PREOPERATIVE DIAGNOSIS: , Partial rotator cuff tear, left shoulder.,POSTOPERATIVE DIAGNOSIS: , Partial rotator cuff tear, left shoulder.,PROCEDURE PERFORMED:, Arthroscopy of the left shoulder with arthroscopic rotator cuff debridement, soft tissue decompression of the subacromial space of the left shoulder.,ANESTHESIA: ,Scalene block with general anesthesia.,ESTIMATED BLOOD LOSS: , 30 cc.,COMPLICATIONS: , None.,DISPOSITION: ,The patient went to the PACU stable.,GROSS OPERATIVE FINDINGS: , There was no overt pathology of the biceps tendon. There was some softening and loss of the articular cartilage over the glenoid. The labrum was _____ attached permanently to the glenoid. The biceps tendon was nonsubluxable. Upon ranging of the shoulder in internal and external rotation showed no evidence of rotator cuff tear on the articular side. Subacromial space did show excessive soft tissue causing some overstuffing of the subacromial space. There was reconstitution of the bursa noted as well.,HISTORY OF PRESENT ILLNESS:, This is a 51-year-old female had left shoulder pain of chronic nature who has had undergone prior rotator cuff debridement in May with partial pain relief and has had continued pain in the left shoulder. MRI shows partial rotator cuff tear.,PROCEDURE: , The patient was taken to the operating room and placed in a beachchair position. After all bony prominences were adequately padded, the head was placed in the headholder with no excessive extension in the neck on flexion. The left extremity was prepped and draped in usual fashion. The #18 gauge needles were inserted into the

left shoulder to locate the AC joint, the lateral aspect of the acromion as well as the pass of the first trocar to enter the shoulder joint from the posterior aspect. We took an #11 blade scalpel and made a small 1-cm skin incision posteriorly approximately 4-cm inferior and medial to the lateral port of the acromion. A blunt trocar was used to bluntly cannulate the joint and we put the camera into the shoulder at that point of the joint and instilled sterile saline to distend the capsule and begin our arthroscopic assessment of the shoulder. A second port was established superior to the biceps tendon anteriorly under direct arthroscopic visualization using #11 blade on the skin and inserted bluntly the trocar and the cannula. The operative findings found intra-articularly were as described previously gross operative findings. We did not see any evidence of acute pathology. We then removed all the arthroscopic instruments as well as the trocars and tunneled subcutaneously into the subacromial space and reestablished the portal and camera and inflow with saline. The subacromial space was examined and found to have excessive soft tissue and bursa that was in the subacromial space that we debrided using arthroscopic shaver after establishing a lateral portal. All this was done and hemostasis was achieved. The rotator cuff was examined from the bursal side and showed no evidence of tears. There was some fraying out laterally near its attachment over the greater tuberosity, which was debrided with the arthroscopic shaver. We removed all of our instruments and suctioned the subacromial space dry. A #4-0 nylon was used on the three arthroscopic portal and on the

skin we placed sterile dressing and the arm was placed in an arm sling. She was placed back on the gurney, extubated and taken to the PACU in stable condition.