Global Surgery Center

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Right Shoulder Arthroscopy Operative Report

Patient Name:	Hernandez, Concepcion
Medical Record Number:	03749
Date of Birth:	10/21/1962
Date of Procedure:	07/16/2022
Surgeon:	Michael Murray, MD.
Assistant:	Robert Yuen, P.A.
Anesthesiologist:	Dr. Sany.

Preoperative Diagnosis:
Rotator cuff tear, right shoulder.

Postoperative Diagnoses:
1. M75.41 Impingement syndrome, right shoulder.
2. M75.121 Complete rupture, rotator cuff, right shoulder.
3. S43.431A Labral tear, right shoulder.
4. M65.811 Synovitis, right shoulder.
5. M75.51 Bursitis, right shoulder.
6. M24.10 Glenoid chondral defect, right shoulder.

Operative Procedure:
1. 29805 Shoulder diagnostic.
2. 29823 Major debridement.
3. 29821 Complete synovectomy.
4. 29999 Coblation arthroplasty glenoid.
5. 29825 Lysis of adhesions.
6. 29999 Bursectomy.
7. 29826 Decompression, partial acromioplasty.
8. 29999 Release of CA ligament.
9. 29999 Chondroplasty glenoid.
10. 29827 RC repair arthroscopically.

Anesthesia: Deep sedation with regional nerve block.

Estimated Blood Loss: Minimal.

Complications: None.

Instrumentation: Arthrex SwiveLock.

Intraoperative Findings:

1. Hypertrophic synovitis.
2. Partial thickness tearing of the biceps.
3. SLAP tear.
4. Full thickness tearing of the supraspinatus tendon.

Indications for Surgery:

The patient failed a course of nonoperative therapy. The patient elected to undergo the about procedures. The risks and possible complications of the shoulder arthroscopy were discussed in detail with the patient. These risks include, but are not limited to ongoing pain, immobility, infection, vascular injury and nerve damage including axillary nerve dysfunction, reflex sympathetic dystrophy, compartment syndrome, limb loss and even death.

The patient understood the risks, complications and the possible benefits of the procedure and verbalized understand. The patient was also made aware of the alternatives to surgery. An informed consent was obtained, and was checked immediately preop.

Description of Procedure:

The patient was identified in the preoperative holding area. The operative site was signed by a surgeon. Informed consent was obtained. The patient was then brought to the operating room. The patient was positioned in a beach chair position and was given Ancef intravenously. Adequate anesthesia with IV sedation and an interscalene nerve block was achieved. The right upper extremity was prepped and draped in the usual sterile fashion. Anatomic landmarks were marked out. A time-out was performed and the laterality was confirmed to the right shoulder.

The posterior portal was made for access of the scope and cannula. Upon entering the joint, the examination was begun. There was extensive hypertrophic synovitis throughout the joint. There were no loose bodies seen. The articular surfaces were relatively clean. The biceps had a partial thickness tearing on its more lateral surface on its insertion superiorly to the glenoid and there was a SLAP tearing extending somewhat down the anterior rim partial thickness. The subscapularis was intact. There were no loose bodies in the anterior region and the rotator cuff had a full thickness tearing of the supraspinatus tendon.

At this point, an anterior rotator interval portal was developed through which we placed a shaver to perform an extensive synovectomy both anteriorly and posteriorly removing the extensive hypertrophic synovitis encountered within the glenohumeral compartment. Once this was accomplished, a thorough intra articular debridement of the SLAP tearing was performed, down to a smooth and stable rim. This was followed by a thorough debridement of the biceps tendon tearing, down to a smooth and stable surface. Hemostasis was then achieved.

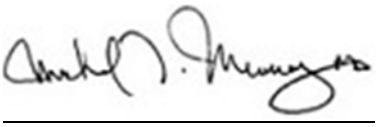
We then advanced the scope into the subacromial compartment where significant hyperemic bursitis was seen and multiple adhesions were restricting the mobility of the rotator cuff. Through a lateral portal, we placed the shaver to perform an extensive bursectomy removing the significant hyperemic bursitis encountered within the subacromial space.

Once this was accomplished lysis of multiple adhesions was performed extending from anterior to posterior allowing greater mobility of the rotator cuff. This was followed by lysis of thickened coracoacromial ligament attachment to the undersurface of the acromion preserving its medial attachment. We then performed a subacromial decompression with partial acromioplasty for the Type III acromion.

Next, we prepared the greater tuberosity footprint with a high-speed burr. Once this was done, we passed two Suture tapes in a horizontal mattress fashion. We then brought all four limbs laterally in an Arthrex 4.75 mm Biocomposite SwiveLock. Once this was accomplished, we noticed a dog ear of the repair posteriorly. Using the knotless mechanism, we passed a suture through the dog ear and was able to tension it down. The repair was probed and noted to have excellent reduction of the tear. Trial range of motion was carried out and seemed satisfactory. Hemostasis was maintained. Arthroscopic pictures were taken throughout the procedure for documentation.

A 3–0 Monocryl was used to close the entrance portals. Dry sterile dressing was applied. The patient was transferred to PACU in stable condition.

Physician Assistant:
Throughout the procedure, I was assisted by a physician assistant, licensed in the State of New York/New Jersey. He assisted in positioning the patient on the operating room table as well as transferring the patient from the operating room table to the recovery room stretcher. He assisted me during the actual procedure with positioning of the patient's extremity to allow for ease of arthroscopic access to all areas of the joint. The presence of physician assistant as my operating assistant was medically necessary to ensure the utmost safety of the patient in the operative, interim and postoperative period.



Michael Murray, MD
Board Certified Orthopedic Surgeon