case described, the procedure succeeded. In the remaining twenty cases we had no recurrences.

Lastly we believe that the two bone fixation stitches are simpler, firmer and more efficient than the four posited by Bankart[1]. Moreover, as far as the other details of the procedure are concerned, hey contribute to achieving a strong shoulder, which has in no case been incompatible with good shoulder mobility.

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Commentary

Dr. Garaizábal Bastos' paper was presented in 1955 at the 4th National SECOT Congress in Asturias, only sixteen years after Bankart's classic article in the *British Journal of Surgery*.

On reading it, one realizes that the author knows exactly what he is talking about and that it reflects the experience of a frank scientist. Furthermore, the paper is a highly illuminating compendium on shoulder instability, dealing with notions that might seem obvious today but which in those days were still controversial.

Dr. Garaizábal's description of intraoperative findings in recurrent dislocations is impeccable. He insists that most of his patients had a labral defect that could be an avulsion, a tear or the apparent disappearance of the labrum. According to the author, these defects can only be identified by means of an intraarticular inspection conducted through the capsular opening. Nowadays we know that this is the determining factor accounting for the instability of most of our patients, i.e. those we group under the post-traumatic unidirectional instability heading. He also mentions that in two of his cases the above mentioned injury did not exist and he suggests that the cause for the instability could be an excess of capsular laxity. This is an unquestionably apt comment, made 15 years before the publication of Neer and Foster's paper on multidirectional instability[1].

Dr. Garaizábal describes in a straightforward manner the two most common kinds of instability we find in our practices. Sometimes pathological findings coincide and it is not infrequent to find Bankart lesions associated with redundant capsules that require combined treatment.

The paragraphs devoted to the surgical technique reveal the author's preference for performing an anatomical reconstruction of the lesion. He makes a detailed description of how the patient should be positioned and what approach should be used to reach the anterior glenoid rim with ease, carrying out a coracoid osteotomy to increase exposure. Later, he describes the technique he uses to perforate the glenoid and reinforce the medial capsule, insisting on the difficulty of the technique and recommending the use of two holes, «one at the top and the other at the bottom», instead of the four holes suggested by Bankart.

With a few variations, this technique is similar to what we do nowadays in our open surgeries. The passage of time and the evolution in instrument design have allowed us to achieve the same results with a less aggressive open procedure where it is possible to anatomically repair the labrum, preserve in some cases the subscapularis attachment, working through this structure, and posteriorly displace the humeral head by means of a Fukuda retractor. In that way, we can perform this surgery through an incision of as little as 4 cm.

The factor that unequivocally determines anterior posttraumatic instability is the presence of an injury at the anterior portion of the labrum, an area we must strive to repair.

The precise knowledge of the pathological pattern of instabilities gained in the last decade has led to the consolidation of arthroscopic surgery as an alternative to classical techniques. Currently, the results published by different groups on the arthroscopic reconstruction of labral lesions are fully comparable to open techniques, but have an undeniable benefit for the patient in the first three months post-op[2,3].

The same could be said about instabilities resulting from capsular laxity, in which arthroscopy play san increasingly important role since it can intraarticularly replicate Neer's classic plicature[4]. In our view, the next decade will see how arthroscopy consolidates its position as the technique of choice for treating shoulder instability, to the detriment of older methods.

It is interesting to stop to consider the results presented by Dr. Garaizábal. He meticulously describes each one of his patients, their return to sport activity, their relapses and what he considers good and bad results. At a time at which most of our research draws on solid statistical foundations that validate our conclusions, we may be surprised by the lack of a specific analysis of the different cases. All the cases presented show an impaired external rotation, although «none of them has perceived the slight reduction in external

rotation». Such a reduction is attributable to the association of a Putti-Platt-type subscapularis plicature in all cases. We are nowadays extremely careful to avoid this complication both in open surgery and in arthroscopy when we associate a capsule plicature to Bankart's repair.

Undoubtedly, in the fifty years elapsed since the publication of Dr. Garaizábal Bastos' paper, great strides have been taken in the diagnosis and treatment of the unstable shoulder.

At present it is possible to know the cause and direction of our patients' instabilities. We possess both diagnostic tools that allow us to reliably confirm our initial suspicions and arthroscopic surgical techniques that show us any existing lesions and make it possible to correct them.

All in all, it is very likely that half a century ago not many surgeons had the experience and clear ideas reflected in this classic paper of our Journal.

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