

## Discussion

**1. Dr. Sommer Hammoud: In the surgical management of MDI, what are the differences between suture capsular plication and use of bony anchors?**

**Authors' answer:** The primary etiology of MDI is a loose and redundant capsule, especially resulting in inferior laxity. This can be treated by shortening the static stabilizers and reduction of capsular volume. This can be achieved through both suture capsular plication and the use of bony anchors. In suture capsular plication, the redundant capsule is sutured to the intact labrum. When using bony anchors, the capsulolabral tissue is secured to bony anchors that are placed in the glenoid rim. Both methods can be successful in treating these patients, however, for suture capsular plication there should be an intact labrum in order to have secure fixation. If the labrum is not intact, bony anchors should be used. A biomechanical study by Provencher *et al.* (54) showed that suture capsular plication to the intact posteroinferior or anteroinferior labrum provided similar fixation strength to a glenoid anchor, though suture plication demonstrated more labral displacement than suture anchor fixation.

**2. Dr. Sommer Hammoud: Furthermore, is poor tissue quality ever an issue in the surgical management of these patients? What are the surgical options?**

**Authors' answer:** Poor tissue quality can be an issue in these patients, especially in a revision surgery setting or in those that have connective tissue disorders. In these cases an open stabilization should be preferred over arthroscopic stabilization. If tissue quality is deficient enough that an open stabilization is not possible, capsular reconstruction using hamstring tendon, iliotibial band, or tibialis anterior autograft or allograft can be considered. Additionally, particularly in patients with bone loss and poor tissue quality, a bone block procedure such as a Latarjet is an option.