09/28/2010 - Operative Report: OPERATIVE REPORT
Provider: Derek E Lamprecht, DO
Location of Care: Northwest ASC

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OPERATIVE REPORT

DATE OF PROCEDURE: 09/28/2010

PATIENT NAME: FRANK

MRN: 10506

PREOPERATIVE DIAGNOSES:
1. Acute-on-chronic mass of right rotator cuff tear.
2. Biceps tear.

POSTOPERATIVE DIAGNOSES:
1. Acute-on-chronic mass of right rotator cuff tear.
2. Biceps tear.

PROCEDURE PERFORMED:
1. Right shoulder arthroscopy with arthroscopic rotator cuff repair.
2. Subacromial decompression.
3. Biceps tenotomy.

SURGEON: Derek Lamprecht, D.O.

FIRST ASSISTANT: Marilyn Webber, M.D.

ANESTHESIA: General with interscalene block.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: Minimal.

COMPONENTS: Three Dupuy Mitek 5.5-mm BR anchors double loaded with Orthocord were used.

HISTORY: Patient is a 66-year-old right-hand-dominant male who has had significant dysfunction and pain in his shoulder since an injury on 08/20/2010. Of note, he had a previous rotator cuff repair several years ago and did fairly well after that. Physical

examination as well as MRI were consistent with the above-named diagnoses. Due to the patient's large tear and significant dysfunction, I did recommend the above-named procedure. A PAR-Q conference was held. Risks of the procedure included but were not limited to infection, injury to nerve, artery, or vessel, shoulder stiffness, failure to relieve all symptoms, and need for further surgery. He understood his diagnosis, treatment options, and risks involved and agreed to proceed with surgery as indicated.

DESCRIPTION OF PROCEDURE: The patient underwent an interscalene block in the preoperative area. He was then transferred from the preoperative area to operative suite #1 and placed on the operating table in the supine position. All bony prominences were well padded. The Department of Anesthesia administered general anesthetic to the patient. Once sufficient anesthesia was obtained, he was properly placed in the beach-chair position. An examination under anesthesia was performed. He had elevation to 180 degrees, external rotation to 90 degrees, and internal rotation to 70 degrees. Negative load and shift test. The right upper extremity and shoulder were then sterilely prepped and draped in the usual sterile fashion.

All bony prominences were outlined. The McConnell arm holder was used throughout the procedure. The shoulder joint was insufflated. A posterior portal was established. A camera was inserted into the glenohumeral joint. An accessory anterior portal was established, and a gray cannula was inserted. The shoulder joint was then sequentially examined and pictures taken of each area. The biceps tendon was subluxed out of the groove and displaced anteriorly anterior to the subscapularis tendon. Some fraying and peripheral tearing of the labrum but overall, it remained intact. The glenoid cartilage was intact. There was grade 3 chondromalacia in the humeral head and superior aspect. The main articular portion was intact. There was 100% tear of the supraspinatus and infraspinatus tendon. The teres minor was intact. The axillary pouch was clear. The posterior labrum was intact. An arthroscopic shaver was inserted, and the intra-articular portion was debrided. A scissor was then inserted, and a biceps tenotomy was performed. The biceps stump was then debrided back to a stable portion. Pre and post pictures were taken.

The camera was redirected in the subacromial space. An accessory lateral and anterolateral portal was established. A VAPR wand was inserted, and a subacromial bursectomy was performed. There was noted to be 2 large inferior osteophytes off the acromion. Using a 5.5 arthroscopic shaver, a subacromial decompression was performed. There was no significant underhang of the AC joint, and that was left alone. There was noted to be a very large complete tear again of the supraspinatus and infraspinatus tendons. The teres minor was intact. At this time, the greater tuberosity was debrided of soft tissue, and the bone was lightly debrided to a good a bleeding bone base. Three 5.5-mm BR anchors were placed in the greater tuberosity, one anteriorly, one centrally, and one posteriorly in the greater tuberosity. An ExpresSew suture passer was used to pass all limbs through the cuff as it was mobilized up and onto the greater tuberosity. Arthroscopic knot-tieing techniques were used to snug all these down. This gave a nice reduction. There was still a vertical split in the cuff, and a #2 Orthocord suture was used in a side-to-side fashion in order to close this. Final pictures were taken. The cuff was noted to move as a unit on the humeral head.

The joint was then copiously irrigated and suctioned dry, and all instrumentation was removed. The portals were closed using a nylon stitch. A sterile dressing was then applied as well as an ice cuff and an UltraSling. The Department of Anesthesia reversed the anesthetic. The patient was transferred back to the hospital gurney to the postanesthesia care unit. The patient tolerated the procedure well, and there were no complications.

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Derek Lamprecht, D.O.
DL/at/cf
D: 09/28/2010 1:01 PM T: 09/29/2010 8:27 AM MTID#: 2268261

cc: Marilyn Webber, M.D.

Signed by Derek E Lamprecht, DO on 09/29/2010 at 5:57 PM