TUALITY COMMUNITY HOSPITAL
Hillsboro, Oregon

OPERATIVE REPORT

FRANK

A. Brooke Benz, MD

MRN: 40-80-91

Date: 06/02/2005

Acct.No.: 00081613960

SURGEON: A. Brooke Benz, MD
ASSISTANT: John Voss, PA-C
ANESTHESIOLOGIST: Darin Brandt, DO

PREOPERATIVE DIAGNOSIS
Left massive rotator cuff tear.

POSTOPERATIVE DIAGNOSIS
Left massive rotator cuff tear.

OPERATIVE PROCEDURES
1. Biceps tenotomy.
2. Rotator cuff repair.
3. Placement of pain pump catheter.
4. Acromioplasty.

SUMMARY
The glenohumeral space was characterized by mild degenerative changes particularly anterior and inferior in the anterior glenoid area. Dynamic testing showed there was significant laxity with the arm at 30/30 and 0/30. There was some Hill-Sachs type lesions posterior as well. He came out about 60%. I ultimately elected not to do anything about this at that time. The superior labrum was in reasonable condition but the biceps was extremely frayed as it entered into the groove and it remained frayed all the way down through what was visible in the groove. I ended up simply doing a tenotomy. The glenohumeral surfaces were satisfactory though; no serious damage. The labral structures were just frayed and not actually torn.

The rotator cuff was just as the MRI suggested. There was a bunched up portion of the supraspinatus that had become located posterior. The big question was would there be substantial rotator interval for closure and ultimately there was. Even though it was frayed, what did remain beyond the fraying was in reasonable condition. The supraspinatus had basically completely become detached and ultimately retracted. I did a very extensive dissection in the posterior area, freeing it up. I ultimately used 3 anchors in the lateral aspect of the footprint in combination with 3 Ethibond sutures for interval closure. A nice tight repair resulted. A pain pump catheter was placed at the conclusion.

DESCRIPTION OF PROCEDURE
The patient was properly identified, brought to the operating room, and placed under satisfactory general anesthesia. Dr. Brandt had previously performed a scalene block in the holding area. The patient was placed in a Schlein in an upright position and the arm was prepped and draped in a sterile fashion. The McConnell was used throughout the operating for positioning of the arm.

I ended up using 5 arthroscopic portals, 1 posterior, 1 lateral, 1 anterior, and then 1 in between each of these portals. We went into the glenohumeral space first and made the above findings. We then went in the subacromial space. I did a biceps tenotomy, right at the groove actually where the maximal fraying was, and then resected it back to the superior labrum. I then took a single stay suture of Ethibond, passed it with the

Expressew through the leading edge of the supraspinatus. Applying traction to this I then debrided the tissues surrounding the supraspinatus, including scar tissue and adipose, and controlling bleeding as I went. I exposed all the way back to the scapular spine. This was with the expectation that I was going to have to do a release, but ultimately it was not necessary. We were able to pull the supraspinatus all the way anterior with very little tension on it. The cuff was debrided, however. The posterior leading edge of the rotator interval was debrided and defined and felt to be adequate. We then passed 2 additional #2 Ethibond sutures and, in combination with the bird-beak suture passer, I passed it through the rotator interval as well and then tied each of these knots, performing a margin convergence. I then debrided the tuberosity, placed three 5.0 anchors in the lateral aspect of the footprint, and then carefully, using the Expressew once again, passed each of the 6 sutures through the lateral edge of the supraspinatus and then tied each of these passed sutures, securing the rotator cuff to the tuberosity. Each of the knots was a 5 half-hitch throw knot, the first 2 constituting a slipknot and then the last 3 changing post and version, locking the knot into place. The pain pump catheter was left in the subacromial space at the conclusion.

Prior to initiation of the rotator cuff repair, I did do an acromioplasty converting the acromion to a type 1.

Each of the wounds was closed with an interrupted suture of 3-0 Vicryl and Steri-Strips.

The patient tolerated the procedure well.

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