Oregon Outpatient Surgery Center 7300 Southwest Childs Road Suite A Tigard, Oregon	PATIENT: MEDICAL RECORD #: PHYSICIAN: DATE OF SERVICE:	Cook, Frank 0018983 Ronald R. Bowman, M.D. 06/15/2012

DATE OF PROCEDURE: 06/15/2012

DICTATING PHYSICIAN: Ronald R. Bowman, M.D.

PREOPERATIVE DIAGNOSES: Possible SLAP tear and recurrent rotator cuff tear, right shoulder.

POSTOPERATIVE DIAGNOSES: Degenerative SLAP II tear, full-thickness supraspinatus tear, right shoulder, status post arthroscopic repair.

OPERATIVE PROCEDURES: Diagnostic arthroscopy, arthroscopic SLAP repair with SpeedLock system, and mini-open rotator cuff repair with platelet-rich plasma augmentation.

SURGEON: Ronald R. Bowman, M.D.

ASSISTANT: Nikki Seidner, CRNFA

ANESTHESIA: General.

ANESTHESIOLOGIST: Arley L. Voves, M.D.

INDICATIONS:

The patient is a 68-year-old male with a history of three previous rotator cuff repairs and ongoing symptoms unresponsive to conservative management. He is indicated for the above procedure.

FINDINGS:

Exam under anesthesia showed full range of motion, no instability. Arthroscopic findings showed intact labrum with just some very early degenerative softening of articular cartilage, particularly on the humeral articular side. There was some grade I to II changes, but no significant changes. The labrum was patulous and anteriorly it was attached, but was floppy and it was felt that this might lead to some abnormal motion and pathology. He had had a previous biceps tenodesis and the biceps was absent. There was a visible full-thickness tear of the supraspinatus, but it was retracted partially back, but not as far as indicated on the MRI that is approximately a centimeter or so. The tissue was not excellent, but it was not poor either. It was of adequate quality for repair and mildly adhesed posteriorly. One of the arthroscopic suture anchors remained intact. The stitch remained tied and was holding portion of the rotator cuff back from parachuting, but not completely. The infraspinatus was intact and the subscapularis was intact and the rotator interval was intact.

OREGON OUTPATIENT SURGERY CENTER
OPERATIVE NOTE

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DESCRIPTION OF PROCEDURE:

The patient was identified, brought to the OR, and transferred to OR table where general endotracheal anesthetic was administered. He had been given an interscalene block and 2 g of IV Ancef preoperatively. He was now transferred to the left lateral decubitus position and prepped and draped in the usual fashion after infiltration of 30 cc of 0.25% Marcaine with epinephrine 1:200,000 in the glenohumeral and subacromial space. A diagnostic portal was made inferomedial to the posterolateral corner of the acromion and an anterior portal was made in an inside-out technique utilizing Wissinger rod. The labrum was evaluated. It was decided to repair this, so the anterosuperior edge of the labrum was prepared by elevating the soft tissue off of the glenoid and preparing the anterior edge of the glenoid with curettage and rasp. A drill hole was placed and then a speed stitch was used to run the stitch through the labrum. It partially came loose, so a BirdBeak was used to grasp through the end and pull it through. This was placed into the applicator, which was set at the edge of the hole and then the slack was taken out of the stitch. The applicator was then buried. The stitch was tightened and then the end twisted and the applicator was removed. The excess suture was cut. This gave an excellent reattachment of the labrum.

Next, the instrument was then placed in the subacromial space. He had had a prior acromioplasty, so nothing was done in this area. Next, an incision was made of the anterolateral corner of the acromion and the deltoid was split. The acromion was flattened with rasp. A pull stitch was then placed in the rotator cuff and it was mobilized using a large key elevator. The cuff could be pulled over the greater tuberosity. The greater tuberosity was next prepared. The arthroscopic suture was more lateral on the tuberosity and two DoublePlay suture anchors were placed medially at the edge of the articular surface. With the first pass suture placed in the device, the sutures were placed sequentially, then the arm was taken off traction and the assistant held the arm in abduction and assistant held back pressure on untied sutures while the sutures were sequentially tied by the surgeon. They were then separated into two bundles and two Quattro lateral row anchors were placed in a standard technique utilizing a punch followed by the anchor and then tightening the sutures, then twisting the applicator until it clicks, then hammering the anchor all the way in, and removing the anchor, and cutting excess suture. This gave an excellent footprint of compression to this suture material. The wound was then irrigated with saline. The instruments were removed. The wounds were closed with #0 Vicryl figure-of-eight sutures. The platelet-rich plasma was injected into the subdeltoid area once the deltoid was closed. The skin was closed with 2-0 Vicryl and a running 4-0 Monocryl on the skin. Mastisol and Steri-Strips were applied. The patient reversed from anesthesia. There were no complications. He tolerated the procedure well.

X
Ronald R. Bowman, M.D.

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