SURGICARE OF BROOKLYN

313 43rd St.
Brooklyn, NY 11232
Phone: (201) 549-9998 – Fax: (646) 585-4468

Right Shoulder Arthroscopy Operative Report

PATIENT NAME:	Cardenas, Nilson
MEDICAL RECORD NUMBER:	16092
DATE OF BIRTH:	03/31/1955
DATE OF PROCEDURE:	09/22/2022
SURGEON:	Richard E. Pearl, MD.
ASSISTANT:	Angel M. Leal, PA-C.
PREOPERATIVE DIAGNOSIS:	Internal derangement, right shoulder.
POSTOPERATIVE DIAGNOSES:	M75.01 Adhesive capsulitis, right shoulder. M75.41 Impingement syndrome, right shoulder. M24.811 Internal derangement, right shoulder. S46.011A Partial rotator cuff tear, right shoulder. S43.431A Labral tear, right shoulder. M65.811 Synovitis, right shoulder. M75.51 Bursitis, right shoulder. M75.81 Subacromial adhesions, right shoulder. M94.211 Chondromalacia glenoid/humeral head, right shoulder.
OPERATIVE PROCEDURE:	29823 Major debridement. 29821 Complete synovectomy. 29819 Loose body removal or fragments. 29999 Coblation arthroplasty glenoid. 29825 Lysis of adhesions. 29999 Bursectomy. 29826 Decompression, partial acromioplasty. 20610 Intraarticular injection, PRP. 29828 Biceps tenodesis.
ANESTHESIA:	Nerve block, IV sedation.
POSITION:	Beach chair.
ESTIMATED BLOOD LOSS:	Minimal.
COMPLICATIONS:	None.
INSTRUMENTATION:	Speedscrew, 2 tapes.

INTRAOPERATIVE FINDINGS:
Labral tear (anterior, superior, inferior).
Chondromalacia glenoid, grade II.
Chondromalacia humeral head, grade II.
Loose fragments.
SLAP tear, grade IV.
Partial thickness rotator cuff tear, supraspinatus.
Synovitis.
Subacromial adhesions.
Adhesive capsulitis.
Impingement.
Subscapularis tendon tear.
Bursitis.

INDICATIONS FOR SURGERY:
After failing a course of nonoperative therapy, the patient elected to undergo the above procedure. In the office, the risks and possible complications of the procedure were discussed in detail with the patient. The patient verbalized understanding and elected to have the procedure performed today.

Informed consent was obtained and checked immediately preoperatively.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and placed supine on the operating table. The anesthesiologist administered appropriate anesthesia. The patient was placed in a beach chair position. The head was carefully stabilized. All bony prominences were well-padded. The patient's right upper extremity was prepped and draped in the usual standard surgical fashion. A time out was done. The patient was given IV-antibiotic prophylaxis.

A stab incision was made in the posterior portal site 2 cm distal from the posterior acromion and 2 cm medial. A blunt cannula was passed from the posterior portal site into the glenohumeral joint. The arthroscope was placed. The glenohumeral joint was evaluated. A spinal needle was passed in the anterior portal site into the rotator interval. A small stab incision was made and a probe was placed through the anterior portal site into the glenohumeral joint.

Using arthroscopic visualization, the entire glenohumeral joint was evaluated including the subscapularis, supraspinatus, infraspinatus, biceps tendon, the full labrum including the anterior, superior, posterior and inferior surface. All edges were probed. The surface of the humeral head and the glenoid were evaluated with the arthroscope and a probe. The inferior pouch was also visualized for any unstable lesions.

Synovectomy:
There was synovitis seen with the arthroscope at the anterior portal site, near the rotator cuff and at the margins of the labrum. A synovectomy was completed to smooth margins using a full radius shaver and radiofrequency wand. The synovectomy removed inflammatory

synovitis and allowed for full arthroscopic visualization. Hemostasis was maintained. Arthroscopic pictures were taken.

Anterior Capsular Release:
The anterior capsule was visualized with the arthroscope. The subscapularis and middle glenohumeral ligament was visualized and evaluated. Using a radiofrequency wand, the anterior capsule was released to improve range of motion and mobility. Hemostasis was maintained. Arthroscopic pictures were taken.

Anterior Labral Bankart Tear Without Repair:
Using arthroscopic visualization, a tear was seen in the anterior labrum. The tear was probed and there was firm attachment to the underlying glenoid. The tear was debrided to smooth margins using a full radius shaver and a radiofrequency wand. The anterior labrum was probed again and was well attached to the underlying glenoid. Hemostasis was well maintained. Arthroscopic pictures were taken.

SLAP Without Repair:
Using arthroscopic visualization, there was a SLAP labral tear seen underneath the biceps. The tear was probed and was attached to the underlying glenoid. The tear was debrided to smooth margins using a full radius shaver and a radiofrequency wand. The SLAP labral tear was probed again and had a firm attachment to the underlying labrum. The biceps was also stable. A decision was made to avoid a repair. Hemostasis was well maintained. Arthroscopic pictures were taken.

Biceps Tear With Tenodesis:
Using arthroscopic visualization, there was a biceps tendon tear seen and it was evaluated. The tear was probed and was unstable. It was nearly a full thickness tear. Using a working cannula through the anterior portal, a lasso was placed through the biceps near its insertion in the labrum. A suture was then passed and the lasso removed. A tenotomy was completed at the insertion point using a full radius shaver and radiofrequency wand. The remainder of the biceps was carefully debrided at the labrum. All soft tissue was removed from the bicipital groove and the bone was carefully decorticated. The suture was passed to an anchor and the anchor was passed into the bicipital groove under arthroscopic visualization. The suture was shortened and excess suture was removed. The biceps tendon was probed and was stable. The tenodesis was complete. Hemostasis was well maintained. Arthroscopic pictures were taken.

Subscapularis Tear Without Repair:
Using arthroscopic visualization, there was a tear seen in the subscapularis of the rotator cuff. The tear was debrided to smooth margins using a full radius shaver and radiofrequency wand. The subscapularis was then probed and was noted to be stable. No repair was done. Hemostasis was well maintained. Arthroscopic pictures were taken.

Coblation Arthroplasty of the Glenoid:
Under arthroscopic visualization, there was glenoid lesion seen on the glenoid surface. The chondral margins were evaluated with a probe. The shaver was used to debride the chondral lesion of the glenoid rim. Once this was done, there were unstable margins remaining and a

coblation arthroplasty had to be performed to stabilize these margins. Using an ArthroCare wand and its plasma field, we melded the unstable margins down to a stable surface. The chondral surface was evaluated again using arthroscopic visualization and a probe. The surface was stable with no loose fragments. Hemostasis was well maintained and arthroscopic pictures were taken.

Removal of Loose Bodies:
Using arthroscopic visualization, multiple loose bodies were seen in the glenohumeral joint. All loose bodies were removed until none remained. A grasper was used as necessary. The inferior pouch was also evaluated and was free of any unstable lesions. Hemostasis was well maintained and arthroscopic pictures were taken.

Subacromial Decompression With Acromioplasty:
Using a blunt probe, the cannula and arthroscope was placed in the subacromial space through the posterior portal site. The subacromial space was evaluated. A spinal needle was passed through the lateral portal site approximately 1 cm below the lateral acromion margin. The spinal needle was visualized with the arthroscope and a small stab incision was made. A blunt probe was placed. There was excessive bursitis. A bursectomy was completed using a full radius shaver and radiofrequency wand. The coracoacromial ligament was evaluated under arthroscopic visualization and was impinging on the subacromial surface of the rotator cuff. The coracoacromial ligament was excised using a full radius shaver and radiofrequency wand. Hemostasis was well maintained. The acromion was evaluated and was hooked. A full radius burr was used for an acromioplasty. The hook was removed as well as the under surface of the acromion until the underlying rotator cuff was well decompressed. The rotator cuff was fully evaluated from the subacromial space with the arthroscope and a probe. Hemostasis was well maintained. Arthroscopic pictures were taken.

Rotator Cuff Tear Repair with Bioinductive Implant with PLGA Anchor:
The rotator cuff was fully evaluated from the subacromial space using arthroscopic visualization and a probe. A partial tear was seen on the surface. The tear was probed and was not full thickness. There was good coverage of the humeral head. A decision was made to avoid a repair. The subacromial space had adequate space for the underlying rotator cuff. Hemostasis was well maintained. Arthroscopic pictures were taken. The partial rotator cuff tear was repaired using the Smith and Nephew Bioinductive Implant and PLGA anchor.

Lysis of Adhesions:
While evaluating the subacromial space, there were several adhesions seen overlying the rotator cuff and acromion. These adhesions were carefully removed using the arthroscopic shaver and radiofrequency wand. A gentle range of motion procedure was done to ensure the adhesions were adequately removed and no restriction of motion was seen. Hemostasis was well maintained. Arthroscopic pictures were taken.

PRP Injection:
A PRP injection was performed into the right shoulder via an arthroscopically placed needle under direct visualization.

The subacromial space was evaluated once again. No unstable lesions remained. Hemostasis was maintained throughout the procedure. The subacromial space was suctioned. The arthroscope and shaver were removed. The incisions were closed using nylon suture. A sterile dressing was placed. The patient was placed in the supine position, weaned from anesthesia, and brought to the recovery room in satisfactory condition.

PHYSICIAN ASSISTANT:

Throughout the procedure, I was assisted by a physician assistant, licensed in the State of New York. 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.

Richard E. Pearl MD

Richard E. Pearl, MD