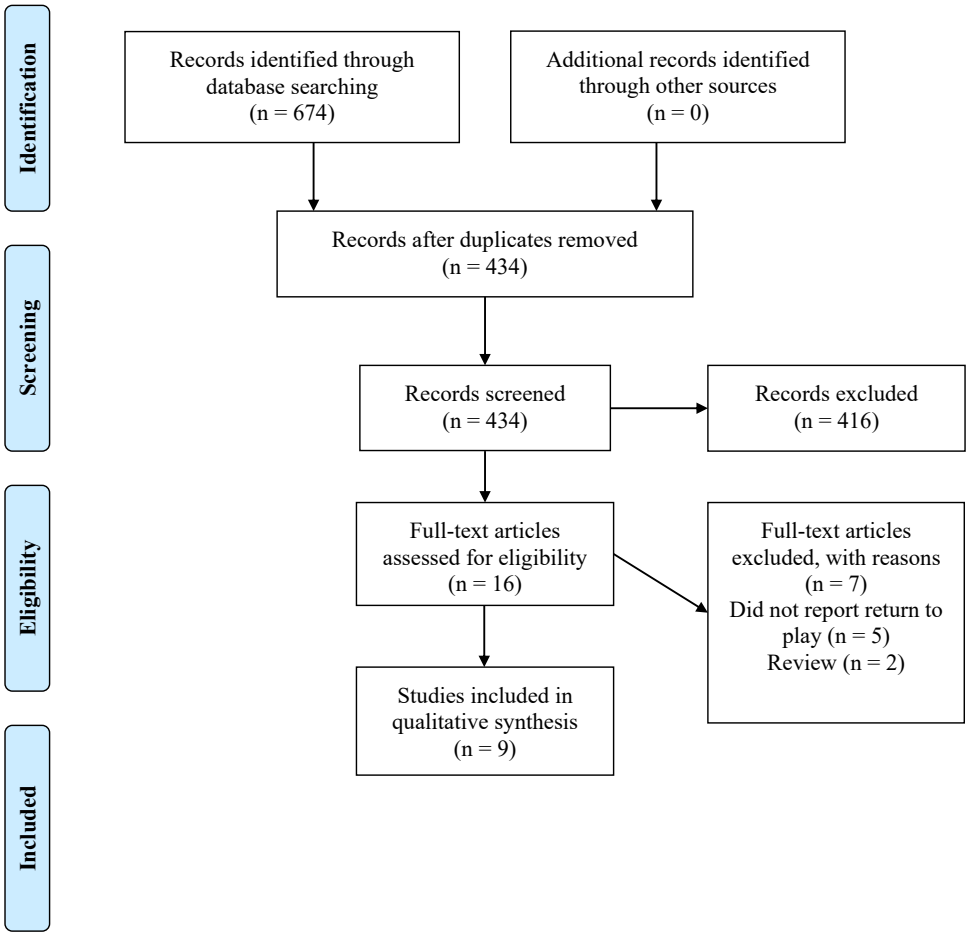

Fig 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart.

improved rate of return to play with the Latarjet procedure, were Level of Evidence III. The overall heterogeneity was moderate ($I^2 = 37\%$). The forest plot is shown in Figure 2.

Return to Play at Preinjury Level

Overall, return to play at preinjury level was reported in 6 comparative studies (595 patients), with no study finding a significant difference ($P > .05$ for all). The rate of return to play at preinjury level was 9% to 83.8% among those undergoing arthroscopic Bankart repair, and 19.4% to 80.6% in those undergoing an open Latarjet procedure. The overall heterogeneity was low ($I^2 = 0\%$). The forest plot is shown in Figure 3.

Time to Return to Play

Overall, time to return to play was reported in 4 comparative studies (380 patients), with no study

Table 1. Study Characteristics and Patient Demographics

Author	No. ABR	No. OL	LOE	MQOE	Male	Age, y	Primary/Recurrent Instability/Revision	Follow-up, mo
Bessiere et al., 2014[20]	93	93	III	8	174	22 (10-43)	Recurrent	72 (48-120)
Blonna et al., 2016[21]	30	30	III	7	52	32 (19-53)	Recurrent	64 (24-108)
Hurley et al., 2021[22]	80	40	III	9	114	27 (18-40)	Primary	51 (24-84)
Hurley et al., 2021[23]	62	62	III	9	124	22 (18-40)	Recurrent	48 (24-84)
Jeon et al., 2018[24]	118	31	III	7	130	26 (N/R)	Recurrent	29 (24-73)
Kukkonen et al., 2022[25]	62	59	I	8	121	21 (16-25)	Primary	24 (N/R)
Laboute et al., 2021[26]	34	72	III	7	108	23 (18-35)	Not specified	26 (12-56)
Rossi et al., 2021[27]	80	50	III	7	130	24 (16-33)	Primary/recurrent	40 (24-90)
Zimmermann et al., 2016[28]	272	93	III	8	266	29 (N/R)	Recurrent	139 (N/R)

ABR, arthroscopic Bankart repair; LOE, Level of Evidence; MQOE, methodological quality of evidence; OL, open Latarjet; No., number; N/R, not reported.

Table 2. Glenohumeral Bone Loss

Author	Glenohumeral Bone Loss	Hill–Sachs Lesion
Bessiere et al., 2014[20]	ABR: 48% vs OL: 67% ($P = .01$)	ABR: 92% vs OL: 90% ($P = .60$)
Blonna et al., 2016[21]	N/R	N/R
Hurley et al., 2021[22]	ABR: 2% vs OL: 13% ($P < .05$)*	ABR: 5% vs OL: 45% ($P < .05$)†
Hurley et al., 2021[23]	ABR: 2% vs OL: 12% ($P < .05$)*	ABR: 10% vs OL: 45% ($P < .05$)†
Jeon et al., 2018[24]	ABR: 18% vs OL: 18% ($P = .16$)	N/R
Kukkonen et al., 2022[25]	ABR: 31% vs OL: 31%	ABR: 31% vs OL: 31%
Laboute et al., 2021[26]	N/R	N/R
Rossi et al., 2021[27]	ABR: 41% vs OL: 36% ($P = .85$)	N/R
Zimmermann et al., 2016[28]	N/R	N/R

NOTE. Patients are presented as percent of patients with Glenohumeral bone-loss.
ABR, arthroscopic Bankart repair; OL, open Latarjet; N/R, not reported.
*Represents mean glenoid bone loss.
†Represents off-track lesions.

finding a significant difference ($P > .05$ for all). The mean time of return to play was 5.4 to 7.3 months among those undergoing arthroscopic Bankart repair and 5.5 to 6.2 months in those undergoing an open Latarjet procedure. The overall heterogeneity was moderate ($I^2 = 39\%$). The forest plot is shown in Figure 4.

Return to Play in Collision Athletes

Overall, return to play among collision athletes was reported in 4 comparative studies (366 patients), with no study finding a significant difference ($P > .05$ for all). The rate of return to play in collision athletes was 67.8% to 91.3% among those undergoing arthroscopic Bankart repair and 75% to 92% in those undergoing an open Latarjet procedure. The overall heterogeneity was low ($I^2 = 0\%$). The forest plot is shown in Figure 5.

Discussion

The most important finding of this study was that there was no significant difference in rate or timing of return to play following arthroscopic Bankart repair or open Latarjet procedure, with only 2 studies finding a difference in favor of the Latarjet procedure for rate of return to play. Furthermore, there was no significant difference in rate of return to play at preinjury level, or rate of return to play among collision athletes. In addition, there was low-moderate heterogeneity in the current study indicating consistent outcomes across included studies. However, our systematic review highlighted the lack of high-level studies, with the majority of studies being retrospective and only one randomized controlled trial, but this is representative of the literature as a whole.

Overall, high rates of return to play were noted in this review, which is one of the most important factors in patient satisfaction with surgical stabilization for anterior shoulder instability.[10,29] Similarly, there was high rates of return to play noted among collision athletes. Collision athletes are a unique population due to the demand they place on their shoulders and risk for recurrence, thus, in order to return to play, they need to be confident in their ability to return without fear of reinjury.[30,31] However, it is important to note that the majority of the included studies found far lower rates of return to play at preinjury levels. Moreover, there was no comparative data on overhead athletes with limited literature on overhead athletes undergoing the Latarjet

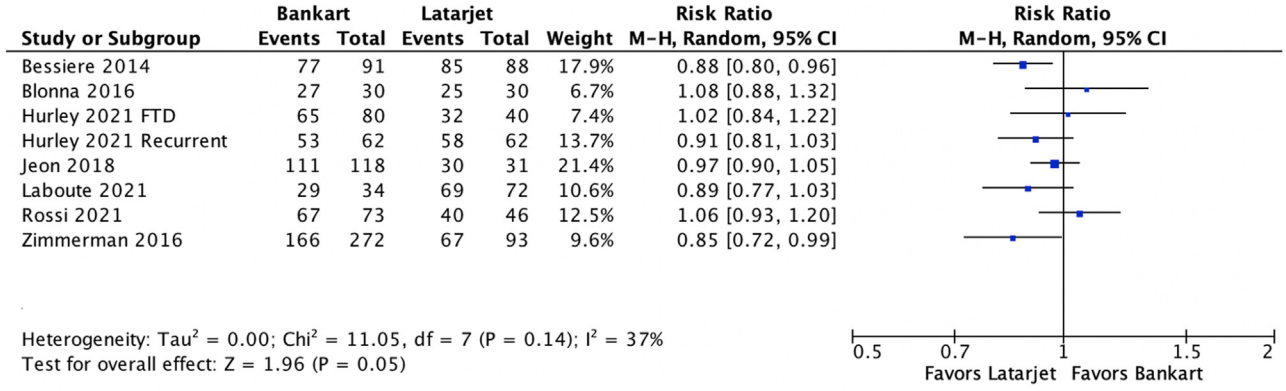

Fig 2. Forest plot of rate of return to play.

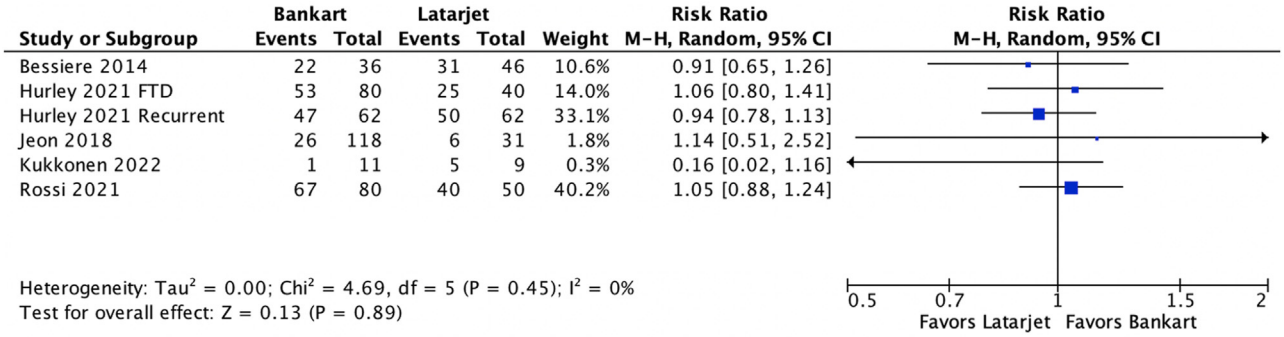

Fig 3. Forest plot of rate of return to play at preinjury level.

procedure.[15,32] While our study did not evaluate the impact of Remplissage procedure on return to play following an arthroscopic Bankart repair, the literature is limited but has shown no impact on return to play, although Garcia et al. found among overhead athletes it resulted in lower rates of return.[33,34]

Overall, none of the included comparative studies found a significant difference in time to return to play despite theories that the Latarjet procedure results in earlier rates of return due to bony healing being faster than soft-tissue healing and previous systematic reviews of case series finding an almost 3-month difference in time to return.[11,15] It is important to evaluate when athletes are safe to return to play beyond just time-based criteria. As recent evidence has suggested the potential of prereturn battery testing to reduce recurrent instability rates once athletes return, similar to anterior cruciate ligament reconstruction.[35] A recent Delphi consensus statement advocated for restoration of strength, restoration of range of motion, free of apprehension, pain-free, sport-specific skills, restoration of proprioception, and in those undergoing a Latarjet procedure/glenoid bone-graft procedure radiographic imaging to assess graft healing.[36] Thus, a further avenue for future research may be comparative analysis to determine whether athletes can safely return to play following a testing battery beyond just timing of return.

Athletes fail to return to play for a variety of reasons, including residual pain, being physically unable to return, fear of reinjury, and lifestyle changes. Tjong et al.[37] reported that fear of reinjury, as well as shifts in priority, mood, social support, and self-motivation, all impacted effects on patients' desire to return to play following arthroscopic Bankart repair. Hurley et al.[38,39] evaluated those who failed to return to play following both arthroscopic Bankart repair and open Latarjet procedure in 2 separate studies. They found that those who were unable to return to play had lower Shoulder Instability—Return to Sport after Injury scores, indicating lack of psychologically being to return to play. Furthermore, they found that thoughts of having to go through surgery and rehabilitation again was significantly associated with lower return to play. Thus, this is an important area for potential research as to optimize athlete's mental readiness to return.

Alongside return to play, recurrent instability is one of the post important factors in patient satisfaction which must be considered and may lead to further instability arthropathy and require a more complicated procedure.[40,41] The current review did not compare recurrent instability as it was often not possible to delineate the data exclusively for athletes and was not the focus of this review. However, the majority of the included studies did note lower rates of recurrent instability with the Latarjet procedure, which is often indicated due to a higher risk of recurrence and has been shown to have a recurrent dislocation rate of approximately 3% at greater than 10-year follow-up.[41] Although, there are concerns in performing a Latarjet procedure due to the

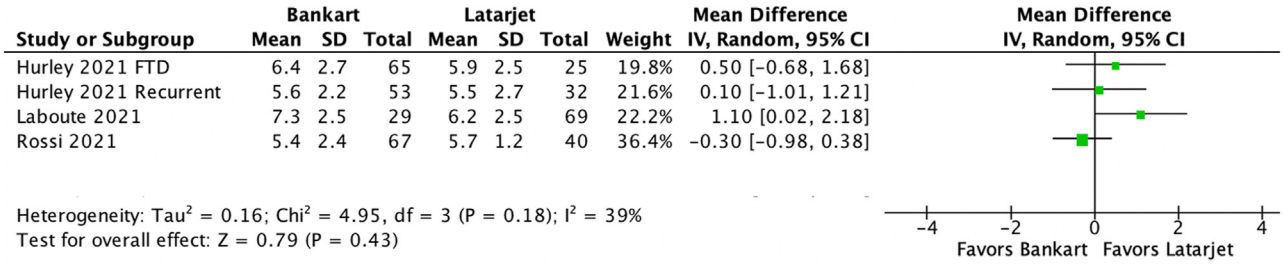

Fig 4. Forest plot of time to return to play.

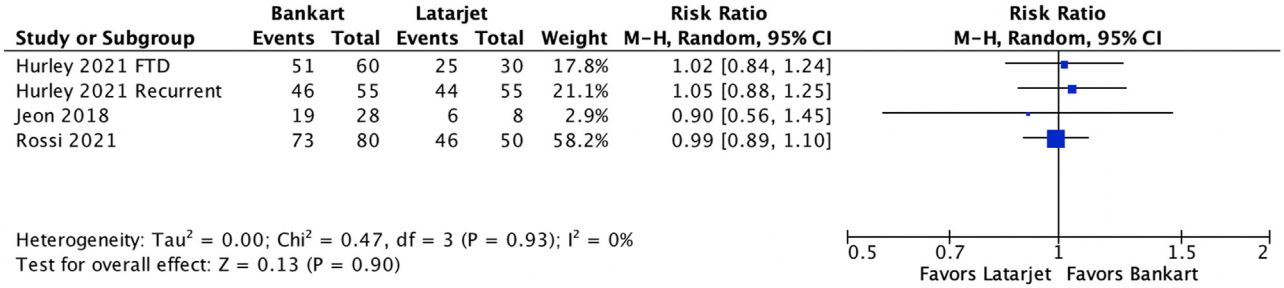

Fig 5. Forest plot of rate of return to play in collision athletes.

greater risk of recurrence compared with an arthroscopic Bankart repair. Recently complication rates of up to 30% were often cited, more recent literature has shown this to be closer to 5%, with revision procedures being at greater risk due to altered anatomy.[42-45] Scanlon et al.[45] found a complication rate of 7.5% in those with previous surgery compared with 3.2% in those done as a primary procedure, and similarly Rodkey et al.[9] showed a 2-fold increase in recurrence rate in those undergoing the Latarjet procedure as a revision procedure. Davey et al.[7] also found a 90% rate of return to play as a primary procedure, which was significantly greater than the 64% rate of return in with a failed previous stabilization.

The indications for arthroscopic Bankart repair and open Latarjet procedure differ, primarily based on risk factors for recurrent instability.[12,13] The Latarjet procedure is indicated for patients with high risk for recurrent instability, such as those with increased glenoid bone loss or off-track Hill–Sachs lesions.[13] There is overlap in patients who may be relatively indicated for either procedure, and thus patient counselling is important with regards to expected outcomes. Increased glenoid bone loss and off-track Hill–Sachs lesions are known risk factors for being unable to return to play postoperatively, but the extent to which they impact return is unclear, or if there is a critical amount of glenoid bone loss as there is with recurrence.[36] It is an area that requires further research, but despite differences in indications for either in the included studies, the overall rates of return to play were similar across all of the included studies. Hurley et al.[22,23] reported large difference in mean glenoid bone loss and off-track Hill–Sachs lesions but no differences in any return to play metric. Thus, how glenohumeral bone loss affects function and inability to return to play may differ between those receiving an arthroscopic Bankart repair and a Latarjet procedure, but the findings from this review could be used to counsel patients on similar rates of return with either procedure. Only the 2 studies by Hurley et al.[22,23] reported on the mean glenoid bone loss, with several reporting on the percent of patients with some degree of glenoid bone loss despite glenoid bone loss being a spectrum. Similarly, these 2 studies[22,23] were also the only studies to report on the presence of off-track Hill–Sachs lesions. As a result, due to the lack of reporting, it is also not possible to assess how this impacts return to play and should form the basis of future study as this could impact decision making in athletes.

Limitations

This study has several limitations and potential biases, including the limitations of the included studies themselves. Although all of the included studies were comparative studies, only one was randomized, thus potentiating selection bias. In addition, it was not possible to adjust for age, sex, type of sports played. There was a significant difference in risk factors for recurrence such as glenohumeral bone loss in the majority of the included studies, which influenced patient selection for their procedure, with patients at greater risk for recurrent instability being more likely to undergo a Latarjet procedure. A limitation is that bone loss was not controlled for, which introduces heterogeneity into the literature. Finally, despite contacting authors when information was not available in the text, there was still an incomplete response rate so some demographic variables are not fully reported.

Conclusions

Overall, the majority of studies showed no significant difference in rates of return to play or timing following arthroscopic Bankart repair or open Latarjet procedure. Furthermore, no study has found a significant difference in rate of return to play at preinjury level, or rate of return to play among collision athletes. A limitation is that bone loss was not controlled for, which introduces heterogeneity into the literature

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