ANJANI SINHA MEDICAL P.C.

ORTHOPEDIC SURGEON

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ANJANI SINHA, M.D., M.S.(Ortho)

POST - OPERATIVE NOTE

Date: 02/21/20

Patient Name: Suarez, Monserrat

The patient is status post arthroscopy of the (R) Shoulder / Knee on 2-13-20 and comes Today for postoperative follow-up.

The surgical site has healed well.

The dressing was removed.

There is no evidence of any drainage, redness, or discharge from the surgical site.

There is no swelling.

The patient is afebrile.

The patient is very happy with the results of surgery.

The patient has regained almost full mobility of the shoulder/knee.

The patient has **no / minimal** pain.

The patient has regained almost _____% of mobility.

The patient is ambulating and full weight-bearing without any support.

The patient was advised physical therapy ___ times a week for ___ weeks to regain full mobility of the **shoulder / knee**.

The patient was encouraged to call my office if there are any problems.

Otherwise, the patient is dischared from my care.

All City Family Healthcare Center
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OPERATIVE REPORT

PATIENT NAME: Suarez, Monserrat **MEDICAL RECORD #**: 3095633

SURGEON: Anjani Sinha, M.D. **DATE OF SURGERY**: 02/13/2020

DATE OF BIRTH: 12/14/2003

PREOPERATIVE DIAGNOSIS: Right shoulder rotator cuff tear.

POSTOPERATIVE DIAGNOSES:

1. Right shoulder anterior labral tear.
2. Rotator cuff supraspinatus tendon tear.
3. Chondral lesion of the glenoid.
4. Significant hyperemic bursitis.

PROCEDURES:

1. Arthroscopy of the right shoulder.
2. Intra-articular debridement of the anterior labral tear and rotator cuff tendon tear.
3. Extensive bursectomy.
4. Coblation Arthroplasty.

ASSISTANT: David Davydov, P.A.

ANESTHESIA: Interscalene nerve block.

ANESTHESIOLOGIST: Dov Ginsberg, M.D.

EBL: Minimal.

ANTIBIOTICS: IV Ancef.

SECOND ASSISTANT: Due to the complexity of the procedure and for optimal patient care, a physician assistant was needed for successful completion of all the procedures performed.

DESCRIPTION OF PROCEDURE: The patient was identified in the preoperative holding area. The operative site was signed by the surgeon. Informed consent was obtained. The patient was then brought to the operating room. The patient was positioned in a beach chair position and was given Ancef intravenously. Adequate anesthesia with IV sedation and an interscalene nerve

block was achieved. The right upper extremity was prepped and draped in the usual sterile fashion. Anatomic landmarks were marked out. A time-out was performed and the laterality was confirmed to the right shoulder. A standard posterior portal was made with the arthroscope introduced into the joint. An anterior portal was made under direct visualization. A diagnostic arthroscopy has begun. There was a grade 3 chondral lesion of the glenoid rim. The humerus was noted to be in good condition. There was a traumatic tearing of the anterior margin of the labrum. The biceps anchor was stable. The biceps tendon was then pulled into the joint and was noted to be intact but with mild hypertrophic tenosynovitis. The rotator cuff had a partial thickness tearing of the supraspinatus tendon; using the shaver we debride the anterior labral tear down to a stable rim. This was followed by a thorough debridement of the rotator cuff supraspinatus tendon tearing, down to a stable surface. We then used the shaver to perform a thorough debridement of the chondral lesion encountered on the glenoid rim. However, there were unstable margins remaining the shaver could not stabilize and a coblation arthroplasty had to be performed; using an ArthroCare wand and its plasma field, we melded the unstable margins, down to a smooth and stable surface with minimal damage to the surrounding tissue. Hemostasis was then achieved. We then advanced the scope into the subacromial compartment and there was significant hyperemic bursitis encountered; using the shaver, we performed an extensive bursectomy removing the extensive hyperemic bursitis encountered within the subacromial space. Hemostasis was then achieved. no significant bleeding was seen. The arthroscope and instruments were withdrawn. The portals were closed with buried 3-0 Monocryl. Steri-Strips and dry sterile compressive dressing was applied. The arm was placed in a sling. The patient was awakened and brought to the recovery room in satisfactory condition.

Anjani Sinha, M.D.