

Posterior Shoulder Stabilisation

Overview

- Arthroscopic stabilization of posterior shoulder instability yields promising early and midterm results [4].
- Arthroscopic stabilization for posterior shoulder instability results in good outcomes, high patient satisfaction, low rates of recurrent instability, low rates of revisions, and low rates of residual pain [14].
- Arthroscopic management of posterior-inferior shoulder instability has a successful track record and a minimal complication profile [8].
- Arthroscopic surgical techniques have facilitated successful management of both recurrent posterior subluxations and frank posterior instability [9].
- Successful correction of scapular anatomy (glenoid and acromion) at a minimum of 2 years can improve static subluxation and restore subjective and objective shoulder stability [2].
- Posterior bone block augmentation for recurrent posterior shoulder instability does not reliably yield substantial improvements in patient-reported outcomes and is associated with frequently observed complications [12].
- There is a high rate of return to sport after arthroscopic posterior shoulder stabilization, ranging from 4.3 to 8.6 months after surgery [15].
- The thresholds defined in recent studies can provide a guideline for interpreting patient outcomes following arthroscopic stabilization for posterior shoulder instability, allowing for earlier detection of recurrent posterior instability [3].
- Coracoid morphology differs significantly in patients undergoing posterior shoulder stabilization when compared to patients undergoing surgery for anterior instability or a comparison cohort [7].
- Over the past several centuries, a number of procedures have been developed to address posterior shoulder instability as this pathology has become better understood [6].
- Additional long-term randomized trials are needed to compare surgical positioning (beach-chair versus lateral decubitus) for posterior shoulder stabilization to better understand potential advantages and disadvantages [1].

Anatomy & Pathophysiology

- Posterior shoulder instability pathology has become better understood over the past several centuries, leading to the development of various surgical procedures [6].
- Advances in understanding posterior glenohumeral anatomy and biomechanics have improved comprehension of this disorder and guided clinical decision-making regarding surgical indications, contraindications, nonsurgical treatments, and stabilization techniques [16].
- Posterior shoulder instability (PSI) is classified using the ABC classification, which distinguishes three groups based on the nature of pathology and two subtypes based on pathomechanical causes [17].
- Female patients are significantly more likely to have posterior shoulder instability compared to anterior shoulder instability, whereas male patients are significantly more likely to have anterior shoulder instability [11].
- Delayed diagnosis of posterior glenohumeral dislocations is common [18].
- Coracoid morphology differs significantly in patients undergoing posterior shoulder stabilization compared to patients undergoing surgery for anterior instability or a comparison cohort [7].
- Patients with constitutional static posterior shoulder instability (Type C1) differ from healthy controls regarding osseous scapular and humeral morphology, scapulothoracic orientation, and shoulder girdle muscle distribution [31].
- Glenoid as well as acromial malalignment alone is associated with pathological posterior translation of the humeral head across the glenoid upon simulated active elevation [24].
- The acromion acts as a mechanical buttress to posterior humeral head displacement [27].
- Successful correction of scapular anatomy (glenoid and acromion) can improve static subluxation and restore subjective and objective shoulder stability at a minimum of 2 years [2].
- Glenohumeral contact patterns highly depend on the amount of glenoid retroversion and posterior labral and/or bony glenoid integrity [25].
- Posterior and posterior superior labral (PPS) injuries produce alterations in glenohumeral kinematics with implications for joint instability, increased joint loading, and potential joint damage [26].
- The long head of the biceps has a pertinent biomechanical role in glenohumeral stability regardless of the condition of the superior labrum [28].
- Surgical treatment of posterior shoulder instability must balance the necessity to repair torn capsulolabral tissues with the tendency to over constrain the shoulder [34].

Classification

- Posterior shoulder instability is an uncommon condition that is often unrecognized, leading to incorrect diagnoses and delays [5].
- The ABC classification distinguishes three groups of posterior shoulder instability based on the nature of pathology and two subtypes based on pathomechanical causes [17].

- The ABC classification provides diagnostic criteria and treatment strategies for posterior shoulder instability [17].
- Female patients are significantly more likely to have posterior shoulder instability compared to male patients, who are significantly more likely to have anterior shoulder instability [11].

Clinical Presentation

- Recurrent posterior shoulder instability is an uncommon condition that is often unrecognized, leading to incorrect diagnoses and delays [5].
- Bilateral posterior shoulder dislocations with reverse Hill-Sachs lesions are uncommon and prone to misdiagnosis [30].
- In patients with suspected posterior glenohumeral instability, imaging can show abnormalities of the bone, labrum, and joint capsule [20].
- Posterior shoulder instability is distinguished into three groups based on the nature of pathology and two subtypes based on pathomechanical causes in the ABC classification [17].
- Female patients are significantly more likely to have posterior shoulder instability compared to anterior shoulder instability [11].
- Successful correction of scapular anatomy can improve static subluxation and restore subjective and objective shoulder stability at a minimum of 2 years follow-up [2].
- Arthroscopic management of posterior-inferior shoulder instability has a successful track record and minimal complication profile [8].
- Arthroscopic stabilization of posterior shoulder instability resulted in good outcomes with high patient satisfaction and low rates of recurrent instability, revisions, and residual pain [14].
- The early and midterm results of arthroscopic stabilization of the shoulder for posterior instability are promising [4].
- Participants with microtraumatic posterior shoulder instability demonstrated significant improvements in patient-reported outcome measures and high rates of return to sport following a 24-week conservative rehabilitation program [21].
- The thresholds defined in the study can provide a guideline for interpreting patient outcomes following arthroscopic stabilization for posterior shoulder instability, allowing for earlier detection of recurrent posterior instability [3].

Investigations

- Delayed diagnosis of posterior glenohumeral dislocation is common [18].
- Regardless of the radiologist interpretation of magnetic resonance arthrogram (MRA), patients with symptomatic posterior shoulder instability benefit from arthroscopic stabilization surgery [19].

- In cases of traumatic posterior shoulder dislocation with associated acromion fracture, anatomical reduction and retention of the acromion fracture may be needed to prevent recurrent posterior instability [37].
- Anterior greater tuberosity malunion after posterior shoulder fracture dislocation is a rare and debilitating condition [38].

Treatment

NON-OPERATIVE MANAGEMENT

- NHL team physicians strongly favor nonoperative management in-season for initial posterior instability events of the shoulder [32].

ARTHROSCOPIC STABILIZATION

- Regardless of the radiologist interpretation of MRA, patients with symptomatic posterior shoulder instability do benefit from arthroscopic stabilization surgery [19].
- Additional long-term randomized trials comparing beach-chair and lateral decubitus positions are needed to better understand the potential advantages and disadvantages of surgical positioning for posterior shoulder stabilization [1].

BONE BLOCK AUGMENTATION

- Posterior bone block augmentation for recurrent posterior shoulder instability does not reliably yield substantial improvements in patient-reported outcomes, and complications are frequently observed [12].
- There is a moderate rate of recurrence following posterior bone block for posterior shoulder instability [13].
- The iliac posterior shoulder bone-block is effective in managing instances of involuntary posterior shoulder instability, showing satisfactory results in terms of non-recurrence, pain relief, and function recovery [10].
- Both glenoid osteotomy and bone block procedures can successfully address symptomatic posterior shoulder instability [22].

SCAPULAR OSTEOTOMY

- At a minimum of 2 years successful correction of scapular anatomy can improve static subluxation and restore subjective and objective shoulder stability [2].

OUTCOME INTERPRETATION

- The thresholds defined in this study can provide a guideline for interpreting patient outcomes following arthroscopic stabilization for posterior shoulder instability, allowing for earlier detection of recurrent posterior instability [3].

Complications

- Posterior bone block augmentation for recurrent posterior shoulder instability does not reliably yield substantial improvements in patient-reported outcomes [12].
- Complications are frequently observed following posterior bone block augmentation for recurrent posterior shoulder instability [12].
- There is a moderate rate of recurrence following posterior bone block procedures for posterior shoulder instability [13].
- Glenoid osteotomy for posterior shoulder instability is associated with a high rate of persistent instability [40].

Recovery

- Arthroscopic stabilization of posterior shoulder instability results in good outcomes with high patient satisfaction [14].
- Arthroscopic stabilization of posterior shoulder instability is associated with low rates of recurrent instability [14].
- Arthroscopic stabilization of posterior shoulder instability is associated with low rates of revisions [14].
- Arthroscopic stabilization of posterior shoulder instability is associated with low rates of residual pain [14].
- There is a high rate of return to sport after arthroscopic posterior shoulder stabilization [15].
- Return to sport after arthroscopic posterior shoulder stabilization ranges from 4.3 to 8.6 months after surgery [15].
- There are high rates of return to sport among athletes who underwent surgical treatment for posterior shoulder instability [23].
- There are relatively high rates of return to preinjury level of sport among athletes who underwent surgical treatment for posterior shoulder instability [23].
- Arthroscopic posterior Bankart repair for traumatic posterior shoulder instability in collision sports athletes results in a low recurrence rate [35].
- Arthroscopic posterior Bankart repair for traumatic posterior shoulder instability in collision sports athletes results in a high return-to-play rate [35].
- Arthroscopic posterior Bankast repair for traumatic posterior shoulder instability in collision sports athletes results in clinically meaningful improvement [35].
- Participants with microtraumatic posterior shoulder instability demonstrated significant improvements in patient-reported outcome measures following a 24-week conservative rehabilitation program [21].
- Participants with microtraumatic posterior shoulder instability demonstrated high rates of return to sport following a 24-week conservative rehabilitation program [21].
- Successful correction of scapular anatomy can improve static subluxation [2].

- Successful correction of scapular anatomy can restore subjective shoulder stability [2].
- Successful correction of scapular anatomy can restore objective shoulder stability [2].
- The iliac posterior shoulder bone-block is effective in managing instances of involuntary posterior shoulder instability [10].
- The iliac posterior shoulder bone-block shows satisfactory results in terms of non-recurrence [10].
- The iliac posterior shoulder bone-block shows satisfactory results in terms of pain relief [10].
- The iliac posterior shoulder bone-block shows satisfactory results in terms of function recovery [10].

Key Evidence

- [L4] Additional long-term randomized trials comparing these positions are needed to better understand the potential advantages and disadvantages of surgical positioning for posterior shoulder stabilization. [1] ([10.1177/2325967118822452](#))
- [L4] At a minimum of 2 years successful correction of scapular anatomy can improve static subluxation and restore subjective and objective shoulder stability. [2] ([10.1016/j.jseint.2025.06.018](#))
- [L4] The thresholds defined in this study can provide a guideline for interpreting patient outcomes following arthroscopic stabilization for posterior shoulder instability, allowing for earlier detection of recurrent posterior instability. [3] ([10.1016/j.jseint.2025.08.006](#))
- [L1] The early and midterm results of arthroscopic stabilization of the shoulder for posterior instability are promising. [4] ([10.1016/j.arthro.2014.11.009](#))
- [L5] Recurrent posterior shoulder instability is an uncommon condition often unrecognized, leading to incorrect diagnoses and delays. [5] ([10.5435/00124635-200608000-00004](#))
- [L5] Over the past several centuries, a number of procedures have been developed to address posterior shoulder instability, particularly as this pathology has become better understood. [6] ([10.1016/j.jses.2019.08.008](#))
- [L3] Coracoid morphology differs significantly in patients undergoing posterior shoulder stabilization when compared to patients undergoing surgery for anterior instability or a comparison cohort. [7] ([10.1177/03635465261421534](#))
- [L4] Arthroscopic management of posterior-inferior shoulder instability has a successful track record and minimal complication profile. [8] ([10.1016/j.arthro.2018.06.057](#))
- [L5] The article outlines the evolution of diagnostic acumen and treatment algorithms for posterior shoulder instability, emphasizing that arthroscopic surgical techniques have facilitated successful management of both recurrent posterior subluxations and frank posterior instability. [9] ([10.1016/j.csm.2008.06.001](#))
- [L4] The iliac posterior shoulder bone-block is effective in managing instances of involuntary posterior shoulder instability, showing satisfactory results in terms of non-recurrence, pain relief, and function recovery. [10] ([10.1016/j.otssr.2008.09.008](#))

- [L4] Overall, male patients were significantly more likely to have anterior shoulder instability, while female patients were significantly more likely to have posterior shoulder instability. [11] ([10.1177/23259671211006437](#))
- [L1] Posterior bone block augmentation for recurrent posterior shoulder instability does not reliably yield substantial improvements in patient-reported outcomes, and complications are frequently observed. [12] ([10.1016/j.arthro.2021.07.018](#))
- [L4] There is a moderate rate of recurrence following posterior bone block for posterior shoulder instability. [13] ([10.1016/j.jse.2021.06.013](#))
- [L4] Arthroscopic stabilization of posterior shoulder instability resulted in good outcomes with high patient satisfaction and low rates of recurrent instability, revisions, and residual pain. [14] ([10.1016/j.jse.2024.04.006](#))
- [L4] There is a high rate of return to sport after arthroscopic posterior shoulder stabilization, ranging from 4.3 to 8.6 months after surgery. [15] ([10.1016/j.asmr.2020.08.007](#))
- [L5] Advances in understanding posterior glenohumeral anatomy and biomechanics have improved comprehension of this challenging disorder and helped guide clinical decision making, including delineation of surgical indications and contraindications, nonsurgical treatment solutions, and appropriate stabilization and bone augmentation techniques. [16] ([10.5435/jaaos-d-15-00631](#))
- [L5] This review guides the reader to correctly identify posterior shoulder instability (PSI) by providing diagnostic criteria and treatment strategies based on the ABC classification, which distinguishes three groups of PSI based on the nature of pathology and two subtypes based on pathomechanical causes. [17] ([10.1530/eor-24-0025](#))
- [L4] Overall, reduction was achieved via open means in the majority of shoulders, and delayed diagnosis is common. [18] ([10.1302/0301-620x.101b1.bjj-2018-0984.r1](#))
- [L3] Regardless of the radiologist interpretation of MRA, patients with symptomatic posterior shoulder instability do benefit from arthroscopic stabilization surgery. [19] ([10.1016/j.xrrt.2026.100675](#))
- [L5] In patients with suspected posterior glenohumeral instability, imaging of the affected shoulder can show abnormalities of the bone, labrum, and joint capsule. [20] ([10.2214/ajr.07.3849](#))
- [L4] Participants with microtraumatic posterior shoulder instability demonstrated significant improvements in patient-reported outcome measures and high rates of return to sport following a 24-week conservative rehabilitation program. [21] ([10.1016/j.jseint.2024.09.016](#))
- [L1] Both glenoid osteotomy and bone block procedures can successfully address symptomatic posterior shoulder instability. [22] ([10.1016/j.xrrt.2025.03.004](#))
- [L4] The systematic review demonstrated high rates of return to sport and relatively high rates of return to preinjury level of sport among all athletes who underwent surgical treatment for posterior shoulder instability. [23] ([10.1016/j.jseint.2020.08.002](#))
- [L5] Glenoid as well as acromial malalignment alone is associated with pathological posterior translation of the humeral head across the glenoid upon simulated active elevation. [24] ([10.1177/03635465251411312](#))

- [L5] Glenohumeral contact patterns highly depend on the amount of glenoid retroversion and posterior labral and/or bony glenoid integrity. [25] ([10.1177/03635465251365497](https://doi.org/10.1177/03635465251365497))
- [L5] The PPS injury produces alterations in GH kinematics with implications for GH joint instability, increased GH joint loading, and potential joint damage. [26] ([10.1016/j.jse.2024.12.023](https://doi.org/10.1016/j.jse.2024.12.023))
- [L5] The acromion acts as a mechanical buttress to posterior humeral head displacement. [27] ([10.1016/j.jse.2024.09.047](https://doi.org/10.1016/j.jse.2024.09.047))
- [L5] The long head of the biceps has a pertinent biomechanical role in glenohumeral stability regardless of the condition of the superior labrum. [28] ([10.1016/j.arthro.2025.05.022](https://doi.org/10.1016/j.arthro.2025.05.022))
- [L4] Bilateral posterior shoulder dislocations with reverse Hill-Sachs lesions are uncommon and prone to misdiagnosis; early recognition and tailored treatment strategies are essential for satisfactory functional outcomes. [30] ([10.1186/s12891-026-09537-y](https://doi.org/10.1186/s12891-026-09537-y))
- [L3] Patients with C1 shoulders differ from healthy controls regarding osseous scapular and humeral morphology, scapulothoracic orientation, and shoulder girdle muscle distribution. [31] ([10.1177/03635465241233706](https://doi.org/10.1177/03635465241233706))
- [L4] NHL team physicians strongly favor nonoperative management in-season for initial posterior instability events of the shoulder. [32] ([10.1177/23259671261440208](https://doi.org/10.1177/23259671261440208))
- [L5] Surgical treatment must balance the necessity to repair torn capsulolabral tissues with the tendency to over constrain the shoulder. [34] ([10.5435/jaaos-d-19-00535](https://doi.org/10.5435/jaaos-d-19-00535))
- [L4] Arthroscopic posterior Bankart repair for traumatic posterior shoulder instability in collision sports athletes resulted in a low recurrence rate, high return-to-play rate, and clinically meaningful improvement. [35] ([10.1016/j.asmr.2025.101264](https://doi.org/10.1016/j.asmr.2025.101264))
- [L4] In such cases, anatomical reduction and retention of the acromion fracture may be needed to prevent recurrent posterior instability. [37] ([10.1016/j.xrrt.2025.09.006](https://doi.org/10.1016/j.xrrt.2025.09.006))
- [L4] Anterior greater tuberosity malunion after posterior shoulder fracture dislocation is a rare and debilitating condition. [38] ([10.1016/j.xrrt.2024.12.002](https://doi.org/10.1016/j.xrrt.2024.12.002))
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