PREOPERATIVE DIAGNOSIS: , Rotator cuff tear, left.,POSTOPERATIVE DIAGNOSES:,1. Sixty-percent rotator cuff tear, joint side.,2. Impingement syndrome.,ANESTHESIA: , General,NAME OF OPERATION:,1. Arthroscopic subacromial decompression.,2. Repair of rotator cuff through mini-arthrotomy.,FINDINGS AT OPERATION: , The patient's glenohumeral joint was completely clear, other than obvious tear of the rotator cuff. The midportion of this appeared to be complete, but for the most part, this was about a 60% rupture of the tendon. This was confirmed later when the bursal side was opened up. Note, the patient also had abrasion of the coracoacromial ligament under the anterolateral edge of the acromion. He did not have any acromioclavicular joint pain or acromioclavicular joint disease noted.,PROCEDURE:, He was given an anesthetic, examined, prepped, and draped in a sterile fashion in a beach-chair position. The shoulder was instilled with fluid from posteriorly, followed by the arthroscope. The shoulder was instilled with fluid from posteriorly, followed by the arthroscope. Arthroscopy was then carried out in standard fashion using a 30-degree Dionic scope. With the scope in the posterior portal, the above findings were noted, and an anterior portal was established. A curved shaver was placed for debridement of the tear. I established this was about a 60-70% tear with a probable complete area of tear which was very small. There were no problems at the biceps or the rest of the joint. The subacromial space showed findings, as noted above, and a thorough subacromial decompression was carried out with a

Bovie, rotary shaver, and bur. I did not debride the acromioclavicular joint. The lateral portal was then extended to a mini-arthrotomy, and subacromial space was entered by blunt dissection through the deltoid. The area of weakness of the tendon was found, and was transversely cut, and findings were confirmed. The diseased tissue was removed, and the greater tuberosity was abraded with a rongeur.
Tendon-to-tendon repair was then carried out with buried sutures of 2-0 Ethibond, giving a very nice repair. The shoulder was carried through a range of motion. I could see no evidence of impingement. Copious irrigation was carried out. The deltoid deep fascia was anatomically closed, as was the superficial fascia. The subcutaneous tissue and skin were closed in layers. A sterile dressing was applied. The patient appeared to tolerate the procedure well.