THE SURGERY CENTER AT DORAL
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OPERATIVE REPORT

PATIENT NAME: GARCIA CORDON DE LEAL, MARIA MERCEDES
MEDICAL RECORD#: 15193
DATE OF BIRTH: 08/11/1965
PHYSICIAN: ALEJANDRO BADIA, M.D.
DATE OF SURGERY: 02/09/2021

PREOPERATIVE DIAGNOSES:
Right shoulder chronic pain with suspected rotator cuff tear.

POSTOPERATIVE DIAGNOSES:
1. Partial thickness tear of the supraspinatus rotator cuff.
2. Diffuse glenohumeral joint synovitis.
3. Mild subacromial impingement with bursitis.

PROCEDURES PERFORMED:
1. Right shoulder rotator cuff repair using biodinductive patch graft.
2. Right shoulder arthroscopic synovectomy and debridement.
3. Right shoulder arthroscopic acromioplasty with subacromial bursectomy.
4. Thermal shrinkage capsulorrhaphy to stabilize labrum and anterior capsule (unlisted procedure).
5. Injection of autologous conditioned plasma.

FIRST ASSISTANT: Kate I. Samuels, PA-C.

ANESTHESIA: Interscalene regional block coupled with LMA anesthesia.

DESCRIPTION OF PROCEDURE:
The right shoulder was sterilely prepped once the patient was placed into the lateral decubitus position. All bony prominences were well padded. Traction was applied to the arm in abduction. The sterile drapes were applied and the bony landmarks of the shoulder were drawn out using a sterile marking pen. We now inserted the arthroscope into the posterior portal immediately noting that there was diffuse synovitis in the glenohumeral joint. Then, as we looked superiorly, there was obvious fraying of tissue suggestive of at least an undersurface rotator cuff tear. To better identify this, the anterior portal was created using a Wissinger rod technique. This allowed us to insert a full-radius shaver and begin the process of arthroscopic debridement. Synovectomy was also performed. This allowed us to better visualize the pathology. There was significant redundancy and thinning of the capsule with marked synovitis and areas of fraying as well. At this point, clinical decision was made that the labrum would not need re-attachment, but rather stabilization which would be done with thermal shrinkage. To prepare for that, we created a lateral portal. The anterior capsule also underwent thermal shrinkage capsulorrhaphy by using a striping technique with the radiofrequency shrinkage probe. Multiple horizontal stripes were created that would avoid thermal injury but stabilize the capsule. We now inspected the biceps tendon nothing that there was no disruption. We confirmed that the labrum had a very stable appearance and we would likely proceed with graft patch of this partial cuff tear. This would be determined from the subacromial space. The arthroscope was now placed subacromially. The subacromial space was exposed and debrided, and we began the bursectomy. As we looked down onto the rotator cuff, we noted that indeed there was fraying of the cuff, but the undersurface tear did not extend fully to the bursal surface. Therefore, we now proceeded with insertion of the bioinductive graft patch.

This was an allograft tissue, which was placed on the outside of the supraspinatus to essentially augment the rotator cuff. To do that, we removed the lateral cannula and an introducer device was inserted through the lateral