PREOPERATIVE DIAGNOSIS:, Torn rotator cuff, right shoulder.,POSTOPERATIVE DIAGNOSES:,1. Torn rotator cuff, right shoulder.,2. Subacromial spur with impingement syndrome, right shoulder.,PROCEDURE PERFORMED:,1. Diagnostic arthroscopy with subacromial decompression.,2. Open repair of rotator cuff using three Panalok suture anchors.,ANESTHESIA: , General.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: ,Approximately 200 cc.,INTRAOPERATIVE FINDINGS: , There was noted to be a full thickness tear to the supraspinatus tendon at the insertion of the greater tuberosity. There is moderate amount of synovitis noted throughout the glenohumeral joint. There is a small subacromial spur noted on the very anterolateral border of the acromion.,HISTORY: , This is a 62-year-old female who previously underwent a repair of rotator cuff. She continued to have pain within the shoulder. She had a repeat MRI performed, which confirmed the clinical diagnosis of re-tear of the rotator cuff. She wished to proceed with a repair. All risks and benefits of the surgery were discussed with her at length. She was in agreement with the above treatment plan.,PROCEDURE: , On 08/21/03, she was taken to the Operative Room at ABCD General Hospital. She was placed supine on the operating table. General anesthesia was applied by the Anesthesiology Department. She was placed in the modified beachchair position. Her upper extremity was sterilely prepped and draped in usual fashion. A stab incision was made in the posterior aspect of the glenohumeral joint. A camera was placed in the joint and was insufflated with saline

solution. Intraoperative pictures were obtained and the above findings were noted. A second port site was initiated anteriorly. Through this a probe was placed and the intraarticular structures were palpated and found to be intact. A tear of the inner surface of the rotator cuff was identified. The camera was then taken to the subacromial space. A straight lateral portal was also used and a shaver was placed into the subacromial space. Further debridement of the anterolateral border of the acromion was performed to remove evidence of the subacromial spur, which had reformed. The edges of the rotator cuff were then debrided. The camera was then removed and the shoulder was suction and dried. A lateral incision was made over the anterolateral border of the acromion. Subcuticular tissues were carefully dissected. Hemostasis was controlled with electrocautery. The deltoid musculature was then incised and aligned with its fibers exposing the rotator cuff tear and the edges were further debrided using a rongeur. A trough was then made in the greater tuberosity using the rongeur. Two Panalok anchors were then placed within the trough and weaved through the suture and third Panalok anchor was placed medial to the trough and weaved through the rotator cuff. The ends of the suture were tied down from the fixating the rotator cuff within the trough. The rotator cuff was then further oversewed using the Panalok suture. The wound was then copiously irrigated and it was then suction dried. The deltoid muscle was reapproximated using #1 Vicryl. A continuous infusion pump catheter was placed into the subacromial space to help with

postoperative pain control. The subcutaneous tissues were reapproximated with #2-0 Vicryl. The skin was closed with #4-0 PDS running subcuticular stitch. Sterile dressing was applied to the upper extremity. She was then placed in a shoulder immobilizer. She was transferred to the recovery room in apparent stable and satisfactory condition. Prognosis for this patient was guarded. She will begin pendulum exercises postoperative day #3. She will follow back in the office in 10 to 14 days for reevaluation. Physical therapy initiated approximately six weeks postoperatively.