* If we use distance to dislocation as our primary metric then we can compare how the presence of a bone defect affects the distance relative to the intact glenoid (i.e. as a %)
* We can then apply this same approach to testing how completing the Latarjet procedure changes the distance, still probably keeping this in the same relative scale to the intact model (i.e. does it get back to 100%, or how close to intact does the Latarjet get to).
* We can then look at the data across Latarjet variations (i.e. displacement in the vertical and horizontal directions, graft size) in isolation and see what impact this has. From a practical perspective, this might tell us where the optimal positioning is to maximise distance to dislocation; whether larger grafts equate to better outcomes; whether a smaller graft can be used with optimum placement; whether you need bigger grafts if you stray away from optimum placement etc. Examining the results from the individual variations in the context of one another, given they are on the same proportional scale, should theoretically help answer these questions.
* It’s also possible that the above mentioned aspects may vary with different bone defect sizes or types (e.g. Hill-Sachs included?)
* ~~The stress on the glenoid/humerus is probably not a primary measure given some of the more basic approaches or assumptions being made in modelling the cartilage – it is more so there to serve as a somewhat appropriate interaction surface and for a more appropriate joint structure. It may still offer some use in understanding how variations of the Latarjet could alter internal joint structure outside of the focus on dislocation distance (or congruency arc). For example, the medial offset of the bone graft may not have a substantial impact on distance to dislocation, but could introduce an increase in the stress present on the cartilage near the graft (i.e. some ‘pinching’ of cartilage to the bone graft could occur). This would represent a relevant clinical outcome for why not to use such an approach.~~
* ~~How do we model the cartilage in the defect state (is a Bankart type approach akin to Klemt et al. needed here first?) and with the Latarjet graft? How do they do it in clinical practice?~~ 
  + ~~Check how these studies have treated the cartilage (i.e. Klemt et al.; Walia et al. studies)~~
  + ~~Also look at how the meshes are constructed for the cartilage in these studies to determine mesh edge length etc.~~