PREOPERATIVE DIAGNOSIS: , Rotator cuff tear, right shoulder.,POSTOPERATIVE DIAGNOSIS: , Superior labrum anterior and posterior lesion (peel-back), right shoulder.,PROCEDURE PERFORMED:,1. Arthroscopy with arthroscopic SLAP lesion.,2. Repair of soft tissue subacromial decompression rotator cuff repair, right shoulder.,SPECIFICATIONS: , The entire operative procedure was done in Inpatient Operating Suite, room #1 at ABCD General Hospital. This was done under a interscalene block anesthetic and subsequent general anesthetic in the modified beachchair position.,HISTORY AND GROSS FINDINGS: ,This is a 54-year-old white female suffering an increasing right shoulder pain for a few months prior to surgical intervention. She had an injury to her right shoulder when she fell off a bike. She was diagnosed preoperatively with a rotated cuff tear.,Intra-articularly besides we noted a large SLAP lesion, superior and posterior to the attachment of the glenoid labrum from approximately 12:30 back to 10:30. This acted as a peel-back type of mechanism and was displaced into the joint beyond the superior rim of the glenoid. This was an obvious avulsion into subchondral bone with bone exposed. The anterior aspect had degenerative changes, but did not have evidence of avulsion. The subscapular was noted to be intact. On the joint side of the supraspinatus, there was noted to be a laminated type of tearing to the rotated cuff to the anterior and mid-aspect of the supraspinatus attachment.,This was confirmed subacromially. The patient had a type-I plus acromion in outlet view and thus

it was elected to not perform a subacromial decompression, but soft tissue release of the CA ligament in a releasing resection type fashion.,OPERATIVE PROCEDURE: , The patient was placed supine upon the operative table after she was given interscalene and then general anesthesia by the Anesthesia Department. She was safely placed in a modified beachchair position. She was prepped and draped in the usual sterile manner. The portals were created from outside the ends, posterior to the scope and anteriorly for an intraoperative portal and then laterally. She had at least two other portals appropriate for both repair mechanisms described above.,Attention was then turned to the SLAP lesion. The edges were debrided both on the bony side as well as soft tissue side. We used the anterior portal to lift up the mechanism and created a superolateral portal through the rotator cuff and into the edge of the labrum. Further debridement was carried out here. A drill hole was made just on the articular surface superiorly for a knotless anchor. A pull-through suture of #2 fiber wire was utilized with the _____. This was pulled through. It was tied to the leader suture of the knotless anchor. This was pulled through and one limb of the anchor loop was grabbed and the anchor impacted with a mallet. There was excellent fixation of the superior labrum. It was noted to be solid and intact. The anchor was placed safely in the bone. There was no room for further knotless or other anchors. After probing was carried out, hard copy Polaroid was obtained.,Attention was then turned to the articular side for the rotator cuff. It was debrided.

Subchondral debridement was carried out to the tuberosity also. Care was taken to go to the subchondral region but not beyond. The bone was satisfactory.,Scope was then placed in the subacromial region. Gross bursectomy was carried out with in the lateral portal. This was done throughout as well as in the gutters anterolaterally and posteriorly. Debridement was carried out further to the rotator cuff. Two types of fixation were carried out, one with a superolateral portal a drill hole was made and anchor of the _knotless suture placed after PDS leader suture placed with a Caspari punch. There was an excellent reduction of the tear posteriorly and then anteriorly. Tendon to tendon repair was accomplished by placing a fiber wire across the tendon and tying sutured down through the anterolateral portal. This was done with a sliding stitch and then two half stitches. There was excellent reduction of the tear.,Attention was then turned to the CA ligament. It was released along with periosteum and the undersurface of the anterior acromion. The CA ligament was not only released but resected. There was noted to be no evidence of significant spurring with only a mostly type-I acromion. Thus, it was not elected to perform subacromial decompression for bone with soft tissue only. A pain buster catheter was placed separately. It was cut to length. An interrupted #4-0 nylon was utilized for portal closure. A 0.5% Marcaine was instilled subacromially. Adaptic, 4x4s, ABDs, and Elastoplast tape placed for dressing. The patient's arm was placed in a arm sling. She was transferred to PACU in apparent satisfactory condition. Expected surgical prognosis

on this patient is fair.