PREOPERATIVE DIAGNOSIS: , Femoroacetabular impingement.,POSTOPERATIVE DIAGNOSIS: , Femoroacetabular impingement.,OPERATIONS PERFORMED,1. Left hip arthroscopic debridement.,2. Left hip arthroscopic femoral neck osteoplasty.,3. Left hip arthroscopic labral repair.,ANESTHESIA: , General.,OPERATION IN DETAIL: , The patient was taken to the operating room, where he underwent general anesthetic. His bilateral lower extremities were placed under traction on the Hana table. His right leg was placed first. The traction post was left line, and the left leg was placed in traction. Sterile Hibiclens and alcohol prep and drape were then undertaken. A fluoroscopic localization was undertaken. Gentle traction was applied. Narrow arthrographic effect was obtained. Following this, the ProTrac portal was made under the fluoro visualization, and then, a direct anterolateral portal made and a femoral neck portal made under direct visualization. The diagnostic arthroscopy showed the articular surface to be intact with a moderate anterior lip articular cartilage delamination injury that propagated into the acetabulum. For this reason, the acetabular articular cartilage was taken down and stabilized. This necessitated takedown of the anterior lip of the acetabulum and subsequent acetabular osteoplasty debridement with associated labral repair. The labrum was repaired using absorbable Smith & Nephew anchors with a sliding SMC knot. After stabilization of the labrum and the acetabulum, the ligamentum teres was assessed and noted to be stable. The remnant articular surface of the femoral artery

and acetabulum was stable. The posterior leg was stable. The traction was left half off, and the anterolateral aspect of the head and neck junction was identified. A stable femoral neck decompression was accomplished starting laterally and proceeding anteriorly. This terminated with the hip coming out of traction and indeterminable flexion. A combination of burs and shavers was utilized to perform a stable femoral neck osteoplasty decompression. The decompression was completed with thorough irrigation of the hip. The cannula was removed, and the portals were closed using interrupted nylon. The patient was placed into a sterile bandage and anesthetized intraarticularly with 10 mL of ropivacaine subcutaneously with 20 mL of ropivacaine and at this point was taken to the recovery room. He tolerated the procedure very well with no signs of complications.