Title
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Permalink
https://escholarship.org/uc/item/0932z6tn

Journal
Arthroscopy techniques, 11(6)

ISSN
2212-6287

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Publication Date
2022-06-01

DOI
10.1016/j.eats.2022.02.018

Peer reviewed
Capsule Closure of Periportal Capsulotomy for Hip Arthroscopy

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Abstract: Multiple approaches for management of the hip capsule during hip arthroscopy for femoroacetabular impingement syndrome have been reported. Capsular closure is advocated in the setting of larger capsulotomies, including interportal and T-capsulotomies, to reduce the risk of iatrogenic instability or microinstability of the hip. The periportal capsulotomy technique has been described for conservative management of the capsule that would not necessitate closure. However, hip arthroscopy for patients with ligamentous laxity or joint hypermobility may warrant capsule closure or plication even with use of conservative capsulotomy techniques. We introduce a technique for closure of periportal capsulotomy as a means to repair or plicate the hip capsule in the at-risk hypermobile patient.

Hip arthroscopy has become the standard in the surgical management of femoroacetabular impingement syndrome (FAIS) and serves as a minimally invasive, less morbid, effective means of addressing bony deformity and chondrolabral pathology. Multiple approaches for management of the hip capsule during arthroscopy have been reported, including interportal capsulotomy,1 T-capsulotomy,2 and periportal3,4 capsulotomy. Capsular closure is advocated in the setting of larger capsulotomies such as interportal and T-capsulotomies, to reduce the risk of iatrogenic instability or microinstability.5,6 For more conservative capsule management approaches such as periportal capsulotomy, capsule closure is not needed in the general FAIS population without joint hypermobility or dysplasia.1 While there remains no consensus regarding capsule management during hip arthroscopy, there remains a subset of the patient population who may benefit from meticulous closure.

Generalized ligamentous laxity (GLL) is defined as supraphysiologic range of movement and is measured by the Beighton score.7 While the hip joint’s osseous anatomy imparts inherent stability, capsular management becomes a crucial consideration in patients with a Beighton score of ≥4. In a retrospective review of prospectively collected data, Saadat et al.8 demonstrated patients with GLL undergoing hip arthroscopy for FAI are generally younger, have lower body mass index, and are more often female. The study also found patients with greater preoperative Beighton scores had greater hip range of motion and smaller intraoperative labral size and tear dimensions. Maldonado et al.9 reported improved patient-reported outcomes and visual analog scale scores at 2-year postoperative for patients with GLL treated with capsular plication, with outcomes comparable with the non-GLL cohort. The association between GLL and microinstability has been proposed,9 and capsular plication and closure may be becoming the standard in hip arthroscopy.6,10-12 In an at-risk population, capsular closure is crucial to restoration of hip stability and improved clinical outcomes.

Although it has been reported that conservative capsule management with periportal capsulotomies do not necessitate closure in the general FAIS population, capsule repair or plication may be considered in certain at-risk individuals with ligamentous laxity or joint hypermobility. In this Technical Note, we describe our technique for capsule closure of periportal capsulotomy.

Surgical Technique (With Video Illustration)

The patient is positioned supine on a traction table for hip arthroscopy. Bilateral feet and legs are well padded...
Dynamic limb positioning. A perineal post or and positioned into the boots that allow for traction and positioning while the ALP is the main viewing portal.

Arthroscopic management of intraarticular hip pathology is then carried out based on the pathology. Pincer lesions are resected with a 5.5-mm round burr (Stryker, Kalamazoo, MI) mainly through the MAP. Labral repair in our practice is performed mostly through the MAP using all-suture anchors with flexible drills for placement (Pivot NanoTack Flex; Stryker). Once pincer and labral pathology is address, traction is released and femoroplasty of the CAM lesion is performed in a systematic fashion as previously described.13

Although capsular closure is not necessary after periportal capsulotomy in most patients, it can be considered in hypermobile patients with GLL to close or plicate the MAP, as this portal is centered in the iliofemoral ligament. The ALP, In contrast, does not require closure as it rests in the capsular interval of the hip which is an anatomically thin transition zone and it undergoes minimal dilation with periportal capsulotomy (Fig. 2A). After completion of arthroscopic FAI treatment, the leg is placed in neutral rotation and flexion and capsule closure of the periportal capsulotomy can be performed (Video 1). The 70° arthroscope in the ALP is used to view the closure intraarticularly underneath the hip capsule. The 8-mm plastic working cannula that was used for labral repair and femoroplasty in the MAP is withdrawn superficial to the hip capsule to the level of the musculature (Fig 3A). This allows the 70° SlingShot (Stryker) suture passer to have increased maneuverability and enables outside-in passing of the suture (Fig 3B). A high tensile strength nonabsorbable suture is loaded onto the SlingShot suture passer for capsular closure. In our practice, #2 ultra-high molecular weight polyethylene suture is used (ORTHOCORD; DePuy Synthes, Warsaw, IN). The slishot is used to first penetrate the proximal capsular leaflet from outside-in through the proximal/medial aspect of the MAP (Fig 3C), and the #2 suture is deposited into the joint (Fig 3D). Intra-articular visualization of this steps ensures there is no damage to the labrum/labral repair from the slingshot. The suture passer is then withdrawn from the proximal leaflet; care is taken not to withdraw the suture that was passed along with the passer. Next, the suture passer is used to penetrate the distal capsular leaflet from outside-in, and the suture that was passed through the proximal leaflet is retrieved (Fig 3E). This creates a simple suture configuration through the periportal capsulotomy. If plication of the capsule is desired, then a more distal entry point can be made with the slingshot so a bigger “bite” is taken of the distal aspect of the capsule to advance the tissue. The suture limbs are then tied from outside through the disposable working cannula using an arthroscopic knot-pusher and

Fig 1. Arthroscopic view of a left hip from the ALP showing the integrity of the iliopsoas ligament remains intact with creation of periportal capsulotomies. The arthroscope is withdrawn so the proximal leaflet (black circle) and distal leaflet (black triangle) of the ALP capsulotomy are shown. (ALP, anterolateral portal; FH, femoral head; IFL, iliopsoas ligament.)
alternating half-hitches. The arthroscope is left deep to the capsule to visualize the closure as the knots are tied and the peripheral compartment space is tightened (Fig 3 F-H). Figure 2B shows an illustration of the closed MAP portal.

Pearls and pitfalls (Table 1) as well as advantages and disadvantages (Table 2) of this technique are summarized.

**Discussion**

Described capsular entry techniques in hip arthroscopy include periportal, interportal, and T-capsulotomies, all of which have the potential to provide varying levels of visualization and access to central and peripheral compartments. The current literature lacks a clear consensus regarding risks and benefits of various capsular management strategies and their respective biomechanical and clinical outcomes. Some authors have shown capsular deficiency may be associated with revision surgery and iatrogenic instability. While some studies demonstrate repair provides improved hip stability, biomechanics, and range of motion, others suggest no adverse clinical consequences when the capsule is left unrepaired.

Cadaveric studies demonstrate hypermobility after large interportal (4-6 cm) or T-capsulotomies. The iliofemoral ligament (Y ligament of Bigelow), the strongest of 3 capsular ligaments, is transected during interportal or T-capsulotomy, eliminating static restraint to hip extension and anterior translation. As the pseudonym implies, the Y-shape of the iliofemoral ligament describes a proximal convergence of fibers resulting in a thin transition zone, or capsular interval, between it and the ischiofemoral ligament where the ALP is made (Fig 3). The ALP, used primarily for viewing, is dilated only 6 to 7 mm as described for periportal capsulotomy. It is located in this capsular interval and consequently does not necessitate closure. Closure of the working MAP within the substance of the iliofemoral ligament provides leaflet apposition for sound healing and restoration of intrinsic static restraint.

Instability following hip arthroscopy is multifactorial with limited reports in the literature. In a systematic review of subluxation and dislocation following hip arthroscopy, Duplantier et al. identified 10 articles with 11 patients, 9 of whom suffered dislocation and 2 subluxations. Of the 8 reported interportal capsulotomies, only 2 were repaired. Wuerz et al. demonstrated capsulotomies were accompanied by increased joint mobility and showed restored range of motion when compared with the intact condition. With respect to short-term clinical outcomes, Frank et al. found improved outcomes and patient satisfaction following complete repair in comparison to partial repair at 2 years’ postoperative. McCormick et al. reviewed patients undergoing revision hip arthroscopy and after excluding patients with residual FAI as
cause for revision, the investigators found 9 of 25 patients with hip capsule abnormalities, 7 of whom had capsular defects detected on MRA. Notably, no patients with capsular closure at the index procedure were found to have residual capsular defects. In another study, of 229 patients undergoing revision hip
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Advantages and Disadvantages of Periportal Arthroscopy, Selley et al.\(^2\) found revision for instability with capsular management will become ever more crucial to clinical efficacy and patient outcomes.

Periportal capsulotomy, as previously described,\(^4\) has been shown to not necessitate capsule closure in patients with FAI without ligamentous laxity.\(^3\) However, in patients with hypermobility, even partial injury to the iliofemoral ligament may result in microinstability. It is in this at-risk patient population where periportal capsulotomy closure may be considered, with particular attention to closure of the mid-anterior capsulotomy.

In conclusion, periportal capsulotomy for hip arthroscopy in patients without ligamentous laxity does not necessitate capsule closure but for patients with joint hypermobility a simple technique to repair or plicate the periportal capsulotomy can be used.

**Table 2. Advantages and Disadvantages of Periportal Capsulotomy Closure for Hip Arthroscopy**

| Advantages | Disadvantages |
|------------|---------------|
| - Only one simple configuration suture is needed for periportal capsulotomy closure. | - Increased cost to case with additional instruments needed compared with no capsular closure. |
| - Decreased risk for post-operative instability or microinstability with capsular closure in hypermobile patients. | - Capsular closure of a periportal capsulotomy in patients without hypermobility may lead to potential excessive constraint. |

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