The Tripod-Pulley Technique for Arthroscopic Remplissage in Engaging Hill-Sachs Lesions

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Abstract: Arthroscopic Bankart repair is now a well-established technique for the treatment of shoulder instability. However, failure rates are considerable when significant bony defects are not addressed. Hill-Sachs lesions, present in the vast majority of those with recurrent anterior instability, when of significant dimension and location, may account for some of these failures. The remplissage procedure involves capsulotenodesis of the posterior capsule and the infraspinatus tendon to fill the Hill-Sachs lesion. “Double-pulley” remplissage is a transtendinous technique that has been described elsewhere and that may simplify the procedure. We present a modification of this technique, the “tripod-pulley” technique, which we feel may potentiate healing of the Hills-Sachs lesions of the capsule and infraspinatus by increasing the surface contact area. At the same time, this technique minimizes the risk of potential damage to the infraspinatus as it uses 2.3-mm “all-suture” anchors.

Surgical Technique

The procedure is performed under general anaesthesia combined with interscalene nerve block with the...
The patient is in the lateral position and longitudinal traction (8-10 pounds).

**Camera in the Posterolateral Portal**

The camera is initially inserted in the standard posterolateral portal, and a diagnostic arthroscopy is performed. The position and the features of the anterior labral lesion are observed as well as the depth, the position, and the size of the HS lesion. An 8.5-mm cannula (Dri-Lok disposable cannula; Stryker, San Jose, CA) is inserted in the rotator interval space, and it will be used to perform the anterior labral repair.

**Table 1. Remplissage Techniques (RTs)**

| RT                  | Authors                      |
|---------------------|------------------------------|
| RT, double anchors  | Wolf et al. 2004              |
| RT, single anchor   | Camp et al. 2015              |
| Double-barrel RT    | Bhatia 2015                  |
| Arthroscopic transtendinous double-pulley RT | Parnes et al. 2015 |

**Camera in the Anterolateral Portal**

The camera is now switched to anterolateral portal to have a better view of the HS lesion (through the cannula; Stryker Dri-Lok disposable cannula; Fig 2).

If the lesion was confirmed to be an “off-track” lesion by the radiologist who has reported the computed tomography scan, a tripod-pulley RT is performed (Table 2).

Three 2.3-mm double-strand all-suture anchors (Stryker Iconix 2.3 mm) are used to perform this technique (Fig 3). Any anchor can be used, but the advantage of all-suture anchors is the small size both in relation to

**Table 2. Knot Tying**

| Anchors                  | Technique          |
|--------------------------|--------------------|
| Anteromedial             | Pulley             |
| Anteromedial             | Lateral            |
| Anteromedial             | Arthroscopic knot  |
| Anteromedial             | Pulley             |
| Anteromedial             | Lateral            |
| Anteromedial             | Pulley             |
| Anteromedial             | Lateral            |
| Anteromedial             | Arthroscopic knot  |

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Fig 1. (A) Standard remplissage technique as described by Wolf et al. (B) View of the anchors inserted in the Hill-Sachs lesion. Two 5.5-mm anchors are inserted in the humeral head, and the sutures are passed through the infraspinatus tendon using suture passer instruments. (Arthroscope is in the anterolateral portal of the right shoulder with the patient in the lateral position, but the arthroscope is rotated so the images appear as though the patient is in the beach chair position.)

Fig 2. (A, B) Visualization of the Hill-Sachs (HS) lesion from the anterolateral portal. Once the diagnostic arthroscopy is complete, an 8.5-mm cannula (Stryker Dri-Lok disposable cannula) is placed in the rotator interval through the anterolateral portal. The posterior aspect of the shoulder and the HS lesion are assessed. (Arthroscope is in the anterolateral portal of the right shoulder with the patient in the lateral position, but the arthroscope is rotated so the images appear as though the patient is in the beach chair position.)
the bone and the tendon, which is not damaged more than necessary. A 5-mm cannula (Stryker Dri-Lok disposable cannula) is positioned in the posterolateral portal through the deltoid muscle fibers without violating the integrity of the infraspinatus tendon (Fig 4). A 4-mm shaver (Dyonics Helicut burr 4.5-mm; Smith & Nephew, London, UK) can be used to freshen the bone to enhance the tendon healing (Table 3). The shaver can be easily inserted through the hole in the capsule left by the trocar used at the beginning of the procedure when the camera was inserted in the posterolateral portal. This minimizes the damage to the infraspinatus tendon and capsule complex.

The guide for the all-suture anchor (Stryker Iconix 2.3 mm) is inserted through the cannula (Stryker Dri-Lok disposable cannula) in the subacromial space, and the correct position for the posteromedial anchor is found by applying pressure with the smooth tip of the guide on the infraspinatus tendon without the need to violate its integrity (Video 1). This anchor is the first inserted because it is the furthest away from the camera and positioning of the other 2 anchors before this can reduce our view due to the suture strands. The anteromedial anchor can usually be inserted through the same hole in the capsule mentioned above. This anchor instead needs to go through the infraspinatus tendon.

### Table 3. Surgical Steps Involved in the Tripod-Pulley Technique

| Camera in the posterolateral portal |
|-----------------------------------|
| Diagnostic glenohumeral joint arthroscopy. |
| 8.5-mm cannula inserted in the anterolateral portal. |
| Camera in the anterolateral portal |
| Arthroscope introduced in the anterolateral portal through the cannula. |
| 5-mm cannula introduced in the posterolateral portal through the deltoid only into the subacromial space. |
| Hill-Sachs (HS) lesion refreshed with bone shaver. |
| 3 all-suture double-strand anchors are inserted in the HS defect in a triangle configuration. |
| Medioposterior anchor first through a new hole in the tendon/capsule. |
| A marker clip is put at the end of the suture strands to recognize them and keep them separate from the suture of the other anchors that will follow. |
| Medioanterior anchor is positioned and passed through the hole already made in the capsule by the trocar when inserted in the posterolateral portal at the beginning of the procedure. |
| The suture ends are marked differently. |
| Lateral anchor is inserted. A more lateral hole in the tendon/capsule complex is made. |
| The suture ends are marker differently and kept separate from the others. |
| Camera in the posterolateral portal |
| A standard Bankart repair is performed. |
| Camera in the anterolateral portal |
| The first 2 knots are tied outside the shoulder. One suture from each anchor is used to be tied with another anchor suture. |
| Two ends of 2 different sutures (A-B) of 2 different anchors are sutured outside the shoulder, and the final ends are cut. The other ends of each suture are then pulled to slide the knot down into the subacromial space. The same procedure is repeated with a suture end (C) of the third anchor. At this point suture B is knotted with suture A and suture C. Suture A and suture C have one end each free that needs to be knotted together (A + C). |
| Refer to Table 2 for the sequence. |
| Using a pulley technique, the knots can slide into the shoulder, and direct visualization of the tenodesis effect can be observed with the camera pointing at the HS lesion. |
| The remaining sutures are tied together in an arthroscopic fashion with a knot pusher to close the triangle. |
| The same process is repeated with the other 3 strands, one for each anchor. Refer to Table 2 for the sequence. |
and the capsule in a different position to have a bridge left between the 2 medial anchors. Once the surgeon is happy with the position and the angle of the guide, a drill is used to weaken the bone and a 2.3-mm anchor is inserted. It is important to keep the position of the guide to find the drilled hole where the anchor needs to be inserted (Fig 5).

The procedure is repeated for the anteromedial anchor (Stryker Iconix 2.3 mm) even if, as mentioned above, the surgeon can use the hole already made in the capsule by the trocar at the beginning of the procedure. The guide is inserted through the cannula, and the correct position is searched on the anteromedial border of the HS lesion. When a good position is achieved, the bone is drilled and another 2.3-mm all-suture anchor (Stryker Iconix 2.3 mm) is inserted (Fig 6). It is important to put clips at the end of the sutures of each anchor to recognize them at the end of the procedure when the surgeon will need to tie knots.

The same procedure is repeated for the lateral anchor (Stryker Iconix 2.3 mm; Fig 7). A new hole is made in the infraspinatus tendon and in the capsule by the drill tip to create a bridge between the lateral and the medial anchors. This will allow the surgeon to complete the procedure using the pulley technique. Once again, it is crucial to mark the end of the medial anchor with a different clip or marker to avoid confusion when tying the knots.

Four sutures for each anchor are now coming out from the cannula positioned initially in the
posterolateral portal (Fig 8). Each anchor (Stryker Iconix 2.3 mm) is recognized by a different marker positioned at the end of the suture strands.

The first part of the procedure is completed.

**Camera in the Posterolateral Portal**

At this stage, the camera is switched back to the posterolateral portal and the anterior labral repair is performed. The surgeon can use the technique he or she prefers to repair the anterior labrum. This will not affect the RT procedure.
The camera is now in the anterolateral portal again, and the RT needs to be completed. One at a time, the surgeon ties knots between the ends of the sutures (suture A + B and B + C) and cuts them outside the shoulder. The remaining sutures (the free end of A and C) are pulled to slide the knots into the subacromial space (Figs 9 and 10). The same procedure is performed for the other 3 sutures (one for each anchor). Therefore, knots are first tied outside the shoulder (sutures A1 + B1 and B1 + C1) and the suture ends are cut (Fig 11). The remaining sutures (the free end of A1 and C1) are pulled to slide the knots into the subacromial space (Fig 9). At this point the free suture ends (A and C) are tied together (Fig 12) in an arthroscopic fashion with a knot pusher (Table 2).

Direct successful tenodesis is confirmed by direct visualization of the tenodesis (reduced distance between the bone and the tendon) through the camera looking at the HS lesion/infraspinatus tendon (Table 3).

The procedure is repeated for the other strands, and the last 2 + 2 ends are tied together (Fig 11) in an arthroscopic fashion with direct visualization of the result of the tenodesis of the infraspinatus (Fig 12).

Table 4. Key Points

Remplissage technique is a reliable technique to address engaging Hill-Sachs lesions.
It can be technically challenging.
Secure tendon-bone surface contact is mandatory to achieve good results.
Our technique minimizes the risk of technical errors, is minimally invasive, and increases the tendon-bone surface contact.
At this stage the suture ends are cut and assessment of the repair is performed (Fig 13).

**Discussion**

Arthroscopic Bankart repair is now a well-established technique for addressing shoulder instability with very good outcomes. However, the dislocation recurrence rate is still high in anterior shoulder instability if bony defects are not addressed. These bony lesions may occur both at the glenoid or the humeral head HS lesion. It is accepted that an anteroinferior glenoid bone loss of 25% or more needs to be addressed with a bone block procedure (Latarjet procedure, iliac crest, or allograft) to restore the anterior edge of the glenoid. Options for addressing HS lesions include glenoid bone block procedures such as Laterjet, iliac crest, or allograft bone grafting, reducing external rotation with either anterior soft-tissue shortening or rotational osteotomy of the humerus and filling the HS defect with soft tissue, bone graft, arthroplasty, or transhumeral headplasty. The remplissage procedure, first described by Wolf et al., is an arthroscopic technique that involves filling the HS defect with soft tissue by capsulotenodesis of the posterior capsule and the infraspinatus tendon into the defect to prevent the engagement of the lesion. It is indicated in combination with Bankart repair in those patients with an “engaging” HS lesion or “off-track” lesion in the absence of significant glenoid bone defect.

Reported results of arthroscopic remplissage have so far been promising with good functional outcomes and low recurrent instability rates when used for correct indications. Wolf et al. reported a recurrent instability rate of 4.4% with an average follow-up of 58 months. Similarly, Zhu et al. found a failure rate of 8.2% (4 out of 49) with a mean follow-up of 29 months, whereas Boileau et al. reported recurrence instability only in one of the series of 47 patients. Additionally, there is biomechanical evidence that remplissage and Laterjet have similar instability recurrence rates in a 25% HS defect model.

There are a number of concerns with the procedure, including risk of possible damage to the infraspinatus, loss of external rotation, and healing rates. There are a number of studies that report no loss of external rotation, whereas there are others that indicate a loss of external rotation in the region of 7° to 8°.

Most of the RT previously described involve inserting one or 2 standard anchors into the HS lesion through the infraspinatus and then perforating the infraspinatus with a “clever hook” equivalent suture passer to retrieve the anchor suture limbs. Our concern with this technique is the damage sustained to the infraspinatus when inserting 2 standard anchors through the infraspinatus (as a result of the holes made in the tendon). There are a number of investigators who have advocated use of a single-anchor technique with the potential advantage of less damage to the infraspinatus. However, the issue here is whether remplissage with one anchor provides the optimal surface contact area between the bone and infraspinatus as well as adequate construct strength.

The transtendinous double-pulley technique for remplissage described by Parnes et al. is a simplified reproducible technique that involves the use of
2 standard anchors in an innovative method. Our concern with this technique, however, is the limited contact surface area between the infraspinatus and the bone and the possible consequence that this may have on the healing rate. Furthermore, this technique involves passage of a cannula through the infraspinatus and the insertion of 2 standard anchors through the tendon, therefore raising the possibility of infraspinatus tendon damage.

The tripod-pulley technique described in this paper uses the transtendinous pulley principles but has a number of further advantages over the previously

Table 5. Pearls and Pitfalls

| Pearls | Pitfalls |
|--------|----------|
| Minimally invasive technique: tendon and bone preservation. | Blind positioning of the anchors can be difficult for not experienced surgeons. All-suture anchors may pull out in very weak bone. |
| Secure fixation: a larger footprint allows better tendon-bone healing. | Good positioning of the anchors is needed, and good triangulation skills are expected. |
| Alternative progression (posterior/anterior) allows the surgeon to work in the best conditions with more space and better view. | Working with the camera from anterior can be difficult at the beginning. |
| The pulley technique can be performed very quickly and reduces the surgical time. | Sutures management can be fiddly if maximal care is not kept throughout all the procedure. |
| No need to violate the subacromial space using a cannula in the posterolateral portal. | A certain amount of experience is required to tie knots blind without looking for the sutures in the subacromial space. |
describe RT (Table 4). First, it maximizes the contact surface area between the tendon and bone with the aim of optimizing healing. With the transtendinous double construct, the contact area between the tendon and the bone is in the shape of a line (it has one dimension; Fig 14). In contrast, with the tripod-pulley technique, the contact surface area of the construct is in the shape of a triangle (2 dimensions) and therefore offers a much larger surface contact area for healing (Fig 15). Second, with this technique we use all-suture anchors simplifying the procedure (Fig 16). Initially we release the anterior labrum but we do not repair the labrum at this stage in order not to tighten the space available for insertion of the HS anchors in the appropriate location. This is followed by insertion of the all-suture into the HS lesion, but again we do not tie the suture anchor limbs at this stage to avoid tightening the space available for anterior labrum repair, which is performed next. The HS anchor suture limbs are then tied following the anchor insertion.

There are a number of possible concerns with the tripod-pulley technique. Some investigators may argue that with the small holes made in the infraspinatus, one may use a small shaver or use the drill guide for the all-suture anchor to freshen the HS bone surface. As with all RT, there is a worry with external rotation deficit. So far with our small series with this technique, we have not detected a significant loss of external rotation. Additionally, there may be a concern with the pull-out strength of the all-suture anchors. There is now evidence that modern all-suture anchors have comparable pull-out strengths to standard anchors. All-suture anchors are certainly gaining popularity at a fast rate for labrum and rotator cuff repairs. It also important to emphasize that in the presence of significant glenoid bone loss, we favor the use of a glenoid bone block procedure rather than remplissage and Bankart repair.

In summary, the tripod-pulley technique described here offers the simplicity of the transtendinous double-pulley system in addition to optimizing the healing area by maximizing the surface contact area between the tendon and bone. Furthermore, it minimizes the risk of infraspinatus damage as it uses 2.3-mm all-suture anchors without a standard cannula going through the tendon. We feel that it is a very reproducible technique (Tables 5 and 6).

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