Franklin C Cook [illegible] Home [illegible] Office [illegible]
Male DOB: [illegible] [illegible] Ins: [illegible]

07/06/2011 - Office Visit: Second Opinion R Shoulder w/xr
Provider: Paul Switlyk, MD
Location of Care: The Orthopedic and Sports Medicine Center of Or LLC
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CHIEF COMPLAINT: Right shoulder pain and restricted movement.

HISTORY: Mr. Cook is a 67-year-old right handed retired businessman who comes in for an additional opinion regarding his right shoulder. He has had two rotator cuff repairs on this shoulder. The first was done by Dr. Butler in 2002. He had a very large rotator cuff repair at that time. He did well for awhile, but then started having significant symptoms. Dr. Lamprecht did a second revision rotator cuff repair in September of 2010. An arthroscopic repair was able to be performed of the supraspinatus and infraspinatus and a biceps tenotomy and a decompression. When last seen in April, he was doing relatively well. He was better than he was before surgery as far as pain and even functional use of his arm, although he still had limited elevation to about 90 degrees. He has also had some trouble with his left shoulder more when he was using it primarily when recovering from his right shoulder.

Over the last three months, his shoulder has tended to hurt more and he does not have quite the same degree of functional use of it without pain that he had early after his surgery. He got my name for an additional opinion.

His primary area of pain is deep in the lateral shoulder primarily just with elevation and movement. As he approaches the horizontal position, it hurts a lot. He used to do more without it hurting as much. He has some more trouble at night where intermittently it wakes him up. He can use it pretty well with the arm at the side. He can do his office work as a businessman using the computer without difficulty. He cannot mow a lawn because the shoulder will hurt too much.

PAST MEDICAL HISTORY: He is generally reasonably healthy. He has a number of musculoskeletal complaints including some trouble with his back.

PAST SURGICAL HISTORY: In addition to his shoulders, he has had right and left hip arthroscopy in 2007. He has a history of a malignant melanoma with surgery in 2005.

MEDICATIONS: Current medicines are Testosterone injections and thyroid.

ALLERGIES: None.

PHYSICAL EXAMINATION: Mr. Cook is a very pleasant gentleman with some atrophy of the infraspinatus fossa on the right and left mildly. He has retracted biceps muscles in both arms. His deltoid has good bulk without atrophy. Cervical rotation is painful.

SHOULDER RANGE OF MOTION	RIGHT	LEFT
	Active/Passive	Active/Passive
Flexion	90/110	160/

External Rotation	30/	45/
Total Rotation at the Side	60/	80/

On the right shoulder, he has a 1+ painful arc as he approaches about 80 degrees. It grinds and hurts as he tries to get it to or use it at the horizontal position. Resistance to his external rotators Demonstrates 4/5 weakness, his internal rotators 4+ trace weakness. He has a positive subscapular lift-off on the right and a weak belly press sign. He does not have pain on the extremes of rotation with the arm at the side.

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RADIOGRAPHIC EVALUATION: I reviewed outside x-rays from March 2, 2011. A true AP view shows superior migration of the humeral head with acromial humeral distance now to maybe 3-4 mm. The glenoid joint space is maintained. There is some reabsorption of the area of the greater tuberosity. A supraspinatus outlet view suggests previous acromioplasty and resultant Type I acromion. An axillary lateral view shows good maintenance of glenoid joint space on this projection. There are some small anatomical osteophytes anteriorly and posteriorly on the humerus.

I reviewed an MRI scan of the right shoulder from May 18, 2011. The coronal oblique view shows superior migration of the humeral head. All of the anterior supraspinatus is torn and retracted back. There appears to be some component of maybe the posterior supraspinatus still attached, but it is thin. The upper portion of the subscapularis on the anterior cuts appears partially torn. An axillary lateral view shows some intercleavage plane and tearing of probably the upper subscap. There is some narrowing of the joint space more superior between the humeral head and glenoid. The sagittal oblique view shows atrophy of the supraspinatus muscle of maybe 60 percent of normal. There seems to be some fatty infiltration of the infraspinatus with some atrophy. The subscapularis does not appear atrophied.

Two x-rays were taken today of the right shoulder. A true AP view shows some progressive superior migration of the humeral head. The humeral head rides underneath a somewhat thinned acromion. The acromial humeral distance is only 2-3 mm. Glenohumeral joint space is maintained. An axillary lateral view shows reasonable glenohumeral space.

IMPRESSION:

1. Failed massive rotator cuff repair status post recent revision rotator cuff surgery.
2. Early cuff tear arthropathy, right shoulder.

DISCUSSION AND RECOMMENDATIONS: At this point, Mr. Cook is having enough arthritic problems with superior migration of the humeral head that I think the only surgical treatment would be a reverse total shoulder arthroplasty. I do not think he is quite bad enough for that, however, if everyday things on a daily basis get more painful or he has more night or rest pain, that might be very indicated. We talked a little bit about what that would entail. I think he will probably wind up needing that sometime in the future.

Paul A. Switlyk, M.D./mr D: 07/06/2011 T: 07/10/2011 VF: 0039/0041

cc: Mark McKinstry, M.D. (Fax: 503-885-1663)

Signed by Ronda Stith on 07/11/2011 at 11:22 AM