

All City Family Healthcare Center

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Right Shoulder Arthroscopy Operative Report

Patient Name: Rosario, Roberto

Medical Record Number: 3357389

Date of Birth: 04/07/1992

Date of Procedure: 10/19/2022

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.
S46.101A Biceps tendon tear, 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, right shoulder.

Operative Procedure: 29805 Shoulder diagnostic.
29823 Major debridement.
29821 Complete synovectomy.
29819 Loose body removal or fragments.
29999 Coblation arthroplasty glenoid.
29825 Lysis of adhesions.
29999 Bursectomy.
29999 Release of CA ligament.
20610 Intraarticular injection.
0232T PRP injection.

ANESTHESIA: Nerve block, IV sedation.

POSITION: Beach chair.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None.

INSTRUMENTATION: None.

Intraoperative Findings:

Labral tear (anterior, superior).

Chondromalacia glenoid, grade I.

SLAP tear, grade I.

Partial thickness rotator cuff tear, supraspinatus.

Partial biceps tear, 5%.

Synovitis.

Subacromial adhesions.

Adhesive capsulitis.

Impingement.

Subscapularis tendon tear.

Bursitis.

Indications for Surgery:

Indications: After failing a course of nonoperative therapy, the patient elected to undergo the above 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 continued pain, lack of motion, infection, vascular injury and nerve injury including axillary nerve dysfunction, reflex sympathetic dystrophy, compartment syndrome, limb loss and death.

The patient expressed an understanding of the risks and possible benefits of the procedure and 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 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.

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.

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.

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.

Subacromial Bursectomy:

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. Using arthroscopic visualization, the space was evaluated and there was excessive bursitis. A bursectomy was completed using a full radius shaver and radiofrequency wand. Hemostasis was well maintained. The acromion was evaluated and was not impinging on the underlying rotator cuff. A decision was made to avoid an acromioplasty as it was not compressing the underlying rotator cuff. The rotator cuff was fully evaluated from the subacromial space with the arthroscope and a probe. 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.

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.

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.

PRP Injection:

Blood was drawn from the patient's arm and processed in the centrifuge. The PRP was injected into the right shoulder subacromial space, after the surgical incisions were closed, with the patient still in the operating room. A sterile dressing was placed. The patient was then weaned from anesthesia, transferred to a postoperative stretcher 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