



OPERATIVE REPORT

1301 4th Ave NW
Suite 201

PHYSICIAN: Thomas Trumble, M.D.

PREOPERATIVE DIAGNOSES:

1. Tendinitis and contracture of the pectoralis minor and short head of the biceps tendon, M75.22.
2. Compressive neuritis of the brachial plexus, G54.0.
3. Impingement syndrome of left shoulder with acromioclavicular joint arthrosis, M75.42 and M19.112.

POSTOPERATIVE DIAGNOSES:

1. Tendinitis and contracture of the pectoralis minor and short head of the biceps tendon, M75.22.
2. Compressive neuritis of the brachial plexus, G54.0.
3. Impingement syndrome of left shoulder with acromioclavicular joint arthrosis, M75.42 and M19.112.

PROCEDURES PERFORMED:

1. Tenotomy of the biceps and pectoralis, 23405 with the step-cut lengthening and repair.
2. Decompression of neurolysis of brachial plexus, 64713.
3. Injection of the shoulder joint with platelet-rich plasma under fluoroscopic guidance, 20610 and 77002.
4. Injection of acromioclavicular joint, 20605 under fluoroscopic guidance, 77002.

ASSISTANTS: Keith Lemay, PA-C and Derek Omori, PA-C.

ANESTHESIA: General.

PREPARATION: ChloraPrep and intravenous antibiotic.

DESCRIPTION OF PROCEDURE: After proper level of anesthesia was obtained, the patient was prepped and draped in the usual fashion

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in the beachchair position. The entire left upper extremity was prepped and draped out free. Fluoroscopy helped to confirm the location of the coracoid. A longitudinal incision was made in the deltopectoral groove. Incision was carried down through the skin and subcutaneous tissue, which was carefully mobilized. The cephalic vein was identified and retracted laterally. The pectoralis major and biceps tendon formed a single very tight tendon. There was really restricted and had significant synovitis. A synovectomy was completed with tenotomy scissors to remove the inflamed tissue. Then, a step-cut lengthening was completed in the pectoralis and short head of the biceps. This have to expose the brachial plexus, which explored and noticed to have involved in a very dense fascial layer along the course of the plexus, which was mobilized and released with tenotomy scissors using bipolar cautery to help obtain hemostasis. There was noted to be extremely thick fascial band that had to be released overlying. Once this was released, it was noted to be a dramatic improvement, the overall capillary refill around the brachial plexus at the level of the cords where the release was completed. Care was taken to gently retract these as well as especially the musculocutaneous nerve and then complete a repair of the lengthened pectoralis minor and short head biceps tendon. These were repaired with a Krakow or 0 Polydek suture repairing the pectoralis and the short head of the biceps. Once this was completed, there was going to be much more generous space beneath the tendons, no pressure in the brachial plexus.

The patient had a blood drawn for a PRP injection. Injection was performed into the AC joint under fluoroscopic guidance as well as into the subacromial space. The wounds were irrigated with saline. The wound margins were checked with 0.25% Marcaine with epinephrine. The remainder of the plasma spray was then applied over the repaired pectoralis minor and short head of the biceps. The wounds were then closed with buried 3-0 Monocryl suture and a Prolene suture. A bulky dressing was applied with a sling and abduction pillow. The patient was then awakened and brought to recovery room in stable condition.

Keith Lemay, PA-C and Derek Omori, PA-C required to assist in this complex surgery requiring tenotomy and lengthening of the pectoralis minor as well as the short head of the biceps combined with neurolysis of the brachial plexus. The patient also had PRP

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injections of the shoulder into the AC joint as well as plasma
spray applied to the repair tendons.

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