Peer Review File

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Review Comments

Reviewer A

Comment 1: The introduction is well-written and relevant but should be more concise. Recently, many techniques have emerged for describing the arthroscopic repair of bony Bankart lesions. I suggest focusing more on the current techniques in your introduction section. I recommend searching in the Arthroscopy Technique journal or on PubMed.

Reply 1: Thank you for your comment to ensureemphasis on current literature. We have added more context on newer technqiues, especially those described within the last 3 years, to contextualize that although there are newer techniques, bony bankart bridge is still a viable technique with adequate outcomes.

Changes in the text:

- Lines 34-37: "*Even in the context of more novel techniques for bony bankart repair, such as flexible drilling for transosseous repair, suture suspension to increase bone contact area, or transosseous sling-suture techniques, all-arthroscopic double row suture bridge remains a viable approach (16-19).*"

Comment 2: The case presentation is well-constructed. If possible, please add the Patient-Reported Outcome Measures (PROMs) for this patient, both preoperative and postoperative.

Reply 2: Thank you for bringing this up, we would have included PROMs, however, upon chart review that information was not available either pre- or postoperative.

Changes in the text: NA

Comment 3: Line 211, Please provide more details about the MINORS score that was used to assess methodological quality.

Reply 3: Thank you for bringing this to our attention, we apologize for the oversight and initial lack of follow up information. Below are the changes that we made.

Changes in the text:

Lines 174-178: "*Only the non-comparative potion, the first 8 questions, of the MINORS criteria were used, as no studies compared outcomes between different tear locations (i.e., proximal vs. midsubstance). Some studies compared repair vs. reconstruction but this control group was not considered relevant for this study. The average MINORS criteria score was 9 with a range of 7-10, and standard deviation of 1.4.*"

Comment 4: If possible, please describe the postoperative rehabilitation in each of the included studies.

Reply 4: Thank you for the comment on additional rehab information. The general rehabilitation protocol used in each study has been added to the results section of the paper

Changes in the text:

Lines 216-238:

"*Postoperative Rehabilitation*

Each of the included studies allowed for specific tailoring and adjustments based on patient fracture and repair characteristics, however, the general postoperative guidelines were used as a guide for patient rehabilitation.

Millett et al. immobilized all patients with a sling for 3 weeks. Patients were encouraged to perform early PROM exercises with supervised AROM starting at 2 weeks. Strength training began at 6 to 8 weeks postoperatively. Patients were then cleared for return to noncontact sport activities at 3 to 4 months postoperatively. Return to throwing and/or contact sports was allowed at the 6 month postoperative period.

Godin et al. had patients immobilized in a sling for 3 weeks. Patients were encouraged to perform early PROM exercises, and supervised AROM within 2 weeks. Strength training began 6 to 8 weeks postoperatively. Release to noncontact sport activities was at 3 to 4 months postoperatively. Full return to contact and/or throwing sports was allowed after 6 months.

Guo et al. had patients use for 6 weeks after surgery. PROM exercises were started at 4 weeks postoperatively under the supervision of a physical therapist. Terminal stretching exercises were allowed at 3 months postoperatively. Overhead and/or contact sports activities were not allowed until 1 year after surgery, when full ROM was restored and no apprehension was detected.

Itoigawa et al. immobilized patients in internal rotation and 0° abduction using a Sigmax Arm Sling (SIGMAX MEDICAL, Tokyo, Japan) for 4 weeks postoperatively. Starting postoperative day one patients started with pendulum, elbow, and wrist and hand ROM exercises. Fully AROM and PROM progressed after 4 weeks. Patients were instructed to avoid heavy work and sports using the upper limb."

Comment 5: Please add information about the advantages and disadvantages of Arthroscopic Suture Bridge Fixation in bony Bankart repair.

Reply 5: Thank you for pointing out the opportunity to summarize the advantages and disadvantages of arthroscopic suture bridge fixation for bony Bankart repair. A brief paragraph that captures the characteriztics of this technique is now in the discussion.

Changes in the text:

- Lines 342-354: "*In short, the advantages of arthroscopic suture bridge fixation include increased bone contact surface area with greater compressive forces and higher load needed for failure of the glenoid, potential for standardization regardless the of percent of the glenoid involved, and all arthroscopic technique. However, there are disadvantages that include the technically challenging nature of the approach, especially with regards to bone resection, final anchor seating, and risk of lateralizing the bone fragment, as well as limited long-term patient reported and clinical outcomes and inability to use this technique in more chronic injuries. Despite these disadvantages, there is still great long-term potential in this technique, especially in the ideal patient.*"

Reviewer B

Comment 6: line 18-19: it is stated the patient had a superior labral tear, however in manuscript lines 126-130 it is stated the superior labrum was intact; please clarify and edit as appropriate

Reply 6: Thank you for the opportunity to clarify this concern. The MRI read suggested involvement of the superior labrum, however upon diagnostic arthroscopy, the labrum was intact and instead had a small anterior superior labral variant. This has been clarified.

Changes in the text:

- Lines 92-94: "*Contrary to preoperative MRI results, inspection of the labrum showed that it was superiorly intact, instead with a medialized attachment and a small anterior superior labral variant.*"

Comment 7: line 52: please clarify what type of bone loss, ie glenoid?

Reply 7: Correct, glenoid bone loss. The clarification in below, thank you.

Changes in the text:

- Lines 6-9: "*However, surgical intervention is often necessary if a primary anterior shoulder dislocation results in significant glenoid bone loss and is essential after a second dislocation, due to a nearly threefold increase in glenoid bone loss upon second injury (5,6).*"

Comment 8: lines 58-60: what about open bankart repair? please comment and edit as appropriate

Reply 8: Thank you, open bankart repair was alluded to, but not specifically stated. This has been corrected.

Changes in the text:

- Lines 12-16: "*Bony Bankart lesions add a level of complexity, as treatment is driven by the size of the lesion. Small lesions, less than 12.5%, can be repaired using an all-soft tissue form of fixation (8). Medium-size lesions, ranging from 12.5 to 25%, often require an arthroscopic bone fixation such as the double-row suture bridge or reconstruction with a Latarjet procedure or other form of bony augmentation, such as open bankart repair (7-9).*"

Comment 9: lines 86-88: did she sustain subjective or objective shoulder dislocation or subluxation with either spontaneous reduction or need for formal reduction? please clarify

Reply 9: Thank you for the opportunity to better define her history. She did not have objective or subjective shoulder dislocations, nor the need for spontaneous reduction.

Changes in the text:

- Lines 54-57: "*She had no prior shoulder surgeries, objective shoulder dislocations, formal reductions, or documented episodes of shoulder instability. She also did not endorse subjective shoulder dislocations, although she was uncertain if her shoulder dislocated during her seizures.*"

Comment 10: line 122: delete "in arthroscopy journal"

Reply 10: The revision has been made, thank you

Changes in the text:

- Lines 85-88: "*The shoulder was insufflated and standard posterior superior and anterior portals were established percutaneously along with eventual posterior-inferior (7 o'clock) and anterior inferior (5 o'clock trans-subscapularis) portals, as noted by Seroyer et al. in 2010 (17).*"

Comment 11: line 132: please clarify "drill 2.4mm", do you mean "a 2.4mm drill bit"?

Reply 11: Yes, thank you for that correction

Changes in the text:

- Lines 99-101: "*In the 7 o'clock portal, a 2.4mm drill bit was used to drill into the glenoid for a double-loaded anchor (2.4 mm biocomposite SutureTak, Arthrex, Naples, FL) at the 6 o'clock position (Figure 10).*"

Comment 12: lines 250-279: please cite each article with reference every time it is discussed

Reply 12: Thank you for recognizing the need for citations. They have been added at the respective locations

Changes in the text:

- Lines 225-227: "*Millett et al. assessed several outcomes and found a mean ASES score of 98.3, a mean SF-12 score of 56, a mean QuickDASH score of 2.8, a mean SANE score of 99, and a median satisfaction score of 10/10 (13).*"
- Lines 231-232: "*Godin et al. found a mean ASES score of 93.1, a mean SF-12 score of 55.1, a mean QuickDASH score of 6.2, a mean SANE score of 92.8, and a median satisfaction score of 10/10 (12).*"
- Line 237: "*Guo et al. looked at ASES and VAS with mean scores of 94.87 and 0.48, respectively (19).*"
- Lines 238-239: "*Itoigawa et al. found that 30 of the patients analyzed were athletes and all returned to their previous level of sport (20).*"
- Lines 241-242: "*Millett et al. did not report on ROM. There was a single reported case (7%) of recurrent instability after a traumatic re-dislocation (13).*"
- Lines 243-244: "*Godin et al. did not report on ROM. They reported three cases (12%) of instability: one after an injury and two with recurrent instability without an identifiable injury (12).*"
- Lines 243-246: "*Guo et al. looked at ROM and found a mean post-operative FF of 165.8, ER of 33.2, and an IR of T9 (19).*"
- Lines 249-251: "*Itoigawa et al. assessed the ROM of the patients and found a mean FF of 171.5, an ER of 63.9, an IR of TH 6, an AbdIR of 71.2, and an AbdER of 87.8. One patient (2%), who was a baseball player, had recurrent instability (20).*"

Comment 13: line 332: consider rephrasing "said study" to be more specific

Reply 13: The phase "said study" has been revised to be more specific.

Changes in the text:

- Lines 305-308: “*However, a limitation of the study by Giles et al. was that the glenoid defect was 15%, whereas several studies by Yamamoto et al. in 2009 and 2010 demonstrate recurrent instability when the fracture encompasses more than 20% of the glenoid (7, 14).”*

Comment 14: line 339: please define "um", possibly consider staying consistent with "mm" as used previously in text.

Reply 14: Thank you for identifying this inconsistency. It has been revised.

Changes in the text:

- Lines 313-315: “*Finally, a study by Greenstein et al. found a decreased step-off, 436 mm vs 896 mm, for double vs single row as well as decreased displacement of 795 mm vs 1265 mm respectively (28).*”