POST STREET SURGERY CENTER
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San Francisco, CA 94115
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PATIENT NAME: Frank

DATE OF SURGERY: 3/14/07

SURGEON: Thomas G. Sampson, M.D.

ASSISTANT: Connie Jardine, PA-C

PREOPERATIVE DIAGNOSIS: Left hip possible loose bodies and femoral acetabular impingement, CAM and pincer type, and articular cartilage defect.

POSTOPERATIVE DIAGNOSIS: Left hip, no loose bodies with femoral acetabular impingement, both CAM and pincer type, and delamination defect articular cartilage acetabulum, and mild arthritis.
(843.9, 716.95)

OPERATION: Left hip arthroscopic partial labrectomy, acetabular rim trimming with abrasion chondroplasty of the acetabulum with synovectomy, and labral refixation using bioabsorbable anchors, as well as notch osteophytectomy 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 left hip pain for 15 to 20 years, which has become much worse in the last year. He has had trouble putting on his shoes and socks, etc. He was evaluated in Oregon and it was felt

that he was not yet ready for a hip replacement and it was recommended he consider arthroscopy. He came back here and I felt he had the above diagnosis. One of the studies indicated that he might have loose bodies, but I felt he had more impingement. I thought he might have a loose body at the base of the labrum. 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 no loose bodies. He had a large rim osteophyte anteriorly, a delamination defect from 7 to 12 o'clock associated with labral degeneration, and he had some head degeneration centrally, and a head/neck bump with poor offset.

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 right lateral decubitus position so that we could operate on the left hip. Downside bony prominences were well padded and an axillary roll was placed.

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

The left 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 2 minutes.

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.

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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.

Following this, the anterior portal was created in the same fashion and the motorized shaver was brought in to create the space for the capsulectomy.

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 7 to 12.

The rim was then further trimmed down medially, taking it down to the delamination defect, and the delamination defect was excised with the 4-0 shaver on the surface.

The joint was then entered and the damage was seen internally where he had some arthritis and loss of articular cartilage, and delamination defect. There was also a notch osteophyte. Exploration for loose bodies showed there was none and this was just hypertrophic posterior labrum which had probably calcified.

Next, after abrading the articular cartilage of the acetabulum, and the head where there was some damage, the notch osteophyte was removed with a 4-0 burr. After this, further debridement was carried out of the joint and the rim was trimmed slightly further to get the ideal curvature.

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Next, the labrum was re-fixed using a third anterior mid portal. The scope was placed anteriorly and a clear cannula through the anterolateral portal. The first anchor was placed about 10 o'clock, drilling this and then pounding in the anchor. This was then looped around the labrum and tied down, placing the knot into the hole. The joint was checked for no anchor penetration.

The second anchor was placed about 8 o'clock and the same was done, securing the anchor and peeling the labrum back to the rim.

Traction was let down once again.

The head/neck junction was then cut, contoured, and shaped, using the same burr, starting with the hooded burr and exchanging this for the unhooded burr to get an area more lateral. After adequate shaping this was checked with x-rays in different rotations, and also different views with the scope.

All the bony crumbs were evacuated out of the joint.

The instruments were removed intact.

The flexion x-ray was also checked for clearance and then the hip was closed with interrupted 4-0 nylon. 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 3/14/07
Transcribed on 3/15/07
TGS/mw
cc: Tandy Freeman, M.D.
7115 Greenville Ave., Ste. #310
Dallas, TX 75231

4-17-07

The left side is a month after surgery. He is doing fine and using no crutches and in fact today walked across the Golden Gate Bridge. The right hip is bothering him a lot. He had some new studies including an Arthro/MRI which made him feel much worse. He also had a CT scan. It looks like there is some head changes beside acetabular changes and he has FAI and arthritis.

We will go ahead and do the right hip tomorrow.

All questions were answered. The alternatives, risks and benefits were well discussed and understood and the patient gave his apparent informed consent and asked to proceed with surgery as planned.

TGS/mdc