Arthroscopic labral repair and refixation have garnered much attention over the past several years. Restoration of suction seal and native labral function has been an evolving focus for achieving excellent results in hip preservation surgery. Authors have reported using several labral management techniques: débridement, labralization, looped suture fixation, base stitch fixation, inversion-eversion, and reconstruction. The optimal technique is yet to be determined. Absolute indications for labral repair are symptomatic intra-articular pain, joint space >2 mm, and failed conservative management. Extreme attention is given to identifying and addressing the cause, whether it be acute or repetitive trauma, instability, or femoroacetabular impingement. In this article, we discuss indications for labral repair; describe Dr. Mather’s preoperative planning, labral repair technique, and postoperative care; and review published outcomes and future trends in labral repair.

Indications
At our institution, anatomical labral repair is the preferred procedure for most primary and revision hip arthroscopy procedures. We aim to restore the suction seal, re-create the contact of the labrum and the femoral head to facilitate proprioception, and restore normal stability of the labrum. Indications for primary repair are labrum width >3 mm, no more than 2 repairs, and ability to hold a suture. Our indications for reconstruction or débridement are stage 3 irreparable labral tear, calcified/cystic labrum, and multiple failed labral repairs or reconstructions. The decision to perform labral débridement or reconstruction is made on a case-by-case basis but is primarily influenced by the stability of the hip joint and the activity goals of the patient.
Take-Home Points

- Labral preservation is recommended when possible to ensure restoration of suction seal, stability, and contact pressure of the hip joint.
- Over 95% of labral tears can be addressed with primary repair.
- Consider using an accessory portal (ie, DALA) to allow for more anatomic placement of suture anchor.
- Mattress stitch when labrum >3 mm and looped stitch when labrum <3 mm.
- Control labral repair to avoid excessive inversion or eversion.

Preoperative Planning

The goals in hip preservation surgery are to identify and address the underlying cause of the labral tear, whether it be FAI syndrome, trauma, labral instability, or all 3, and to re-create the anatomy and biomechanics of the acetabular labrum. For repair, we prefer an inversion-eversion technique with independent control of the labrum. Our initial work-up includes a thorough history and physical examination with baseline patient-reported outcome scores. Standard erect anteroposterior pelvis, Dunn lateral, and false-profile radiographs are obtained. Standard measurements of lateral center edge angle, anterior center edge angle, Tönnis angle, Tönnis grade, lateral joint space, and head extrusion indices are evaluated. Selective in-office ultrasound-guided injections are used to confirm an intra-articular source of pain. At our institution, noncontrast 3.0 Tesla magnetic resonance imaging (MRI) with volumetric interpolated breath-hold examination (VIBE) sequencing and 3-dimensional rendering is obtained for evaluation of labral and FAI morphology. All advanced imaging is performed without arthrogram or radiation exposure (Figures 1A-1C). Although the advanced MRI used is of benefit in preoperative planning, it is limited in detecting labral pathology. Although its results are valuable, they do not predict the operative treatment algorithm of débridement, repair, or reconstruction.

With use of the radiographs and the MRI scans, we engage the patient in an informed discussion about the labral tear, FAI, and concomitant pathology. We discuss expected outcomes of conservative or operative management given the patient's expected functional activities, and inform the patient that primary repair is indicated for many others in similar situations. The potential for possible labral reconstruction is discussed if the patient had prior intra-articular hip surgery, has a large calcified labrum or a cystic labrum, is an athlete with failed prior surgery, or is younger than 40 years.

Labral Repair Technique

The patient is taken to the surgical suite, and a general anesthetic is administered. A peripheral nerve block is not routinely used. The patient's feet are padded, and boots for the traction table are applied. The patient is carefully placed on a Hana table in modified supine position. Balanced traction is used to achieve proper joint distraction. The C-arm is used to verify proper distraction, assess hip stability, and achieve standard anterolateral (AL) portal placement. A midanterior portal (MAP) is created and an interportal capsulotomy is performed. Capsular suspension is performed with the InJector II Capsule Restoration System (Stryker Sports Medicine) and typically 4 or 5 high-strength No. 2 sutures (Zipline; Stryker Sports Medicine). Diagnostic arthroscopy is performed to identify the tear type, measure the labral width, determine the impingement patient. If preoperative presentation and intraoperative examination suggest labral instability as a major component of the pathology, or if the patient wants to return to high-demand activity, we more strongly favor reconstruction over débridement. In our experience, with the technique described in this article, more than 95% of all primary labral tears can be addressed with repair.
area, and identify the intra-articular pathology. After
the intra-articular pathology is addressed, a radio-
frequency Ambient HIPVAC 50 Coblation Wand
(Smith & Nephew) is used to expose the acetabu-
lar rim and subspine as indicated. Acetabuloplasty
or subspine decompression is performed, and
then a primary repair or refixation of the labrum is
performed. We do not routinely detach the labrum
for acetabular rim trimming. A crucial step here is
to expose a bleeding surface to which the labrum
can be repaired. If the rim is sclerotic, or the rim
cannot be removed because of underlying low ace-
tabular coverage, we prefer to obtain the bleeding
surface with a microdrilling device (Stryker) that is
routinely used for acetabular microfracture.

Labrum quality is used to determine which repair
method to use. A hypertrophic labrum is debulked.
The acetabular rim is seldom resected >3 mm,
but, when it is, the newly exposed cartilage is
removed. We have found that >3 mm of residual
cartilage prevents refixation of the labrum directly
to the bone and may interfere with anatomical
positioning. When a labrum is <3 mm in width or
will not hold a base technique, repair stability is the
priority, and a looped method is used. A knotless
anchor with No. 1 permanent suture designed for
hip labral repair (CinchLock; Stryker) is our first-line
anchor choice. A distal anterolateral accessory
(DALA) portal is created with an outside-in tech-
nique, and anchors are drilled through this portal
into zones 2 to 4 (Figures 2A-2E). For far medial
anchor placement, the anchor drill guide is offset
in an attempt to avoid iatrogenic psoas irritation
or medial wall penetration. The socket is visual-
ally inspected before anchor insertion to confirm
complete bony insertion. In the rare case in which
a small part of the medial aspect of the anchor is
exposed toward the psoas, this part of the anchor
is carefully resected with a burr without disrupting
anchor fixation or the suture in the anchor. For
posterior anchor placement, the AL portal is can-
nulated and used for far lateral drilling. The MAP
and the DALA portal traditionally are cannulated for
repairs in zones 2 to 4. With visualization through
the AL portal, the probe is used to apply tension
on the labral segment being repaired for reduction.
A suture-passing device (NanoPass; Stryker) is
used to pass (with base stitch technique) the No.
1 suture for the anchor, and the acetabular (base)
side of the No. 1 suture is marked with a methy-
lene blue marker. The key is to make the first pass
of suture at the base of the chondrolabral junction.
The probe is then used to apply tension on the
labrum and to reduce the labrum to the chondro-
labral junction through the MAP. The second pass
of the suture-passing device is through the labrum
apex, and the suture is retrieved. Care is taken to
make sure the suture is on equal sides of the labral
apex to avoid labrum distortion (Figures 2A-2E).
A 2.4-mm drill guide is advanced through the

![Figure 2. Suture passage. (A) Asterisk represents
distal anterolateral accessory portal, created 4 cm
distal to anterolateral portal. (B) NanoPass device
(Stryker) passes No. 1 suture at base of chondro-
labral junction. (C) Probe reduces chondrolabral
junction after base pass of suture. (D, E) Labrum
is tensioned with probe. Second apex pass of
NanoPass device to complete base stitch.](image)
DALA portal and placed in the appropriate position for drilling. We aim for 1 mm to 2 mm from the chondrolabral junction. Next, the probe is placed intra-articular and medial to the anchor insertion site, and the anchor is loaded and then inserted around the probe (Figures 3A-3E). The probe allows the suture to remain free for independent tensioning. We then remove the probe and independently tension the suture ends. Gentle pulling on the marked suture end and then on the unmarked side allows for proper labrum inversion-eversion as needed, and the device is deployed. If the capsular side of the labrum does not lie flat against the bone, the nonmarked end is tightened to position the labrum so that, when the base stitch is tightened, the tissue is compressed against the bone to maximize healing. For a standard 3-cm repair, it is routine to use 3 or 4 anchors placed 6 mm to 8 mm apart (Figures 4A-4D).

The hip is then reduced. If indicated, a T-capsulotomy is performed for femoral osteochondroplasty. Routinely, the capsule is anatomically repaired with the Injector II Capsule Restoration System and No. 2 permanent suture. The Table presents our technical pearls.

**Table**

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description</th>
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<tbody>
<tr>
<td>DALA portal</td>
<td>Drilling position 1 mm to 2 mm from chondrolabral junction</td>
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<tr>
<td>Anchor insertion</td>
<td>Labral probe insertion, independent tensioning</td>
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<tr>
<td>T-capsulotomy</td>
<td>Femoral osteochondroplasty</td>
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**Postoperative Care**

Patients are placed in a postoperative hip brace and use a continuous passive motion machine 6 hours for a day for 2 weeks, and an ice machine. They
Current Concepts in Labral Repair and Refixation: Anatomical Approach to Labral Management

Discussion

Hip labral preservation has evolved over the past 10 years, and current options for labral management include excision, débridement, labralization, repair, and reconstruction. Labral excision was studied by Miozzari and colleagues, who postulated on the basis of animal models that the labrum may regenerate. In their series of 9 patients treated with surgical hip dislocation and labral excision at average 4-year follow-up, repeat magnetic resonance angiography revealed no regeneration of tissue—modified Harris Hip Score was 83. The hip scores were less than those of patients treated with the same procedure with repair, and the authors concluded that defining labral débridement versus excision in the literature, and treating patients with primary repair or reconstruction techniques, may lead to better results. Their study used a small sample and was limited to an open procedure. Arthroscopic labral débridement in isolation was also a poor option for treatment of a labral tear. In a 2-year follow-up of 59 isolated labral débridement procedures, Krych and colleagues found 47% combined poor results.

There is level I evidence of the importance of labral repair. In 2013, Krych and colleagues conducted a randomized control trial of 38 female patients who underwent hip arthroscopy for FAI. At time of surgery, patients were randomly assigned to either débridement or repair. At 1-year follow-up, activities of daily living and Sports specific Hip Outcome Scores were statistically significantly superior in the repair group. On a subjective scale, 94% vs 78% of patients reported normal or near normal hips in the repair versus débridement groups respectively. Ayeni and colleagues performed a systematic review of 6 studies in an attempt to develop labral management recommendations. Five of the studies (N = 490 patients total) had improved results with labral repair over reconstruction. Although the studies had a low level of evidence, they found a trend toward improved results with labral repair. These studies highlight the importance of labral preservation and proper FAI management.

Techniques for labrum repair have advanced as well—from a looped suture technique to a base stitch and knotless independent tensioning. Restoration of the hip labrum function as a suction

Table. Technical Pearls for Labral Repair

<table>
<thead>
<tr>
<th>Technical Pearl</th>
<th>Rationale</th>
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<tr>
<td>Perform proper preoperative work-up: physical examination, intra-articular injection response, volumetric interpolated breath-hold examination (VIBE) rendering on 3.0 Tesla magnetic resonance imaging</td>
<td>Confirms intra-articular source of pain and identifies cause of labral tear</td>
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<tr>
<td>Use No. 1 suture for labral fixation</td>
<td>Increases precision and management of small labra</td>
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<td>Place base suture against rim</td>
<td>Sets up spacing for second suture pass</td>
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<td></td>
<td>Allows for control of base reduction</td>
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<td></td>
<td>Allows for suture to cross and secure chondrolabral junction</td>
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<tr>
<td>Use probe to reduce labrum</td>
<td>Assists in ideal suture placement</td>
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<td>Facilitates recognition of labral apex</td>
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<tr>
<td>Pass mattress suture on equal sides of labral apex</td>
<td>Keeps labrum from becoming distorted during tensioning</td>
</tr>
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<td>Avoids twisting of labrum with multiple anchors (suture through different planes of labrum)</td>
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<tr>
<td>Create distal anterolateral accessory portal</td>
<td>Facilitates optimal positioning for anchor placement</td>
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<td>Allows anchor to be placed closer to edge of rim</td>
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<td>Keep slack in suture when inserting anchor</td>
<td>Keeps suture loop loose for proper tensioning</td>
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<td>Prevents excessive eversion</td>
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<tr>
<td>Preferentially pull base suture</td>
<td>Reduces chondrolabral junction</td>
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maintain 30 lb of foot-flat weight-bearing for 3 weeks, and begin a standard labral repair protocol on postoperative days 3 to 7.
Future Directions
As our understanding of FAI and labral function evolves, labral preservation surgery continues to advance. With surgeons continually developing new techniques and following up on previous techniques, the ability to preserve the native hip with lasting procedures evolves as well. Proper identification of the underlying cause of the labral tear and proper anatomical repair are paramount to the success of FAI surgery.

References