SURGICARE OF BROOKLYN

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Right Shoulder Arthroscopy Operative Report

Patient Name:	Washington, Bernita
Medical Record Number:	16728
Date of Birth:	12/13/1957
Date of Procedure:	10/13/2022
Surgeon:	Upendra K. Sinha, MD.
Assistant:	Gennadiy Shamalov, P.A.
Preoperative Diagnosis:	Rotator cuff tear, right shoulder.
Postoperative Diagnoses:	M75.01 Adhesive capsulitis, right shoulder. M75.41 Impingement syndrome, right shoulder. M24.811 Internal derangement, right shoulder. M75.121 Complete rupture, rotator cuff, 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 humeral head, right shoulder.
Operative Procedure:	29823 Major debridement. 29821 Complete synovectomy. 29819 Loose body removal or fragments. 29825 Lysis of adhesions. 29999 Bursectomy. 29826 Decompression, partial acromioplasty. 29999 Release of CA ligament. 20610 Intraarticular injection. 29827 RC repair arthroscopically. 29999 Chondroplasty humeral head.
Anesthesia:	Nerve block, IV sedation.
Position:	Beach chair.
Estimated Blood Loss:	Less than 20 mL.
Complications:	None.
Instrumentation:	None.

Intraoperative Findings:
Labral tear.
Chondromalacia humeral head.

Loose fragments.
Full thickness rotator cuff tear.
Biceps tendonitis.
Synovitis.
Subacromial adhesions.
Adhesive capsulitis.
Impingement.
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.

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 Labral Tear With No 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.

Superior Labral Tear With No Repair:
Using arthroscopic visualization, a tear was seen in the superior 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 superior labrum was probed again and was well attached to the underlying glenoid. Hemostasis was well maintained. Arthroscopic pictures were taken.

Inferior Labral Tear With No Repair:
Using arthroscopic visualization, a tear was seen in the inferior 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 inferior labrum was probed again and was well attached to the underlying glenoid. Hemostasis was well maintained. Arthroscopic pictures were taken.

Chondroplasty of the Humeral Head:
Under arthroscopic visualization, there was chondromalacia seen on the humeral head. The chondral margins were evaluated with a probe. A chondroplasty was completed to smooth margins using a full radius shaver and radiofrequency wand. 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.

Lysis of the Coracoacromial Ligament:
Using arthroscopic visualization, the coracoacromial ligament was evaluated and was contributing to impingement in the subacromial space and the rotator cuff. The coracoacromial ligament was lysed using the radiofrequency wand. Hemostasis was maintained. Using arthroscopic visualization and a probe, the ligament was no longer causing impingement. Arthroscopic pictures were taken.

Rotator Cuff Tear With Repair, 2 anchors:
After the subacromial space was cleared, the rotator cuff was evaluated using the arthroscope and a probe. There was a clear full thickness tear. Because of the size and retraction, a decision was made to repair the tear with two anchors. The edges of the tear were debrided to smooth margins and all soft tissue was removed from the greater tuberosity. The rotator cuff was carefully mobilized using a grasper and by

undermining the tear with a blunt probe. The surface of the greater tuberosity was decorticated. The margins were evaluated arthroscopically and with a probe. A Mattress suture was used to mobilize the rotator cuff tear at its anterior margin. A probe was used as well. The tear was well mobilized. The suture was passed with anchor fixation into the greater tuberosity. The excess suture was shortened and removed. In a similar fashion, a second suture was placed posteriorly in the tear. The suture was passed to an anchor and fixed in position to the posterior greater tuberosity. The rotator cuff repair was probed and was stable. There was good coverage of the humeral head. Any remaining bursa was removed with a shaver. All debris was suctioned. The subacromial space had adequate space and there was nothing impinging on the rotator cuff repair. Hemostasis was well maintained. 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. 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.

U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon