

OPERATIVE REPORT

Assistant: (A skilled assistant was necessary for arthroscopic management of sutures during repair of superior labrum)

Anesthesia: General Endotracheal With Interscalene Block

Anesthesiologist:

Preoperative Diagnosis:

1. Superior labral tear.
2. Subacromial impingement with painful acromioclavicular joint.

Postoperative Diagnosis: Same.

Procedure:

1. Diagnostic arthroscopy of the glenohumeral joint.
2. Arthroscopic subacromial decompression.
3. Arthroscopic distal clavicle resection.
4. Arthroscopic repair of type II SLAP lesion.

Complications: None.

Estimated Blood Loss: Minimal.

Findings:

1. Intact anterior and inferior, inferior and posterior labrum.
2. Intact glenohumeral articular cartilage.
3. Intact rotator cuff from bursal and articular surface.
4. Type II SLAP lesion with unstable biceps labral anchor.
5. Degenerative changes AC joint.
6. Subacromial bursal thickening and synovitis.

Indications: The patient is a 42-year-old nurse who has had right shoulder pain refractory to conservative management and MRI-documented SLAP lesion but also has associated impingement of painful AC joint. She had partial relief but not complete relief with subacromial AC injection. She presents today for above-listed procedures. The risks and benefits of the procedure is discussed with the patient. She signed the preoperative consent form.

Description of Procedure: The patient was brought to the operating room, general endotracheal anesthesia administered without difficulty. The patient was examined under anesthesia and noted to have a stable glenohumeral exam with full

range of motion. She was positioned in the lateral decubitus position, left side down and right shoulder placed in an Arthrex shoulder holder, prepped and draped in usual sterile fashion. Arthroscopic portals were established posteriorly, anteriorly and superiorly. Diagnostic **arthroscopy was carried out** through the superior posterior portal. Findings were as noted above.

Attention was turned toward the **SLAP lesion. This was debrided. The superior glenoid was abraded with a rasp.** A tap for the Biofastec anchor was seated superiorly. A Biofastec anchor was then seated but pulled out. It was exchanged **for a 5.5 corkscrew anchor which was seated** without difficulty after tapping a hole and had excellent purchase. Linvatec spectrum suture punch was used to pass pull and passing sutures through the superior labrum anteriorly and posteriorly. These were exchanged for the fiberwire sutures in the anchor. At the **conclusion of the repair, complete stable anatomic repair of the labrum had been obtained.**

Arthroscopes were redirected to the subacromial space. Standard lateral portal was established at the junction of the anterior and third middle of the acromion. A 5.5 synovial resector and Arthrocare wand were used to perform soft **tissue subacromial decompression.** A 5.5 barrel bur was used to perform **acromioplasty until** the anterior third of the acromion was released from the middle and posterior third. The adequacy of the acromioplasty was checked and deemed to be adequate. Portals were established in line with the AC joint. The Arthrocare wand was used to **take down the joint capsule of the AC joint.** A 5.5 barrel bur was used to **perform distal clavicular resection approximately 1 cm distal to bone had been resected.** The clavicular resection and acromioplasty was once again checked. Both were deemed to be acceptable. No rotator cuff tear was identified. The arthroscope was removed from the shoulder.

Attention was turned to closing. The subacromial space and portal sites were infiltrated with .25% Marcaine with epinephrine. The portal sites were closed with nylon sutures. Sterile dressing consisting of Betadine-soaked Adaptic, 4 x 48 and Elastoplast was placed on the shoulder. The patient was awakened, extubated and taken to recovery room in stable condition. She tolerated the procedure well. There were no complications.