PREOPERATIVE DIAGNOSIS:, Rotator cuff tear, right shoulder.,POSTOPERATIVE DIAGNOSES:,1. Massive rotator cuff tear, right shoulder.,2. Near complete biceps tendon tear, right shoulder.,3. Chondromalacia of glenohumeral joint, right shoulder.,4. Glenoid labrum tear, right shoulder.,PROCEDURE PERFORMED: ,1. Arthroscopy of the arthroscopic glenoid labrum.,2. Rotator cuff debridement shaving glenoid and humeral head.,3. Biceps tenotomy, right shoulder.,SPECIFICATION: , The entire operative procedure was done in Inpatient Operating Suite, room #1 at ABCD General Hospital. This was done under interscalene block anesthetic in the modified beachchair position.,HISTORY AND GROSS FINDINGS: , This is a 61-year-old white male who is dominantly right-handed. He had increasing right shoulder pain and dysfunction for a number of years prior to surgical intervention. This was gradually done over a period of time. No specific accident or injury could be seen or pointed. He was refractory to conservative outpatient therapy. After discussing alternatives of the care as well as the advantages, disadvantages, risks, complications, and expectations, he elected to undergo the above-stated procedure on this date.,Preoperatively, the patient did not have limitation of motion. He had gross weakness to his supraspinatus, mildly to the infraspinatus and subscapularis upon strength testing prior to his anesthetic.,Intraarticularly, the patient had an 80% biceps tendon tear that was dislocated. His rotator interval was resolved as well as his subscapularis with tearing. The

supraspinatus was completely torn, retracted back beyond the level of the labrum and approximately one-third or so of the infraspinatus was involved with the remaining portion being greatly thinned as far as we could observe. Glenoid labrum had degenerative tear in the inferior surface. Gross chondromalacia was present to approximately 50% of the humeral head and approximately the upper 40% of the glenoid surface.,OPERATIVE PROCEDURE: , The patient was laid supine upon the operative table. After receiving interscalene block anesthetic by the Anesthesia Department, he was safely placed in a modified beachchair position. He was prepped and draped in the usual sterile manner. The portals were created outside the end posteriorly and then anteriorly. A full and complete diagnostic arthroscopy was carried out with the above-noted findings. The shaver was placed anteriorly. Debridement was carried out to the glenoid labrum tear and the last 20% of the biceps tendon tear was completed. Debridement was carried out to the end or attachment of the bicep itself.,Debridement was carried out to what could be seen of the remaining rotator cuff there, but then the scope was redirected in a subacromial direction and gross bursectomy carried out. Debridement was then carried out to the rotator cuff remaining tendon near the tuberosity. No osteophytes were present. Because of the massive nature of the tear, the CA ligament was maintained and there were no substantial changes to the subacromial region to necessitate burring. There was concern because of instability that could be present at the end of this.,Another portal was

created laterally to do all of this. We did what we could to mobilize all sections of the rotator cuff, superiorly, posteriorly, and anteriorly. We took this back to the level of coracoid base. We released the coracohumeral ligament basically all but there was no excursion basically all to the portion of the rotator cuff torn. Because of this, further debridement was carried out. Debridement had been previously carried out to the humeral head as well as glenoid surface to debride the chondromalacia and take this down to the smooth edge. Care was taken to not to debride deeper than that. This was done prior to the above.,All instrumentation was removed. A Pain-Buster catheter was placed into a separate anterolateral portal cut to length. Interrupted #4-0 nylon was utilized for portal closures. Adaptic, 4x4s, ABDs, Elastoplast tape were placed for a compression dressing.,The patient's arm was placed in an arm sling. He was transferred to his cart and to the PACU in apparent satisfactory condition. Expected surgical prognosis on this patient is quite guarded because of the above-noted pathology.