ProVation® MD

General Hospital – Sample Orthopedics Note

Patient Name: Mabel Davis
MRN: 123456789
Account #: 987654
Surgical Staff: Henry Gulliver, MD (Surgeon)

Procedure Date: 1/3/2011 11:05 am
Admit Type: Outpatient
Note Status: Finalized
Referring MD: Jennifer Jones, MD

Procedure:

Primary Right Shoulder Arthroscopic Rotator Cuff Repair with Subacromial Decompression

Patient Profile:

This is a 42 year old female. Refer to note in patient chart for documentation of history and physical. Due to the nature of the patient's increasing pain, surgery is recommended. The alternatives, risks and benefits of surgery were discussed with the patient. The patient verbalized understanding of the risks as well as the alternatives to surgery. The patient wished to proceed with operative intervention. A signed and witnessed informed consent was placed on the chart. Prior to initiation of the procedure, patient identification and proposed procedure were verified by the surgeon in the pre-op area, and the operative site was marked by the patient and verified by the surgeon.

Pre-OP Diagnosis:

Acute complete tear of the supraspinatus, Shoulder impingement syndrome

Post-OP Diagnosis:

Acute complete tear of the supraspinatus, Shoulder impingement syndrome

Anesthesia:

General - Endotracheal

Findings:

Acromion:
- There was a medium-sized (5 - 10 mm) anterior acromial spur.
- The subacromial bursa was inflamed.
- The subacromial bursa was thickened.

Ligaments / Capsule:
- Joint capsule within normal limits.
- There was thickening of the coracoacromial ligament.

Labrum:
- The labrum is within normal limits.

Rotator Cuff:
- Full thickness tear of the supraspinatus tendon, 5 mm anterior to posterior, by 10 mm medial to lateral.

Muscles and Tendons:
- The biceps tendon is within normal limits.

Joint:
- Normal appearance of the glenoid and humeral surfaces.

Description of Procedure:

Patient Positioning:
- Following induction of anesthesia, the patient was placed in the beach-chair position on the standard operating table. All body parts were well padded and protected to make sure there were no pressure points. Subsequently, the surgical area was prepped and draped in the appropriate sterile fashion with Betadine.

Incision Type/Arthroscope Insertion:
- Small stab incisions were made in the creation of the anterior, accessory anterior and posterior portals.
- A scope was introduced via the arthroscopic portal into the subacromial space.
- The subacromial space and bursa, biceps tendon, coracoacromial and glenohumeral ligaments, biceps tendon, rotator cuff, supraspinatus, subscapularis, infraspinatus, teres minor, capsulo-labral complex, capsule, glenoid labrum, humeral head, and glenoid were visualized and probed.

Instruments and Methods Subacromial Space:
- The subacromial bursa, subacromial soft tissues and frayed rotator cuff tissue were resected and debrided using a motorized resector and 4.5 Synovial Resector.
- The anterior portion of the acromion and acromial spur were resected with the 5.5 acromionizer burr. Approximately 5 mm of bone was removed. The coracoacromial ligament was released with the bony resection. The shoulder joint was thoroughly irrigated.
- The edges of the cuff tissue were prepared, prior to the fixation, using the motorized resector.
- The supraspinatus tendon was reattached and sutured using the arthroscopic knot pusher and Mitek knotless anchor system and curved pointed suture passer and large bore cannula (to pass the sutures). The repair was accomplished in a side-to-side and a tendon-to-bone fashion using three double loaded Mitek G IV suture anchors with 1 PDS suture.

Final Inspection/Scope Removal:
- The instruments and arthroscope were then removed.

Pathology Specimen:
- No pathology specimens.

Wound Closure:
- The joint was thoroughly irrigated with 7 L of sterile saline. The area was infiltrated with 1% lidocaine. The skin was closed with 4-0 Vicryl using interrupted subcuticular technique.

Drains / Dressing:
- Applied sterile dressing including gauze, iodoform gauze and Elastoplast.

Sponge / Instrument / Needle Counts:
- Final counts were correct.

Intraoperative Inputs and Outputs:
- No transfusions; minimal blood loss.

Cast / Immobilization:
- The extremity was immobilized with a shoulder immobilizer.

Patient to Recovery Room:
- The patient tolerated the procedure well, and was brought to the recovery room in good condition.

Complications:

No Immediate Complications.

Post-OP Plan:

DISCHARGE ORDERS:
- Disposition:
  - Discharge patient to home upon release from Post-Op Recovery.
- Medications:
  - Hydrocodone/Acetaminophen (Vicodin 5/500) 1-2 tabs PO q 6 hr PRN (max 8 tabs/day).
- Activity:
  - The patient may shower as tolerated.
- Follow-up:
  - Appointment to Orthopedics Clinic within several days.

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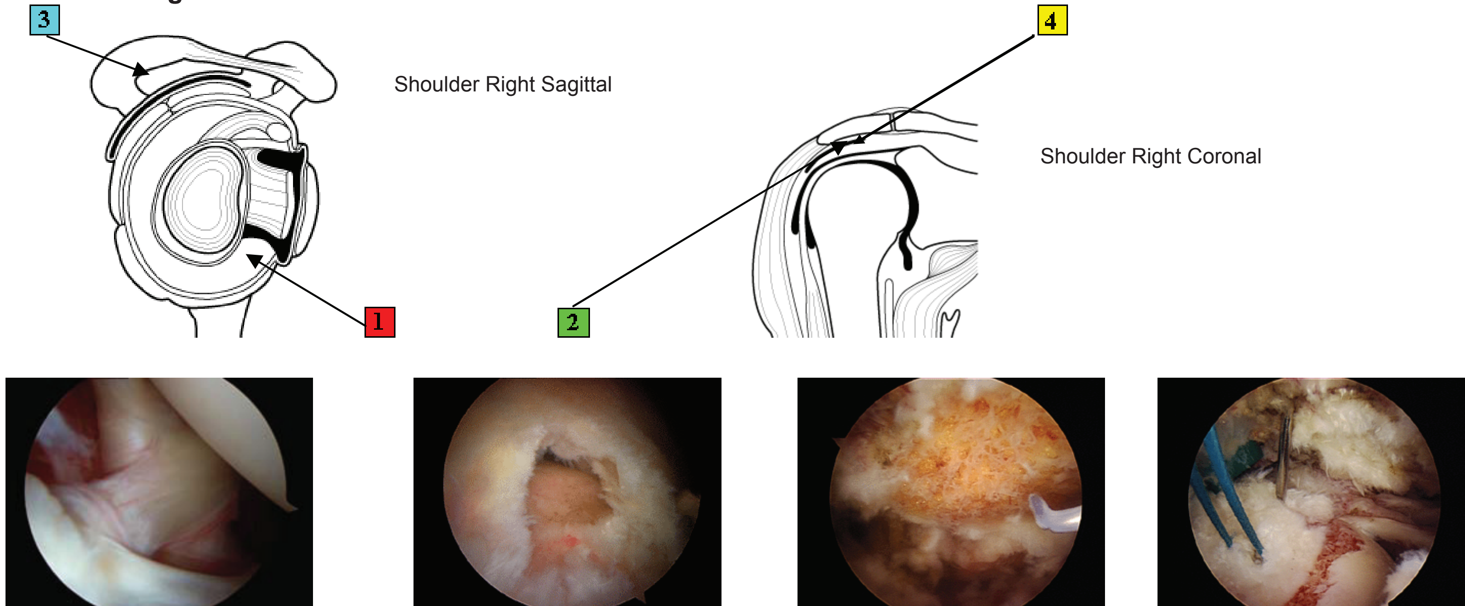
Procedure Images:



1 Labrum and Subscapularis repair

2 Supraspinatus Tear

3 Acriomioplasty

4 Supraspinatus

CPT Code(s):

29827, RT, Arthroscopy, shoulder, surgical; with rotator cuff repair
29826, RT, Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release

ICD Code(s):

840.6 SUPRASPINATUS (MUSCLE/TENDON) SPRAIN
726.2, OTHER AFFECTIONS OF SHOULDER REGION, NOT ELSEWHERE CLASSIFIED

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E-signed by Henry Gulliver, MD

Electronically signed by: Henry Gulliver, MD
Signed Date: 1/3/2011 11:18:48
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