Plaintiff Name: [redacted]
Date of Incident: 07/14/16

Trifecta Medical Chronology/Deposition Questions

Referral Date/ Number of pages:	05/28/22- 1835+ pgs		
Referral Type:	Med Mal		
Completed by:	[redacted]		
Report Submission Due Date:	06/14/22	**Return Date:**	06/14/22

FILE DEMOGRAPHICS

Plaintiff Name:	[redacted]	**Attorney:**	[redacted]
Date of Incident:	07/14/16	**Defendant MD:**	[redacted] MD/ [redacted] MD
Date of Birth:	46yo male	**Defendant Facility**	[redacted] surgery center
Occupation:	[redacted]	**Marital Status:**	Married

Issue(s) of Focus:

Referral Request/ Attorney Questions:

1.	Brief Merit Review
2.	Brief Medical Chronology
3.	Develop Deposition Questions for Defendant Ortho Surgs [redacted]

Missing/ Additional Pertinent Records:

1.	07/14/16- Intra-Operative record from [redacted] Surgery Center w/Dr. [redacted]. This would indicate who the OR circulators, assistants were, as well as the implant log for the anchors and spinal needle used.
2.	Early Jan 2017- MR Arthrogram ordered by [redacted], MD

I. Abstract of Nursing Analysis:

46yo R handed male w/past medical history of GERD, hiatal hernia, lung nodules, ulcers in esophagus & intestines, sleep apnea; past surgical history of appendectomy, Upper GI, gall bladder removal, L knee arthroscopy x2, and gastric fundoplication for breaking up adhesions.

Plaintiff Name: [redacted]
Date of Incident: 07/14/16

On the date of injury, 03/18/16, plaintiff was on a business trip and fell while exiting the shower bracing himself on his R hand resulting in inability to raise his arm; he flew home that same day and was seen in the ER where XRs of the shoulder were negative, diagnosed w/R shoulder strain and R rotator cuff injury.

The following week, plaintiff presented to [redacted], MD- Sports Med with continued complaints of pain 10/10 and now w/some numbness in his fingers, again shoulder XRs were done and negative; given prescriptions for Diclofenac and Norco, And referred to PT x2-3wks w/only 5% improvement.

1 mo later, 05/02/16, [redacted] gets an MRI of the R shoulder showing a non-displaced mildly comminuted fracture on the anterior aspect of the greater tuberosity as well as a high grade partial thickness tear of bursal surface at the distal end of the supraspinatus tendon 1.2cm.

Plaintiff then sees Ortho Surg- [redacted], MD 05/23/16 who suggests surgery; however, a R shoulder injection given 06/15/16 w/significant pain relief until surgery is scheduled and done on 07/14/16.
The operative report indicates an **unknown size spinal needle utilized** for suture marking on the bursal surface of the AC joint, it **does not appear that any intraoperative XRs were done**.

2wks postop- 07/27/16, plaintiff returned to [redacted] who performed an XR R shoulder which **did not show fractured needle tip;** instructed plaintiff to cont modified work duty, gave prescription for Dilaudid and to return in 4wks—but plaintiff did not return until 6wks later and reported doing well. 6wks later – 10/13/16, a R shoulder injection done w/ relief while **waiting for L&I approval** for surgery now complaining **of a sharp pain at times;** frozen shoulder suspected so plaintiff returned to the OR 11/17/16 for manipulation under anesthesia and another injection. Plaintiff released to regular duty 11/23/16 and completes PT on 01/23/17 for a total of 32 visits and finally ceases due to the continued pain.

02/08/17- [redacted] orders a CT R shoulder which reveals "tubular lucency 5cm below the joint", so MR Arthrogram done 1wk later on 02/16/17 **which showed a near full thickness tear of infraspinatus posteriorly of 2.3cm.**

Plaintiff is sent to [redacted], MD for 2nd opinion on 04/25/17 who orders EMG/NCS which ruled out any cervical disc involvement; does another R shoulder aspiration 05/15/17 which is negative for infection.

On 09/06/17- [redacted] takes him back to the OR for **revision R shoulder arthroscopy**, distal clavicle resection, biopsies x3 (all found to be positive for P. Acnes infection).

2 d later- 09/08/17, plaintiff returns to ER for bilateral leg swelling, venous doppler study showed no DVTs (blood clots); admitted to [redacted] Hosp for IV antibiotics and taken BACK to the OR on 09/22/17 for retained needle tip

identified on shoulder XRs, "needle tip found in rotator interval between the supraspinatus and infraspinatus- more of a posteriorly-based needle". Then on 10/05/17 plaintiff noted to now have **rupture of biceps tendon**; Plaintiff began IV antibiotics infusion ending 11/03/17; another R shoulder injection given 10/03/17 w/99% improvement; R shoulder aspiration done again on 12/08/17. MR Arthrogram done early Jan 2017 [records missing] showed another high grade partial thickness tear of infraspinatus- 6mm although now with 2cm medical or substance degeneration.

This is where the submitted medical records end.

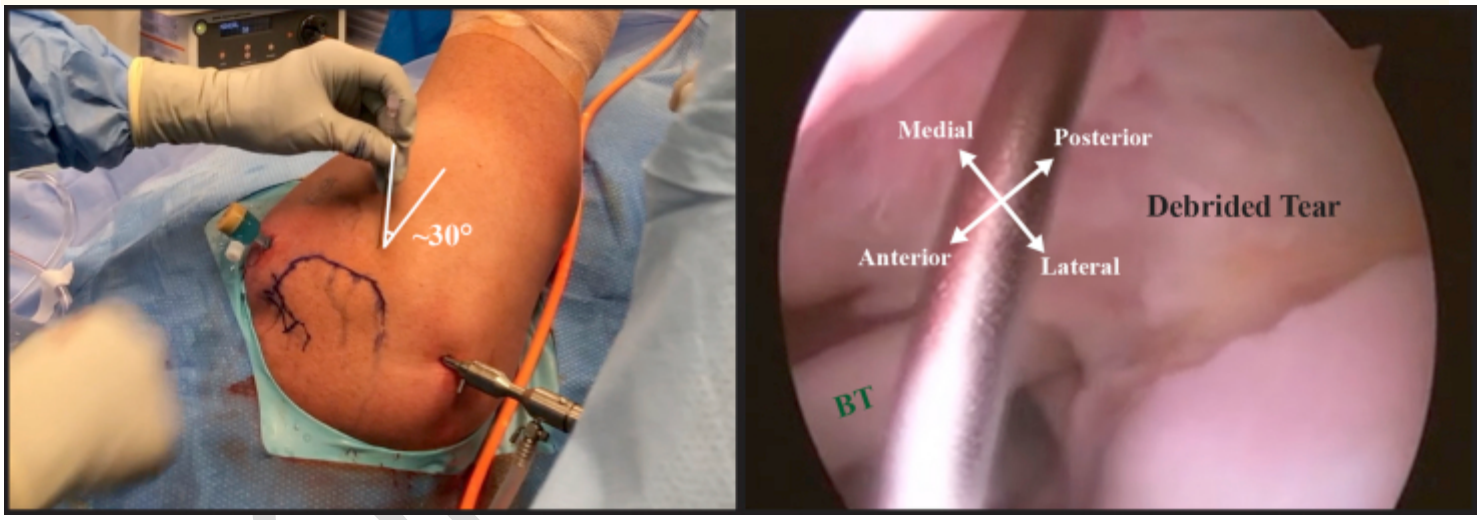
II. Forensic Nursing Conclusions:

Allegations:
Needle fragment left in shoulder inside the tendon used for suture marking causing pain/suffering

Issues	Case Strengths	Case Weaknesses	LNC Rationale for Findings
P. Acnes infection in R shoulder joint		*P. acnes* is a **common cause** of infection following shoulder surgery and is responsible for 1-in-2 shoulder infections after orthopedic implant. Younger men, among the population undergoing shoulder arthroplasty, are particularly at risk. *P. acnes* infection can be difficult to diagnose and delayed diagnosis can result in significant disease states leading up to prosthesis failure. With an increasing rate of antibiotic-resistant bacteria, *P. acnes* infection is becoming increasingly difficult to treat.	This is a very common infection for rotator cuff repairs, affecting younger men… This infection could have happened absent the broken needle fragment
09/06/17- Surgery revision by [redacted]		"I could not ever really see the needle, but could see it bouncing up and down on the XR as I shaved the vicinity and then	The needle could not be seen by the naked eye and ONLY when an additional piece of equipment was utilized.

		suddenly it was gone…Full XRs of the shoulder demonstrated it was no longer in the shoulder"	

With the arthroscope in the posterior portal, an 18-gauge spinal needle is passed through the skin and into the GHJ, 2 to 3 cm posterior and 2 cm lateral to the anterolateral corner of the acromion. The needle is angled 30° above the surface of the arm and in line with the humerus to recreate the normal relationship of the rotator cuff layers (Fig 3). Under direct visualization from inside the GHJ, the needle is advanced through healthy supraspinatus tendon, medial and posterior to the partial thickness tear. A no 1. polydiaxanone (PDS) absorbable monofilament suture (Ethicon, Somerville, NJ) is placed into the needle and directed into the joint. Using an arthroscopic grasper, the PDS suture is removed from the anterior portal. A no. 2 braided, nonabsorbable suture (Orthocord; Depuy Mitek, Raynham, MA) is secured to the PDS outside of the body with a simple loop and shuttled back through the rotator cuff tear (Fig 4).



Plaintiff Name: [redacted]
Date of Incident: 07/14/16

Depo Questions: [redacted] MD

Intra-Operative

1. Were intraoperative Xrays used to determine the joint was free of any loose bodies, foreign materials, to ascertain that the joint was clear to close? [unknown- but it appears not]

If not, why not?

2. Does anyone in particular perform equipment, insturment and supply evaluations during R shoulder arthroscopic acromioplasty, R shoulder arthroscopic distal clavicle excision, R shoulder mini open rotator cuff repair (supraspinatus)?

If so, who? [Intra-Operative record missing from initial surgery on 07/14/16- pg591]

3. Where did you place the spinal needle? [should be between the tendon and supraspinatus]

4. Was only one tract of small hole made in rotator cuff tendon? [should be yes- only 1]

5. Was the spinal needle moved by arthroscopic instruments?

6. What views were used to place the initial suture? [should be both internal and external oblique views to confirm position]

7. Was the posterolateral portal used as the viewing portal? [should be yes]

What is the location/ technique

[should be:

a. 2cm inferior and 1cm medical to posterolateral corner of acromion

b. portal may pass between infraspinatus (suprascapular nerve) and teres minor (axillary nerve) or pass through the substance of infraspinatus

c. this is usually the first portal placed

d. directly anteriorly towards tip of coracoid]

8. Was the lateral portal used as the working portal? [should be yes]

9. What was the anterior portal utilized for?

[should be:

a. viewing and subacromial decompression

b. location/ technique: lateral to coracoid process and anterior to AC joint

c. portal passes between pectoralis major (medial and lateral pectoral nerves) and deltoid (axillary nerve)

d. **this portal is usually placed under direct supervision from the posterior portal with aid of spinal needle]**

10. Were the secondary portals used?

a. Anteroinferior (5 o'clock) portal, Posteroinferior (7'o'clock) portal or Nevasier (supraspinatus) portal

1) function- placement of anchors in anterior labral repair

2) **located slightly inferior to coracoid, used under direct supervision from the posterior portal with aid of spinal needle**

b. Posteroinferior (7'o'clock) portal

1) function- placement of anchors for posterior labral repair

2) **placed under direct supervision from the posterior portal with aid of spinal needle]**

c. Nevasier (supraspinatus) portal

1) function- anterior glenoid visualization

2) located just medial to lateral acromion and goes through supraspinatus muscle (suprascapular nerve)

11. Why did you reverse the arthroscopic viewing and working portals? [should be to convert to a smooth flat surface]

12. How much distal clavicle bone was removed? {should be 8-10cm]

Was this through the posterior or anterior portal, [should be anterior]

and why? [don't know]

13. When the bursal side tear was repaired, did anyone- YOU- observe the instruments to ensure all edges intact? [unknown- no intra-operative records]

14. When you utilized the bur and rongeur to create a healing surface of the greater tuberosity, could this have possibly caused a fracture in the spinal needle used to mark the suture site? [unknown]

PostOp

1. Why did you wait 6mos (02/08/17- pg799) to do a CT of the R shoulder in the setting of continued complaints of "sharp pain", limited range of motion and weakness?

Depo Questions: [redacted] MD—Treating Ortho Surg Who Did Repair:

1. How did the delay in approval from L&I to conduct the surgery to perform excision of the clavicle influence the outcome of the repair surgery have on the retention of the needle fragment? [unknown]

2. Did the fact that per your Op report of 09/06/17 "there were absolutely no signs of tearing of the rotator cuff superiorly" conclude you to find that the retained needle fragment was the culprit of plaintiff's pain and limited range of motion complaints? [should be yes]

3. At the surgery on 09/06/17, Despite obtaining tissue culture results for the presence of P. Acnes and waiting another 3wks to obtain results, Why wasn't the effort made to go in and remove the retained needle fragment at this time? [unknown]

Snips of Key Documents

Pg591- Op Report- 07/14/16- Peterson, MD

The arthroscope was introduced through a standard posterior portal. An anterior portal was made using outside-in technique. Arthroscopic evaluation of the glenohumeral joint showed the above noted findings. The labrum and biceps tendon were unremarkable. The subscapularis was unremarkable.
A articular sided tear of the supraspinatus was noted. This measured 2 centimeters.
A spinal needle was used to pass a 2-0 nylon marking suture through the tear so that it could be assessed from the bursal surface.

Cannulas were now redirected into the subacromial bursa. An additional lateral portal was made. Upon entering the bursa was thickened bursa was debrided using the shaver and the ArthroWand electrocautery. The bursal surface of the cuff could now be assessed. The area of the marking suture was noted. The bursal surface of the rotator cuff was unremarkable without a significant tear. However based on the appearance on the articular side I felt the patient had a high-grade partial-thickness tear that required repair..

Arthroscopic acromioplasty was now carried out. Soft tissue was removed from the undersurface of the acromion. The anterior and lateral margins were defined. AC joint was localized with a spinal needle. Preoperative x-rays had demonstrated a moderate anterior hook of the acromion. This was resected using the arthroscopic bur. With the burr in the lateral portal and the anterior inferior surface of the acromion was resected beginning laterally and extending medially to the AC joint. Several millimeter some bone were resected from the anterior inferior acromion. Arthroscopic viewing and working portals were now reversed. With the bur in the posterior portal. He was converted to a smooth flat surface using a cutting block technique.

Attention was now turned to the AC joint. While viewing from the lateral portal instruments were passed from anterior portal. The ArthroWand was used to remove soft tissue from the AC joint. The distal clavicle was removed using the bur. Approximately 8-10 mm of bone were resected. This was carried out until the superior capsule margin could be well seen. Arthroscope was placed through the anterior portal confirming satisfactory superior bone resection.

The shaver was used to clear the bursa. Bursal surface of the rotator cuff again was assessed. A bursal sided tear could not be seen again felt that he had a high-grade partial-thickness tear that required repair. The cannulas were removed. Arthroscopy portals were closed with nylon suture.

Mini open rotator cuff repair was now performed. An incision was made beginning over the anterolateral acromion and extended laterally several centimeters. This was centered over the previously placed marking suture. The deltoid was exposed. This was split in line with its fibers. The deltoid was not detached from the acromion. Retractors were placed exposing the subacromial bursa and the rotator cuff.

The supraspinatus could be assessed. There was definite thinning of the supraspinatus in the area of the marking suture. The tear was completed. This resulted in an approximately 2 cm transverse tear at the articular margin. The tear was mobilized and margins were debrided.

The area of the greater tuberosity footprint was lightly decorticated with a bur and a rongeur to create a healing surface.
The rotator cuff tear was now repaired using a suture bridge technique. A double loaded Cayenne 5.5 Quadro-X anchor was placed in the greater tuberosity footprint at the articular margin at the anterior margin of the tear. Good purchase was obtained. A second double loaded Cayenne 5.5 Quadro-X anchor was now placed in the greater tuberosity footprint at the articular margin at the posterior margin of the tear. The attached sutures were passed through the lateral margin of the supraspinatus. The sutures were now tied and then were crossed and secured laterally using 2 Cayenne 4.5 Quadro-Link anchor. The rotator cuff was approximated well to the tuberosity. Repair was stable and secure with movement of the shoulder. The remainder of the rotator cuff was assessed and was unremarkable.

The wound was now irrigated. Deltoid was repaired using #2 FiberWire force with 2-0 Vicryl suture. Subcutaneous tissue was closed with 2-0 Vicryl and skin was closed with 3-0 Vicryl subcuticular suture with Steri-Strips. Sterile dressing was applied. Patient was placed into a sling.
The patient was awakened from anesthesia and taken to the recovery area in stable condition.
DISPOSITION:
The patient will be discharged home when stable.

DISCHARGE MEDICATIONS:
Dilaudid and Oxycodone as needed for pain.

Pg799- 02/08/17-CT R Shoulder w/contrast- ordered by [redacted], MD

[redacted]

[redacted]

Name: [redacted]
Exam Date: 02/08/2017 11:24 AM
DOB: [redacted]
Gender: Male
MRN #: [redacted]

Referrer: [redacted] MD
.:
cc 2: CLARITY CLARITY

EXAM DESCRIPTION:
CT SHOULDER W/O CON RIGHT 2/8/2017 11:20 am

CLINICAL INFORMATION:
Nondisplaced fracture of greater tuberosity of right humerus, subsequent encounter for fracture with routine healing S42.254D. Right shoulder CT, to evaluate greater tuberosity fracture.

COMPARISON:
None available.

TECHNIQUE:
Axial CT images are performed through the shoulder without contrast. Sagittal and coronal reformations are performed. 3D reconstructions were performed on an independent workstation.

Scan was performed in compliance with NEMA XR 29-213 Dose Limiting Standard, Automated Exposure Control (AEC) was utilized.

FINDINGS:
AC joint and subacromial space: Normal alignment of the AC joint with joint space widening suggesting there has acromioplasty and distal clavicular resection.

Glenohumeral joint and osseous structures: Normal alignment of the glenohumeral joint. There is mild chondral thinning with joint space narrowing and bony productive spurring. Erosive tracks in the lateral humerus from previous repair of a rotator cuff tear. Mild enthesopathic spurring at the greater and lesser tuberosities. However no acute osseous fracture is demonstrated at this time.

Focal area of endosteal cortical thickening with central tubular appearing lucency, involving the anterior cortex of the proximal humerus, 5 cm below the joint, measuring 0.9 x 0.6 x 1.6 cm. No cortical destruction, periosteal reaction or soft tissue mass. The appearance is unusual but may represent a vascular channel. Other potential etiologies such as osteoid osteoma or small chronic focus of infection are differential considerations.

Periarticular soft tissues: Punctate metallic density just lateral to an anchor defect in the lateral humerus is presumably residua from surgery.

C

Pg 801- Interventional Radiology- R shoulder aspiration- 05/15/17- ordered by [redacted], MD—done by [redacted] MD- Rad

[redacted]

Name: [redacted]
Exam Date: 05/15/2017 04:07 PM
DOB: [redacted]
Gender: Male
MRN #: [redacted]

Referrer: [redacted]
.:
cc 2: CLARITY CLARITY

EXAM DESCRIPTION:
XRAY JOINT ASPIRATION RIGHT 5/15/2017 2:40 pm

FLUOROSCOPIC-GUIDED SHOULDER FLUSH ASPIRATION FOR POSSIBLE INFECTION

CLINICAL INFORMATION:
Increasing right shoulder pain. History of rotator cuff repair surgery July 2016. Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic. M75.121. Possible infection.

COMPARISON:
MRI shoulder 2-16-17 and multiple others.

PRE-PROCEDURE:
Following a thorough discussion of the risks, benefits and alternatives, all questions were answered and consent was obtained and placed in the chart. A pre-procedure time out was performed.

PROCEDURE:
The shoulder joint was localized under fluoroscopy. The site was prepped and draped in the usual sterile fashion and local anesthesia obtained with 1% lidocaine. A 22-gauge spinal needle was advanced into the joint space with flush forward technique. Flush aspiration of the joint was performed with 15 cc of preservative free saline. 1.5 cc were aspirated and submitted to pathology to be held for culture, as well as cell count, Gram stain and crystals.

3.5 cc of Isovue-300 was then injected into the joint to retroactively confirm intra-articular aspiration.

The patient tolerated the procedure well. There were no immediate complications. Routine post procedure instructions were provided.

MEDICATIONS:
3.5ml Isovue 300 used, single-use vial, 26.5ml discarded (30 ml vial).

FLUOROSCOPY TIME: 22.4 seconds.

SPOT FILMS: 0

IMPRESSION:
Technically successful fluoroscopic-guided flush aspiration of the right

Name: [redacted]
Acc #: [redacted]
MRN: [redacted]

shoulder with preservative-free saline.

Report Electronically Signed by: [redacted] M.D.

Pg 454- Op Report- 09/06/17—[redacted], MD

OP Notes (continued)

portion of the intraarticular biceps. I, therefore, placed a single PDS suture through the biceps and amputated just proximal to this, and we trimmed the stump until it was flush with the superior labrum and in and out the biceps tendon itself to retract a short distance, where I would then shuttle the sutures out through tissue overlying the bicipital groove and leave these in the subacromial space for later retrieval and tying. Looking superiorly, his rotator cuff looked completely intact. There were absolutely no signs of tearing. I, therefore, took a biopsy. There was a bit of synovitis in the anterior portion that was a bit frondular. I took a sample of this with a basket and sent this to the lab for a 3-week culture. I then removed my scope and entered the subacromial space. Surprisingly, this looked completely intact as well. Looking at the rotator cuff, I thought it was remarkable how much intact it looked. I ran the shaver from the lateral portal and even switched portals one time for the lateral portal and did a full evaluation of the rotator cuff. I was able to see some of the sutures which were buried in scar tissue, but for the most part, this looked like a native rotator cuff. The needle fragment was not visible. I then cleaned off the undersurface of the acromion. I felt that there was a small amount of bone that likely had regrown. I performed a revision subacromial decompression utilizing a bur from the lateral portal. I did make my way to the AC joint. It did seem a little bit confined in the AC joint, and the bone had a very unusual look to it, such that it likely had regrown in this area. I performed a revision distal clavicle resection and then took 2 more biopsies throughout this subacromial region, going through a plastic cannula to make sure there was no skin contamination, and this was also sent for a 3-week culture. Once this was completed, I again did a full evaluation of the rotator cuff and again felt that it was completely intact, and at this point, my decision making became a lot more difficult. My original plan had been to remove all of the hardware, all of the suture, and re-repair his rotator cuff. However, looking at his rotator cuff actively, I did not feel even the best of circumstances that I could achieve the same result. I also became concerned by the look of the unusual bone that this could actually be a P. acnes infection, and in this situation, I felt the best thing to do would be to stop the procedure, await the culture results in the next 3 weeks, and then make a further decision and from here. On the one hand, if it turns out to be infected, then we will return to the operating room, where we will remove all of the anchors, and at that point, have to rid the patient of the P. acnes infection before we can attempt a revision repair. If, however, the biopsy specimens come back negative for P. acnes, then at that point, I am not certain that further surgery is going to make this

[redacted] Printed by [redacted], MD Page 13 of 15
[N9004655] at 9/7/17 1349

[redacted] Encounter Date: 09/06/2017

OP Notes (continued)

better. I certainly do not think taking down his rotator cuff and re-repairing it will achieve a result even consistent with what his current rotator cuff looks like. That being the case, I felt that the better part of caution was to simply wait and see how this turns out with the culture results.

I, therefore, removed my scope, milked fluid from the shoulder, closed with 3-0 a nylon, placed him in a sling and swath after retrieving my bicipital sutures and tying these to complete the tenodesis. I then closed and placed him in a sterile dressing. He was then transferred to the PACU in stable condition with no known complications.

[redacted] MD

Dictated by [redacted] MD 09/06/2017 10:51:37
Transcribed on 09/06/2017 11:33:36 by jv job# 6267021
Confirmation #: 1778188

Plaintiff Name: [redacted]
Date of Incident: 07/14/16

Pg 736- 09/21/17- OV before surgery-[redacted] MD

Date: 09/22/2017

Dear [redacted]

The following is a summary of your visit today. If you have any questions, please contact our office.

Sincerely,

[redacted] MD

Patient Care Summary for [redacted]

Most Recent Encounter
09/21/2017 [redacted]

Reason for Visit
FOLLOW UP RIGHT SHOULDER

Assessment and Plan

The following list includes any diagnoses that were discussed at your visit.

1. History of arthroscopic procedure on shoulder

2. Rupture of tendon of biceps

- proximal biceps tendon tear: before your surgery

3. Disorder due to infection

Discussion Note

Mr. [redacted] is here today for a follow up on his right shoulder. He is now 2 weeks post surgery. I discussed with him that the results of 2 of his 3 surgical biopsies were positive for a p.acnes infection. I informed him that this infection is related to his previous surgery performed by Dr. [redacted] on 7/14/16 and is therefore related to his L&I claim. Moving forward, I recommend having him consult with Infectious Diseases, then proceed with a removal of hardware, of his 3 prior anchors and the broken needle tip, and I&D. Afterwards he will be placed on IV antibiotics for 6 weeks. I informed him that once the infection is resolved we can then proceed with a revision biceps tenodesis. The patient understands and is agreeable with this plan of care. All questions and concerns were answered.

Pg 475- Op Report- 09/22/17-[redacted], MD

[redacted]

with right-sided shoulder pain. I subsequently was able to identify on biopsy that in fact he had a P. acnes infection. I had discussed with him the risks, benefits, alternatives and complications of operative intervention for a complete hardware removal. There was also a small piece of broken needle that was identified in the shoulder on the x-rays. I felt that this needed to be removed as well. Obviously, this was going to be a very difficult procedure considering the needle was stuck in the tendon. He understood this. He wished to proceed forward and the consent was done.

DESCRIPTION PROCEDURE: The patient was identified preoperatively and the shoulder was signed by me. He was then taken to the operating room where a preoperative regional followed by general anesthetic was administered. He was then placed in the beach chair position and his bony prominences were all well-padded. He had bilateral sequential compression devices and his neck was kept in a neutral position. He was then prepped and draped in standard surgical fashion. Preoperative antibiotics had been delivered earlier today and a timeout was called and documented. I began by entering the subacromial space. There, I was able to identify his rotator cuff repair. I traced all the stitches until I could identify each of the anchors. The anchors were then backed out in their entirety. A picture of this was taken. Each of the sutures was also removed. I then brought in x-ray and was able to identify the location of the needle. I was able to simply remove this with the shaver. I could not ever really see the needle; however, I could see it bouncing up and down on the x-ray as I shaved in the vicinity and then suddenly it was gone. Full x-rays of the shoulder demonstrated that it was no longer in the shoulder. Once this was complete, evaluating the damage to the rotator cuff, there did still appear to be fairly large areas of rotator cuff that were completely intact. We really just had a bore down right on the region of the sutures where the anchors were and these were relatively small areas in the anterior and posterior aspect of the greater tuberosity. In addition, there was one on the lateral aspect of the greater tuberosity that was also removed. The needle itself was really right in the rotator interval between the supraspinatus and infraspinatus, more of a posteriorly-based needle. Once this was complete, I removed my scope, milked fluid from the shoulder, closed with 3-0 nylon, placed him in a sling and swathe and he was transferred to the PACU in stable condition with no known complications.

[redacted] MD

Dictated by [redacted] MD 09/22/2017 19:34:50
Transcribed on 09/22/2017 21:47:07 by kds job# 6277471

Printed by [redacted]

Pg 512- PostOp OV- 10/05/17- [redacted] MD

REVIEW OF SYSTEMS:

ROS as noted in the HPI

PHYSICAL EXAM

Patient is a 46-year-old male.

Post Operative Exam:
General Appearance: no swelling, tenderness, or warmth and wound clean and dry, appropriate range of motion, and neurovascular intact.

Inspection: No soft tissue swelling. No rotator cuff atrophy. No scapular winging. No ecchymosis over shoulder or upper arm.
Skin exam is normal. No lymphadenopathy. Well healing incisions, sutures were not removed.

Popeye deformity of bicep

Range of motion (active):
Not tested 8 days postop

Strength:
Not tested 8 days postop

Sensation: Sensation grossly intact to light touch in median, ulnar, radial, axillary and musculocutaneous distributions.
Motor: Grossly intact EPL, IO, Grip, Pinch, Wrist Extension and Flexion.
Circulation: Radial pulses are regular and symmetric with no clubbing or synosis.

Diagnostic Imaging
I obtained right shoulder x-rays in 4 views. This shows the distal clavicle resected 1 cm. The under surface of the acromion is type 1 in morphology after the subacromial decompression. There is a retained needle present in the rotator cuff from previous rotator cuff repair. No foreign bodies, fractures, or other bony abnormalities.

Impression
Status post above procedure, with no acute findings.

PROCEDURE DOCUMENTATION

None recorded

ASSESSMENT/PLAN

Status post right revision subacromial decompression, revision distal clavicle resection, biceps tenodesis and biopsy x3 on 9/06/17

Postoperative right shoulder pain in the setting of a bicep tendon rupture

1. **Rupture of tendon of biceps**
   M66.821: Spontaneous rupture of other tendons, right upper arm
   - PROXIMAL BICEPS TENDON TEAR: BEFORE YOUR SURGERY

2. **History of arthroscopic procedure on shoulder**
   Z98.890: Other specified postprocedural states

[redacted] ORTHOPAEDIC ASSOCIATES PLLC [redacted]

III. Recommendations:

1.	Depo Questions done above for both Ortho Surgeons- [redacted] MD - #1 and [redacted] MD- #2
2.	Obtain missing documents listed above

IV. MEDICAL HISTORY AT TIME OF SURGERY

Height/Weight:	5ft 11in, 215lbs
Past Medical History:	Osteoarthritis knee Adhesive capsulitis shoulder Supraspinatus tear Closed fracture proximal humerus, greater tuberosity Tear medial/ lateral meniscus of knee' Strain rotator cuff capsule—R- 01/30/17 GERD Lung nodules Ulcer
Past Surgical History:	2003- appendectomy 2004- cholecystectomy 07/31/13- knee arthroscopy 2014- esophageal repair 03/11/14- gastric fundoplication w/lysis of adhesions

V. Medications at time of Surgery:

1.	Tums
2.	Zantac

VI. Co-Morbidities:

1.	Smoker-- ↓ tissue/ wound healing
2.	Sleep apnea--- difficult intubation
3.	GERD, hiatal hernia

VII. Medical Fact Chronology Timeline

Plaintiff Name: [redacted]
Date of Incident: 07/14/16

Medical Fact Chronology Timeline				
Date	**Provider**	**Event**	**Outcome**	**Pg #**
03/18/16	[redacted] Hospital [redacted] ARNP	**EMERGENCY ROOM VISIT:** **CC:** Fell on R shoulder stepping out of shower while on business trip for work, immed severe pain, unable to raise / move arm **MEDS:** Tums, Zantac **PMH:** GERD, hiatal hernia, lung nodules, snores, ulcers- esophageal & intestinal, difficult intubation **PSH:** Appendectomy, cholecystectomy, UGI, L knee arthroscopy x2,03/11/14- gastric fundoplication- lysis of adhesions Seen in ER- [redacted] Hosp- XRs neg **XR R Shoulder**- neg	DX: R shoulder strain R rotator cuff injury	194 188
03/23/16	[redacted] MD	**SPORTS MED OV:** Fell coming out of shower tried to brace fall w/R hand but went straight into counter on R side, flew home that day, seen @ SPH ER that night, told no fx/ dislocations Pain- 10/10, pain w/any movement, reports some numbness in fingers **XR R Shoulder**- negative	Ref to PT x2-3wks w/o improvement RX: Diclofenac RX: Norco	619
03/30/16	[redacted] MD	**SPORTS MED OV:** R shoulder pain, no MRI yet, no N/T	**DX:** Strain Rotator cuff capsule	616
05/02/16	[redacted] Ortho Assoc	**MRI R Shoulder** Mild AC joint arthropathy; **Non-displaced mildly comminuted fracture @ anterior aspect of greater tuberosity**; high grade		286

Medical Fact Chronology Timeline

Date	Provider	Event	Outcome	Pg #
		partial thickness bursal surface tear @ distal end of supraspinatus tendon 1.2cm, infraspinatus tendinosis, mild AC arthropathy		
05/06/16	[redacted] MD	R shoulder- 6/10 Only improved 5% after PT x2-3wks **MEDS:** Chantix (smoking cessation) Diclofenac (inflammation) Norco (narcotic pain)	Nondisplaced fx R humerus Supraspinatus tear- incomplete rotator cuff tear- non-traumatic	300, 609
05/23/16	[redacted] MD	**INITIAL ORTHO SURG OV** Not improved w/time **MEDS:** Chantix (smoking cessation) Diclofenac (inflammation) Norco (narcotic pain)	Wants to proceed w/surgery Rec arthroscopic acromioplasty w/poss mini open rotator cuff repair. XR showed cystic change in AC joint, assoc tenderness c/w moderately severe DJD, therefore,	3, 290
06/15/16	[redacted] MD	**OS OV:** **CC**: cont mod-severe gen R shoulder pain w/limited mobility R AC Joint injection w/improvement	**DX:** 1. closed fx prox humerus greater tuberosity 2. Incomplete rotator cuff tear or rupture of R shoulder- not traumatic 3. Impingement syndrome R shoulder 4. Primary osteoarthritis R shoulder Discuss surg/ rehab on f/u	100, 596
06/20/16		AC joint degeneration mild on MRI, XRs show evidence of cystic changes c/w more moderate disease and significant pain relief w/anesthetic injection		101

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Medical Fact Chronology Timeline

Date	Provider	Event	Outcome	Pg #
07/14/16	[redacted] Surgery Center [redacted] MD	**SURGERY:** 1. R shoulder arthroscopic acromioplasty, 2. R shoulder arthroscopic distal clavicle excision 3. R shoulder **mini open rotator cuff repair (supraspinatus)** **A spinal needle was used to pass a 2-0 nylon marking suture through the tear on the bursal surface…AC joint localized with a spinal needle….[min open rotator cuff repair]…incision centered over previously placed marking suture…**	At time of surg had high grade partial thickness tear of supraspinatus 2cm	590, 761 591
07/27/16	[redacted] MD	**OS OV** Doing well, wearing sling, modified duty @ work re: computer work **XR R SHOULDER:** Negative--- GH joint unremarkable w/o evidence of joint space narrowing/ spurring; AC joint has not been resected; undersurface of acromion has been resected, humeral acromial space maintained [the XR did not show the needle presence]	Initial healing can take 6-8wks, do passive ROM, use sling, avoid stress; Cont modified work duty RX: Dilaudid f/u 4wks w/XRs	583, 765
09/07/16	[redacted] MD	**OS OV** Doing well w/ grad progress of ROM	Cont sling Cont PT Cont modified work duties f/u 6wks	768
10/13/16	[redacted] MD	**OS OV:** R AC joint injection given w/relief	**Awaiting L&I approval for surgery**	534
10/17/16	[redacted] MD	**OS OV** Cont **mod-sev** R shoulder pain, **feels sharp pain at times**, feels has hit plateau in rehab, cont w/PT, HEP,	**DX:** 1. R shoulder strain w/high-grade partial thickness RCT, s/p R shoulder arthroscopic	521

Medical Fact Chronology Timeline

Date	Provider	Event	Outcome	Pg #
		cont w/modified duties @ work since does computer and not physical work	acromioplasty, clavicle excision and R shoulder mini open RCR (supraspinatus) 2. R shoulder nondisplaced greater tuberosity fx/ contusion **PLAN:** Anti-inflammatories- OTC NSAIDs Cont PT Able to work regular duty f/u 1mo	
11/11/16	[redacted] MD/ [redacted] PAC	**OS OV** Eval for R frozen shoulder, elected to proceed w/ manip under anesth	Adhesive capsulitis Sched surg + inj w/ [redacted]	334
11/17/16	[redacted] MD	**SURGERY:** R shoulder manipulation under anesthesia + R shoulder GH joint injection	Some adhesions broken free	337, 775
11/21/16	[redacted] MD	**OS OV** Working modified duties as works on computer; wears sling at all times		325
11/23/16	[redacted] MD	**OS OV** Working w/PT, going well, sl improvement w/ROM, mod-severe R shoulder pain	Cont PT Able to work reg duty f/u 4wks	378
11/28/16	ATI PT	**PT OV #27** Doc wants him to take a break from PT- sees MD again on 11/23 to see about restarting PT		373
12/30/16	[redacted] MD/ [redacted] PAC	**OS OV** Cont w/pain post manipulation under anesth- unable to do PT d/t pain	DX: Adhesive capsulitis Closed fx prox hum/gr tuberosity Supraspinatus tear Released back to full duty	147
- 01/23/17	ATI PT	Seen x 32 visits R shoulder		122

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Medical Fact Chronology Timeline				
Date	**Provider**	**Event**	**Outcome**	**Pg #**
01/23/17-	ATI PT		Auth 12 visits 12/31/16-02/15/17	116
01/30/17		**OS OV** Feels rehab progress declining, numbness/tingling down R arm, const severe pain R shoulder, stopped PT		242
02/01/17	[redacted] MD		**DX:** Poss recurrent RCT Poss brachial flexor inj, cervical radiculopathy **PLAN:** EMG/NCV to r/o neuro pain etiologies for weakness May need revision RC repair	96
02/08/17	[redacted] MD [redacted] Radiology [redacted] MD- Rad	**CT R SHOULDER-** No fracture Endosteal lesion in prox hum shaft 5cm below joint, cortical thickening w/tubular central lucency involving anterior cortex of proximal humerus, 5cm below the joint measuring 0.9 x 0.6 x 1.6cm, may represent vascular channel, possibly osteoid osteoma	…could be vascular channel, osteoid osteoma or small chronic focus of infection….chronic cortical osteomyelitis…	799, 250
02/16/17	[redacted] Ortho Assoc [redacted] MD	**OS OV** R GH joint injection pre-arthrogram **MRI ARTHROGRAM-** NEAR Full thickness tear of infraspinatus, 6mm ant post w/2.3cm of medial prox intrasubstance degeneration, subcapularis tendinosis, biceps tendon intact	**DX:** impingement syndrome R shoulder	99 15, 812
02/24/17	[redacted] MD	**OS OV** Cont w/pain, no progress, throbbing pain w/activ, N/T down R arm, cont to h old off PT, working reg duty	**DX:** Strain R rotator cuff capsule Closed fx prox humerus, greater tuberosity	4

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Medical Fact Chronology Timeline				
Date	**Provider**	**Event**	**Outcome**	**Pg #**
			Could be recurrent RC tear or incomplete healing MR Arthrogram showed high grade partial thickness tear of infraspinatus- 6mm + 2cm of medial substance degeneration--- could be causing pain/ weakness Poss neurogenic etiology—Cervical radic or brachial plexopathy, could have been an addl inj not recognized	
04/25/17	[redacted] MD	**INITIAL OS OV** **CC:** R recurrent RTC tear FT RCT Pain could be d/t recurrent rotator cuff tear d/t poss infection	DX: Strain rotator cuff capsule Full thickness rotator cuff tear Get R shoulder aspiration Released back to work on 03/27/17 F/u 32wks after aspiration	10, 723
05/05/17	[redacted], DO	**EMG/NCS** Normal [actual report missing]		318
05/15/17	[redacted] Radiology [redacted] MD	R shoulder aspiration—NEGATIVE		801
05/25/17	[redacted] MD	**OS OV** Recent EMG/NCV didn't show any cervical radiculopathy or brachial plexopathy	f/u [redacted] for 2nd opinion	311
06/19/17	[redacted] MD	**OS OV:** CC: f/u R shoulder—aspiration culture neg MEDS: Losartan (↑BP)	**DX:** Strain rotator cuff capsule Full thickness rotator cuff tear Closed fx prox humerus/ greater tuberosity Rec surg, he agrees	726

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Medical Fact Chronology Timeline

Date	Provider	Event	Outcome	Pg #
07/10/17	[redacted] Surg Ctr [redacted] MD	**SURGERY:** Repeat R shoulder arthroscopy RTC repair revision, decompression, hardware removal DOI: 03/18/16- slip/ fall **PMH:** GERD, hiatal hernia, former smoker	**DX:** Primary osteoarthritis R Shoulder Complete rotator cuff tear/ rupture R shoulder not traumatic Bursitis R shoulder	18
08/09/17	Case Mgr		**DX:** Nondisplaced fx greater tuberosity R humerus R RC tear R shoulder adhesive capsulitis R shoulder bursitis Osteoarthritis R shoulder	21
08/24/17	[redacted] MD UR Notes	R shoulder injection w/100% relief Surgeon requests R RCR revision, decompression, possible removal of loose bodies, hardware removal and revision of distal clavicle excision on 09/05/17	Surgery planned appropriate--approved	37, 500 502
09/06/17	[redacted] Hospital [redacted] MD/ [redacted] PAC	**SURGERY:** Revision subacromial decompression, revision distal clavicle resection, Biceps tenodesis and bx x3 SAD, DCE Aske to see for recurrent AC arthrosis, recurrent impingement as well as retained hardware and retained needle fragment …no adhesive capsulitis…	**Pre/Post Op DX:** 1. R Recurrent rotator cuff tear 2. Recurrent impingement syndrome 3. Recurrent acromioclavicular arthrosis	87, 453

Medical Fact Chronology Timeline

Date	Provider	Event	Outcome	Pg #
		…absolutely no signs of tearing….so biopsy done…SA space looked completely intact….RC looked remarkably intact… …needle fragment not visible…		
09/07/16	[redacted] MD	**OS OV** F/u 1st postop R shoulder—popping heard was bicep tendon rupturing **XR R SHOULDER: negative**	f/u 6wks	806 807
09/08/17	[redacted] Hospital [redacted] FNP	**EMERGENCY ROOM VISIT** **CC:** Leg swelling- 2d s/p Rotator cuff surgery **HPI:** bilat lower leg edema, R shoulder- 7/10- no chest pain/ pressure US- negative for DVT CXR- negative	DX	640 668
09/15/17	[redacted] MD	**OS OV** F/u R shoulder—popping heard was bicep tendon rupturing	**DX:** Rupture tendon biceps h/o Arthroscopy R shoulder	732
09/18/17	[redacted] MD/ PAC	**OS OV**: 12d postop Rupture tendon biceps--- getting out of chair and felt + hear a pop w/severe pain in shoulder, now w/bruising	**DX:** Popeye deformity R bicep RX: Oxycodone RX: Percocet	91, 711
09/22/17	[redacted] MD	**OS OV** 2 of 3 surgical biopsies were positive for P. Acnes- infection r/t prior surg by [redacted] 07/14/16; needs consult w/ID then move forward for removal of hardware- anchors + broken needle tip…	**DX:** h/o shoulder arthroscopy Rupture tendon biceps Disorder d/t infection	736

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Medical Fact Chronology Timeline				
Date	**Provider**	**Event**	**Outcome**	**Pg #**
09/21/17-09/23/17	[redacted] Hospital [redacted] MD	**ADMITTED TO HOSP** **CC:** persistent pain after debridement/ hardware removal surgery **ID CONSULT** Admitted for removal of remaining staples, lavage and initiation of IV abx	likely requiring prolonged hosp for pain control; anticipate D/C next 1-2d	638 651
09/22/17	[redacted] Hospital [redacted] MD [redacted] MD	**SURGERY:** Manipulation under Anesth R shoulder I&D, ROM, **removal of hardware/ anchors** Cont w/ltd ROM/ pain …bx showed P. Acnes infection…also small piece of broken needle identified in shoulder XRs, needed to be removed as well, difficult procedure considering needle stuck in tendon….brought in XR and able to identify location of needle, could not ever really see the needle, however could see it bouncing up and down on XR as I shaved the vicinity and suddenly it was gone….full XRs of shoulder revealed no longer in shoulder…..needle itself was really right in the rotator interval between the supraspinatus and infraspinatus, more of a posteriorly-based needle. **ID NOTE:** Start 6wks IV abx – ending 11/03/17	**Pre/Post Op DX:** 1. R shoulder postop infection w/retained hardware Rec/approved 12 PT visits 11/26/17-01/07/18 Discharged home for IV abx infusion x6wks	85, 474, 790 475
10/03/17	[redacted] MD	**OS OV**	Wean out of sling Start PT for shoulder protocol	461, 729

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Medical Fact Chronology Timeline				
Date	**Provider**	**Event**	**Outcome**	**Pg #**
		F/u R shoulder surg—saw small regrowth of bone over AC joint and **wants to resect that portion but the procedure denied by L&I…** given diagnostic injection AC joint—reported **99% improvement** immed after	RX: Ambien (insomnia) RX: Dilaudid (narcotic pain)	
10/05/17	[redacted] PA/ R. [redacted] MD	**OS OV** Getting out of chair and **heard pop w/severe pain in shoulder**, now w/bruising anterior/lateral shoulder, wearing sling as advised …obtained R SHOULDER XRs- there is a retained needle present in rotator cuff from previous rotator cuff repair, no foreign bodies.	**DX:** **Ruptured biceps tendon** Pt wants surg to repair biceps but told to wait results of bx from last surg	424 512
10/06/17-11/28/16	[redacted] PT	Shoulder protocol	Seen x27 visits	
10/20/17	[redacted] MD	**OS OV** Postop f/u **XR R SHOULDER:** Showed clavicle resected 1cm …prior needle no longer noted…	**DX:** Postop infection h/o arthroscopic proced shoulder RX: Ambien (insomnia) RX: Dilaudid (narcotic pain) f/u 4wks cont PT	484
11/03/17	[redacted] MD	**ID OV** Completed 6wks IV Abx via PICC line, cont w/ ↓ ROM PICC line pulled	Will likely require at least biceps tendon repair if not reattempted rotator cuff repair	422
11/07/17	[redacted] MD	**OS OV:** Finished Abx, still has severe stiffness severe pain/pressure in shoulder, wearing sling	Rec another aspiration 3wks from today prior to proceeding w/bicep repair- pt agrees F/u 4wks	415, 740

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Medical Fact Chronology Timeline				
Date	**Provider**	**Event**	**Outcome**	**Pg #**
		MEDS: Celebrex (inflammation) Norco (narcotic pain) Oxycodone (narcotic pain) Zolpidem (insomnia)		
12/08/17	[redacted] MD	**OS OV** **CC**: 7wks postop f/u, finished abx, cont severe stiffness/ pain R Shoulder aspiration done	Stop wearing sling Cont PT for scar tissue break down Aspiration in 3wks f/u 4/wks	700 803
12/11/17	[redacted] MD/ PAC	**OS OV** **CC:** f/u R shoulder- making progress w/ROM Aspiration sched for today	F/u 01/01/18	715
01/30/17	[redacted] MD	**OS OV** **CC:** cont w/diff w/pain, ltd ROM, weakness. No evidence of frozen shoulder at time of manipulation. <u>Poss etiologies for failure to progress</u>: 1. recurrent rotator cuff or incomplete healing of greater tuberosity fracture 2. Neurogenic etiology—if eval of rotator cuff & gr tuberosity unremarkable, then 3. based on Mech of Injury, may have been an addl neck or brachial plexus inj not recognized accounting for persistent pain/ weakness.	 Rec MR Arthrogram to assess rotator cuff and CT scan to assess healing of gr tuberosity fx Rec getting MRI C-Spine + poss EMG to r/o cervical radiculopathy or brachial plexopathy Cannot eval neck and brachial plexus until he completes the shoulder MR Arthrogram and CT scan	744
02/24/17	[redacted] MD	**OS OV** **CC:** F/u MR Arthrogram Cont w/ ltd ROM/ weakness	**DX:** strain rotator cuff capsule Close fx prox hum/ gr tuberosity	748

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Date	**Provider**	**Event**	**Outcome**	**Pg #**
		CT scan showed prev gr tuberosity fx well healed. MR Arthrogram suggests high-grade partial thickness tear of infraspinatus, not large- 6mm anterior posterior although there's 2cm medial or substance degeneration—area of previous supraspinatus repair appears well healed—this could potentially cause pain/ weakness.		
03/27/17	[redacted] MD	**OS OV** EMG f/u [no results found]		752

Thank you kindly for this referral. These conclusions and recommendations have been based on those documents currently on file and previously submitted. Should further information become available, this should be reviewed by Trifecta Legal Nurse Consulting to determine content and relationship to the case.

Respectfully Submitted,

[redacted]

Trifecta Legal Nurse Consulting