POST STREET SURGERY CENTER
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PATIENT NAME: Frank

DATE OF SURGERY: 4/18/07

SURGEON: Thomas G. Sampson, M.D.

ASSISTANT: Connie Jardine, PA-C

PREOPERATIVE DIAGNOSIS: Right hip femoral acetabular impingement, both CAM and pincer, with probable delamination defect.

POSTOPERATIVE DIAGNOSIS: Right hip femoral acetabular impingement, both CAM and pincer, with delamination defect. (843.9, 716.95)

OPERATION: Right hip arthroscopic partial labrectomy, acetabular rim trimming, with labral refixation, abrasion chondroplasty acetabulum, synovectomy, and resection osteoplasty head/neck junction. (29863, 29862, 27179-22)

COMPLICATIONS: None.

ANESTHESIA: General endotracheal.

TUBES & DRAINS: None.

ESTIMATED BLOOD LOSS: Minimal.

INDICATIONS: Frank is a 63 year-old white male from Portland Oregon who has had longstanding bilateral hip pain for 15 to 20 years, and we performed surgery on his left hip 3/14/07, with an early excellent result, and he is here for his right hip. The MRI and CT are consistent with the above diagnoses and he elected arthroscopic surgery.

Prior to surgery, all questions were answered. The alternatives, risks, and benefits were well discussed and understood. The patient gave us his apparent informed consent and asked that I proceed with surgery as planned.

FINDINGS: Operative findings showed that he had a delamination defect from 1 to 5 o'clock with associated labral tears, degenerative type, and a large rim anteriorly. He had a head/neck bump.

PROCEDURE: The patient was brought to the operating suite and placed in the supine position, and given general endotracheal anesthetic. He was then rolled to a left lateral decubitus position so that we could operate on the right hip. Downside bony prominences were well padded and an axillary roll was placed.

The patient was set up in the Smith & Nephew hip distractor but no distraction was used at this time.

The right hip was then prepped and draped in the usual fashion. The patient was given 1 gram of IV Cephalosporin.

The anterolateral portal was attempted by first placing the patient in traction, then using the intercath to displace over the anterior capsule. The suction seal could not be released, and therefore it was determined to first work externally before going interarticular.

Traction was let down after about 1 minute.

The anterolateral portal was created by incising with a #11 blade over the nitanol wire. The cannulated sheath was then placed inside the joint, taking care to avoid injury to articular cartilage and labrum.

The 30-degree arthroscope was attached to the sheath and the hip joint was then viewed and swept in the usual fashion. It was first viewed under room air, and then under Ringer's lactate.

Next, the anterior portal was created in the usual fashion, taking care not to injure the lateral femoral cutaneous nerve. The fat pad was exposed and removed over the capsular rectus fascia. The capsule then was opened up using first the 90 and then the 50-degree suction wand RF device linearly along the neck and then T'ing

it over the rim. The bone was exposed with the entire rim from 12 to about 7 counter-clockwise and there was known to be a degenerative portion of the labrum anteriorly about 9. The head/neck junction was well exposed and had a large bump.

Once the rim was exposed, the labrum was partially detached from the rim, and using a 4-0 burr the rim was resected from posteriorly to anteriorly, and the scope was switched anterolateral and this was finished up anteriorly by cutting further soft tissue to expose the anteromedial rim.

The hip was placed in a small amount of traction as we were getting closer to the head, to avoid damage to the head. It became clear that he had a delamination defect from about 1 to 5.

The rim was then further trimmed down, making a good trough for flexion into that.

The joint was then entered and there were no loose bodies and the notch was not as hypertrophic as the other side.

The delamination defect was sculpted using the Arthrocare 50-degree suction wand. The labrum was also debrided next to this.

Next, the sites of re-fixation were determined to be about 1 and 4 o'clock. An accessory anterior inferior portal was created and using the Smith & Nephew bioabsorbable anchor system, the first anchor was placed at the one position, drilled, and then the anchor pounded in place.

Through a cannula in the anterior portal the suture was placed around the degenerative labrum and then tied down. A second anchor was placed at 4 o'clock and the same was done. Following this, the remaining articular cartilage and labrum was sculpted using the RF device.

Traction was then let down.

The head/neck junction was then cut, contoured, and shaped using the 4-0 burr, using the hooded burr the entire time.

The hip was flexed up and externally rotated to get a little bit more medially and posteriorly. The scope was then placed anteriorly and this was finished up, viewing from anteriorly and using the instruments in the anterolateral portal.

The bony crumbs were then removed from the joint with suction and all instruments were removed intact.

X-rays were taken in extension and flexion, showing excellent clearance.

The hip was injected with Marcaine and epinephrine.

A standard bulky dressing was applied.

The patient was then returned to the Recovery Area in good condition.

No specimens were sent to Pathology.

Thomas G. Sampson, M.D.

Dictated on 4/18/07
Transcribed on 4/20/07
TGS/mw

cc: Tandy Freeman, M.D.
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