NORTH QUEENS SURGICAL CENTER
45-64 Francis Lewis Blvd.
Bayside, NY 11361
Phone: (929) 258-7720 Fax: (929) 258-7722

OPERATIVE REPORT

PATIENT NAME: ALVAREZ, ZAIDA **MEDICAL RECORD #**: 18810

SURGEON: ANJANI SINHA, M.D.**DATE OF SURGERY**: 09/14/2019

DATE OF BIRTH: 11/03/1953

PREOPERATIVE DIAGNOSIS: Left shoulder partial rotator cuff tear.

POSTOPERATIVE DIAGNOSIS: Left shoulder partial rotator cuff tear,
SLAP tear type 1
Thickened CA ligament
Multiple adhesions in subacromial compartment
Hyperemic bursitis.

PROCEDURES:

1. Left shoulder arthroscopy.
2. Debridement of SLAP tear
3. Debridement of rotator cuff tear of the supraspinatus tendon.
4. Lysis of multiple adhesions within the subacromial compartment
5. Lysis of thickened CA ligament.
6. Extensive bursectomy.

SURGEON: Anjani Sinha, M.D.

ASSISTANT: Robert Yuen, PA.

ANESTHESIA: Interscalene nerve block with IV sedation.

ANESTHESIOLOGIST: Dr. Kehar.

ANTIBIOTICS: IV Ancef.

EBL: Minimum.

PREOPERATIVE INDICATIONS: The patient is a 65-year-old female who sustained a left shoulder injury in a motor vehicle accident. She failed all conservative treatment and is now indicated for a left shoulder arthroscopy. The patient understood the risks and benefits of the procedure and wished to proceed.

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 brought to the operating room. She was positioned in a beach chair position and IV Ancef was given. Adequate anesthesia with IV sedation and interscalene nerve block was achieved. The left upper extremity was prepped and draped in the usual sterile fashion. Anatomic landmarks were marked out. A time-out was performed and laterality was confirmed to the left shoulder. A standard posterior portal was made and the arthroscope introduced into the joint. An anterior portal was made under direct visualization and

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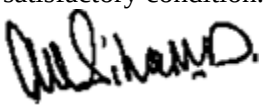
diagnostic arthroscopy was begun. Upon entering the glenohumeral joint, the articular cartilage of the glenoid and the humerus was noted to be in good condition. The labrum was then probed and a type 1 SLAP tear was identified. The biceps anchor was stable. The biceps tendon was then pulled into the joint and noted to have no tear but with hypertrophic tenosynovitis. The rotator cuff was then evaluated and approximately 10% of the partial rotator cuff tear of the anterior supraspinatus tendon was noted. We then used a shaver to perform a thorough debridement of the SLAP tear type 1 down to a smooth and stable rim. Thermal shrinkage was also applied using the radiofrequency device. This was followed by a thorough debridement of the rotator cuff supraspinatus tendon using a shaver and ArthroCare from the articular side down to a stable surface. Next, we turned our attention to the subacromial compartment where a lateral portal was made under direct visualization. There was significant hyperemic bursitis seen and using the shaver and ArthroCare, we performed an extensive bursectomy removing significant bursitis encountered within the subacromial space. This was followed by the lysis of a thickened CA ligament using the ArthroCare wand. The arm was placed into range of motion and there were no rotator cuffs tears noted from the subacromial surface. There were multiple adhesions, which were restricting the mobility of the rotator cuff. Using the shaver, we performed lysis of multiple adhesions also anteriorly and posteriorly allowing a greater mobility of the rotator cuff. Hemostasis was achieved using radiofrequency device with no significant bleeding. Arthroscope and instruments were withdrawn. The portals were closed with buried 3-0 Monocryl. Steri-Strips and dry sterile compressive dressing was applied. The arm was placed in a sling. The patient was awakened and brought to the recovery room in a satisfactory condition.



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Anjani Sinha, M.D.

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