ANJANI SINHA MEDICAL P.C.

ORTHOPEDIC SURGEON

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

POST - OPERATIVE NOTE

Date: 02/21/2020

Patient Name: Choi, Bong Keun

The patient is status post arthroscopy of the (L) Shoulder / ~~Knee~~ on 2/3/20 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.

Left to PT

All City Family Healthcare Center
3632 Nostrand Ave.
Brooklyn, NY 11229
(718) 332-44092

OPERATIVE REPORT

PATIENT NAME: Choi, Bong Keum

MEDICAL RECORD #: 3095790

SURGEON: Anjani Sinha, M.D.

DATE OF SURGERY: 02/13/2020

DATE OF BIRTH: 03/25/1947

PREOPERATIVE DIAGNOSIS: Left shoulder rotator cuff tear.

POSTOPERATIVE DIAGNOSES:

1. Left shoulder superior SLAP tear.
2. Partial rotator cuff supraspinatus tendon tear.
3. Extensive hypertrophic synovitis.
4. Multiple adhesions, subacromial compartment.
5. Significant hyperemic bursitis.
6. Thickened CA ligament
5. Chondral lesion of the glenoid.

PROCEDURES:

1. Arthroscopy of the left shoulder.
2. Intra-articular debridement of the rotator cuff tendon tear, superior SLAP tear and chondral lesion of the glenoid.
3. Lysis of multiple adhesions, subacromial compartment.
4. Extensive bursectomy.
5. Extensive synovectomy.
6. Lysis of thickened CA ligament.

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 left 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 left 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 extensive inflamed hypertrophic synovium encountered throughout the joint. The articular surface showed a grade 3 chondral lesion of the glenoid rim. The humerus was noted to be in good condition. There was a superior SLAP tearing partial thickness. 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 was then evaluated and there was a partial thickness rotator cuff tear of the anterior supraspinatus tendon. Using the shaver, we performed an extensive synovectomy to address the extensive, inflamed hypertrophic synovium encountered both anteriorly and posteriorly within the glenohumeral joint. Once this was done, we used the shaver to debride the superior SLAP tear down to a stable rim. This was followed by a thorough debridement of the partial rotator cuff supraspinatus tendon tearing, down to a stable surface. We then used the shaver to debride the chondral lesion of the glenoid rim, down to a stable surface. Once this was done, we turned our attention to the subacromial compartment. A lateral portal was made under direct visualization. There was significant hyperemic bursitis seen within the subacromial space. There were multiple adhesions, which were restricting the mobility of the rotator cuff. Using the shaver, we performed an extensive bursectomy removing the significant hyperemic bursitis encountered within the subacromial space. Once this was done, we performed a lysis of multiple adhesions both anteriorly and posteriorly allowing greater mobility of the rotator cuff. There was a thickened CA ligament identified; using the shaver a lysis of the thickened CA ligament was performed, down to a stable surface, preserving its medial attachments. The arm was then placed into range of motion and there were no rotator cuffs tears noted from the subacromial surface. Hemostasis was then achieved, no significant bleeding was seen. 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.