

LT

- 45 yo RHD male electrician presented to me Nov 2017 for second opinion
- Left shoulder pain started in 2015- no trauma
- Seen by outside physician. Found to have “small rotator cuff tear”- Left shoulder arthroscopic rotator cuff repair October 2015
 - Initially did well and went back to work for about a year.
 - He had more pain, night pain
 - New MRI showed a large rotator cuff tear
- May 2017
 - Left shoulder arthroscopy with open rotator cuff repair
 - Sling for two months
 - PT after that
 - Started strengthening October 2017
 - He had minimal pain but very poor motion
 - New MRI- concern for recurrent tear so referred to me
- October 2017
 - Doing PT 3 days a week. Feels he is plateaued in motion.
 - Pain 2/10

PE

- October 2017
 - Arthroscopic and open incisions healed.
 - Mild atrophy of infraspinatus fossa

Motion Shoulders

| Active Range of Motion | Right | Left |
|------------------------|-------|------|
| Forward Flexion | 170 | 130 |
| Isolated Abduction | 100 | 85 |
| External Rotation | 60 | 30 |
| Internal Rotation | T8 | T8 |

| Passive Range of Motion | Right | Left |
|-------------------------|-------|------|
| Forward Flexion | 170 | 140 |
| Isolated Abduction | 100 | 90 |
| External Rotation | 60 | 40 |

Neurovascular Exam Upper Extremities

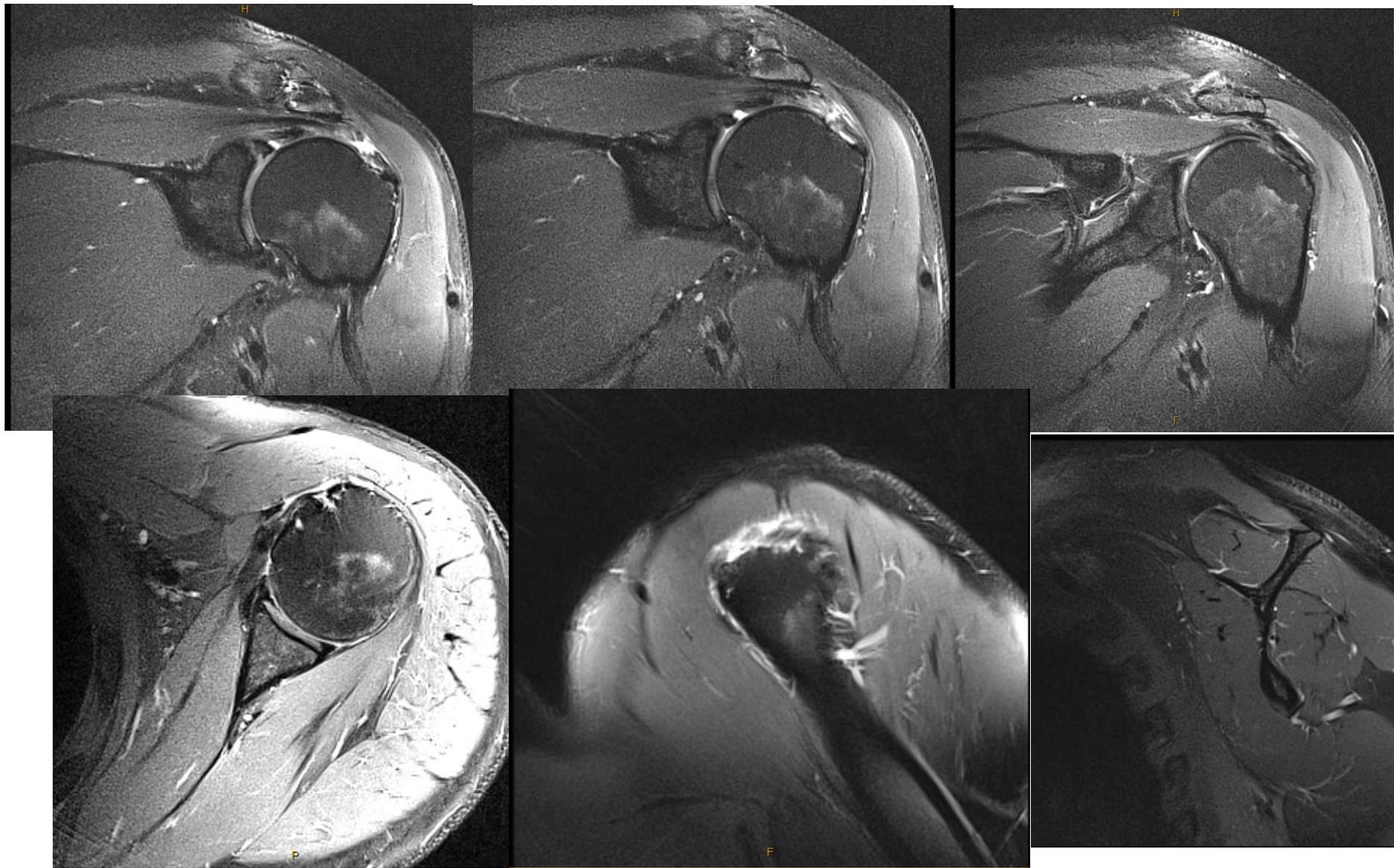
| Strength | Right | Left |
|-------------------|-------|------|
| Abduction | 5/5 | 3/5 |
| External Rotation | 5/5 | 3/5 |
| Internal Rotation | 5/5 | 5/5 |

Axillary, AIN, PIN, UN motor intact
Sensation intact to light touch Axillary, median, radial, ulnar nerves
2+ radial and ulnar pulses

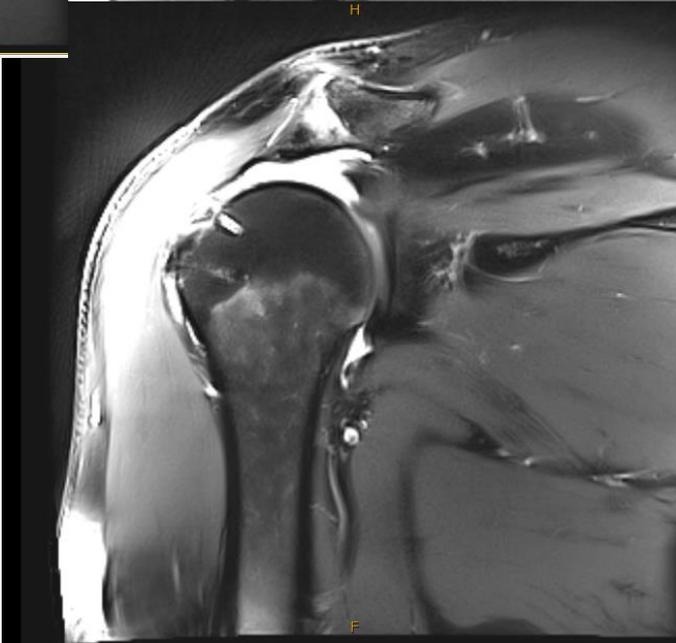
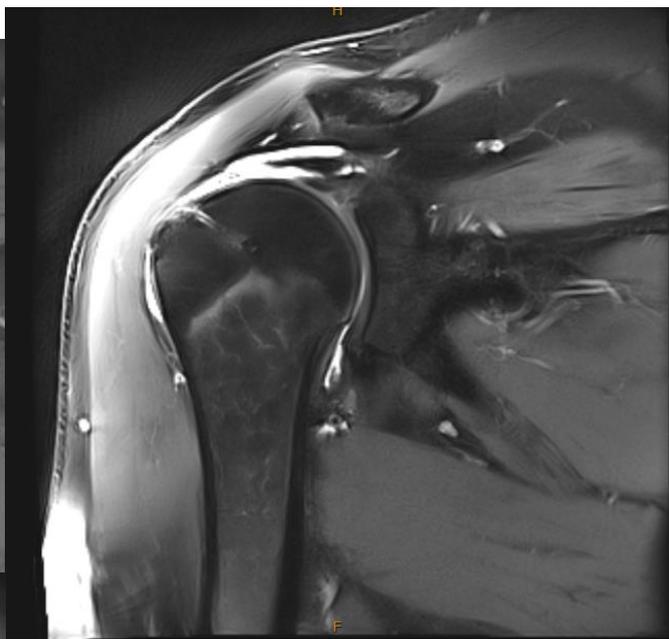
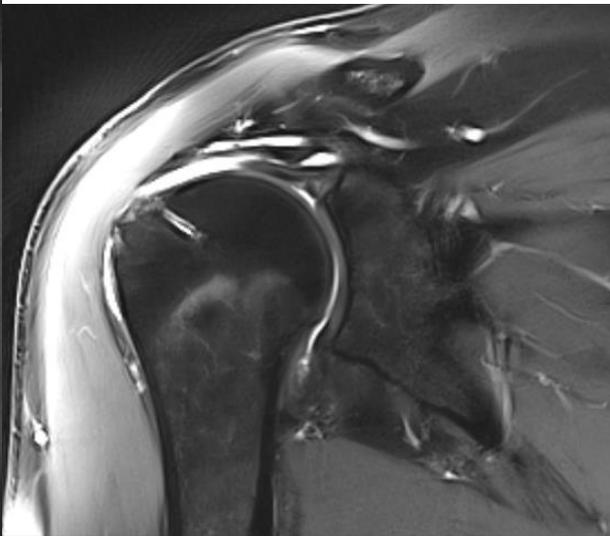
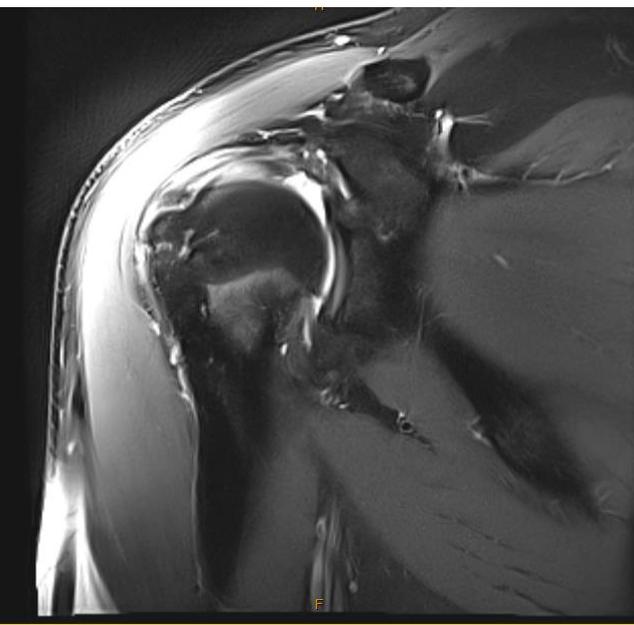
MRI's (all to follow)

- Multiple imaging studies were reviewed including x-rays from an outside source and 3 MRIS all from SJRA
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- Xrays demonstrate a normal shoulder. No lytic lesions or any osseous abnormalities.
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- MRI from 2015 shows a full thickness rotator cuff tear of the supraspinatus without retraction. It does extend the entire supraspinatus footprint.
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- MRI from earlier this year shows a full thickness tear of the supraspinatus leading into infraspinatus with retraction to the medial humeral head and glenoid. There is at least grade II/III atrophy of the supraspinatus muscle.
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- MRI October 2017 shows significant artifact throughout the tendon. It is difficult to discern what this is from. I do believe this is return.
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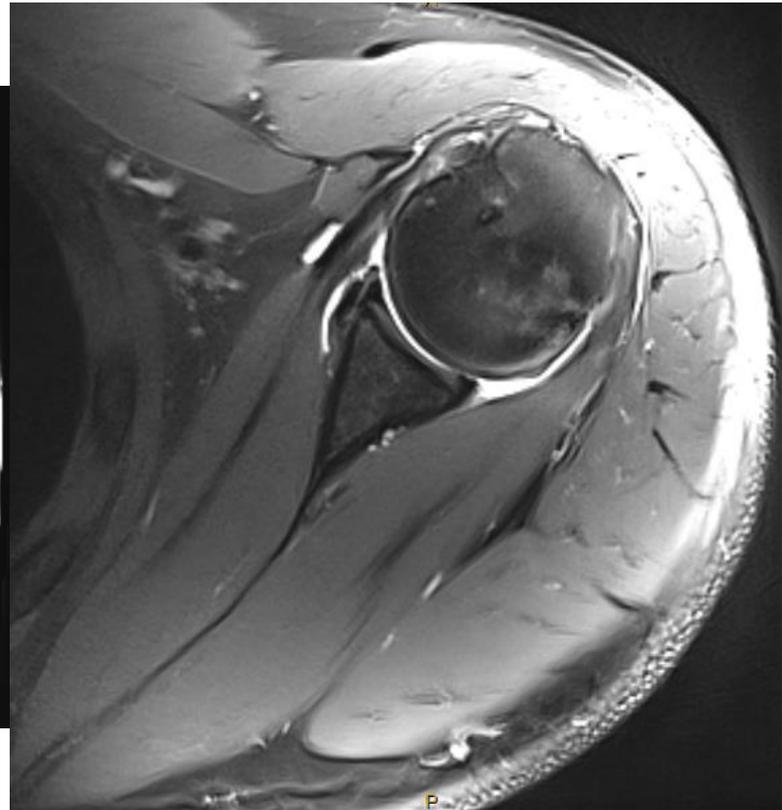
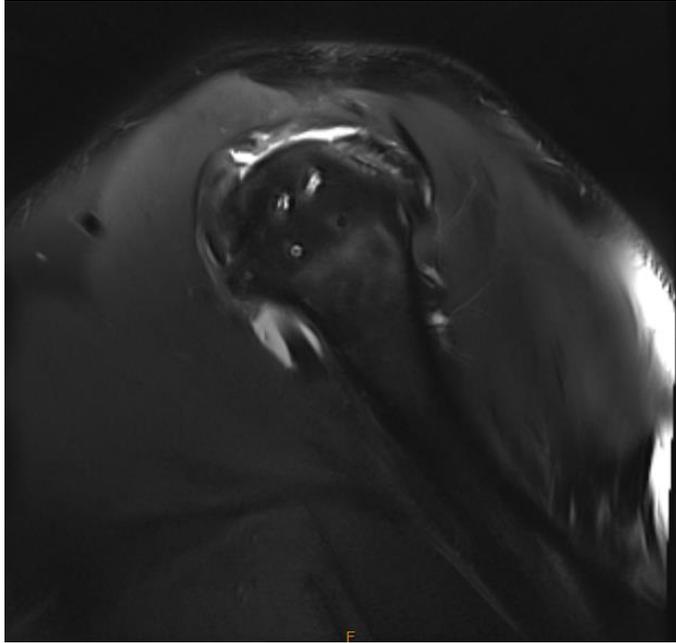
MRI October 2015



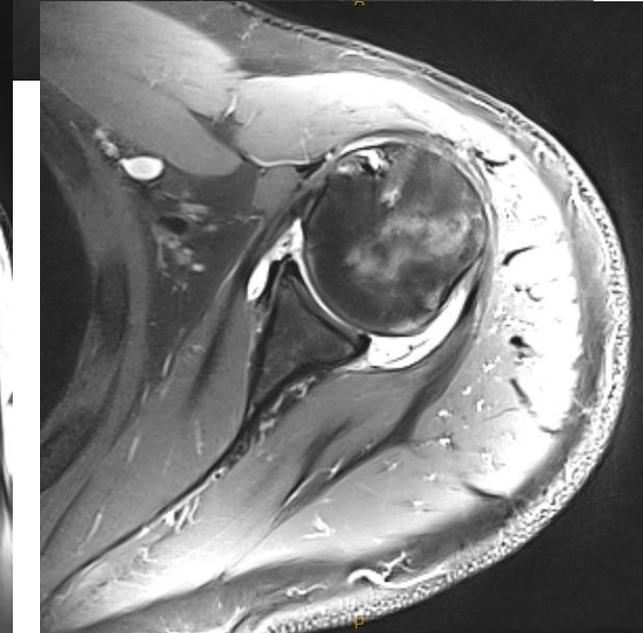
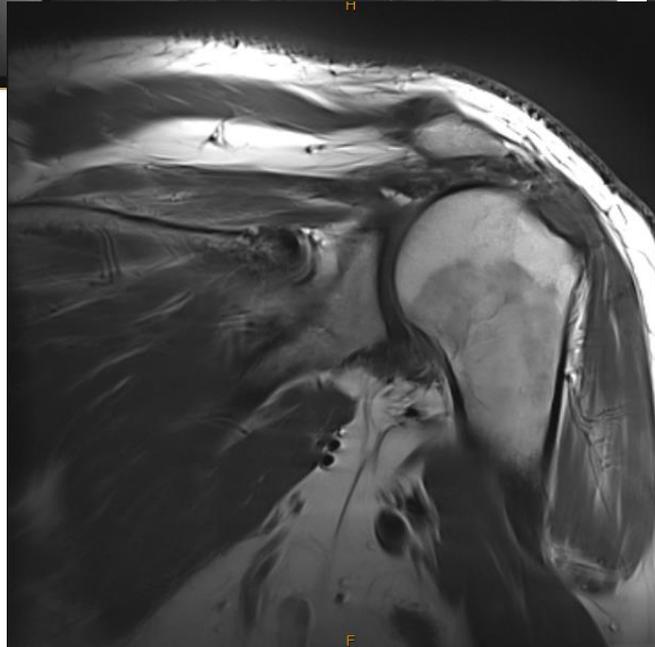
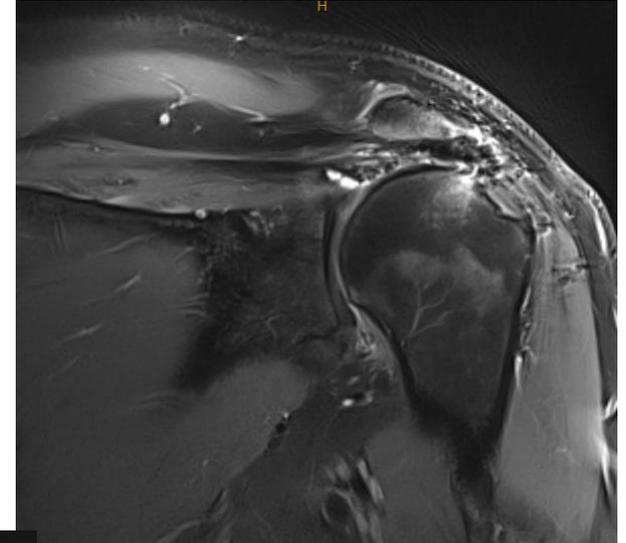
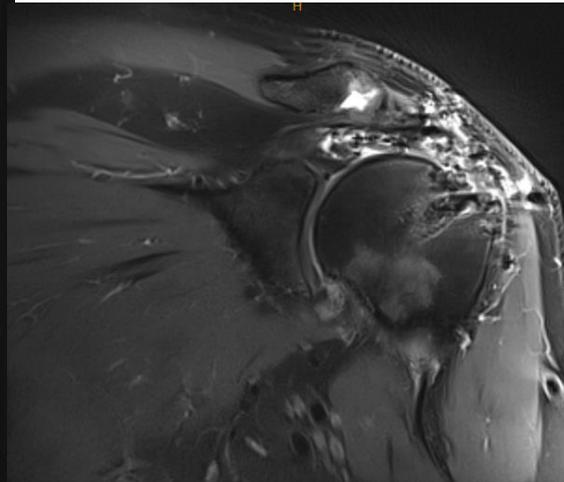
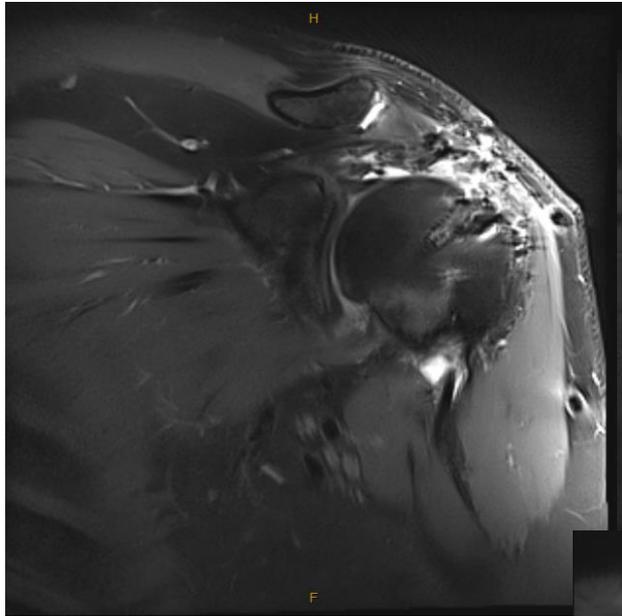
MRI Jan 2017



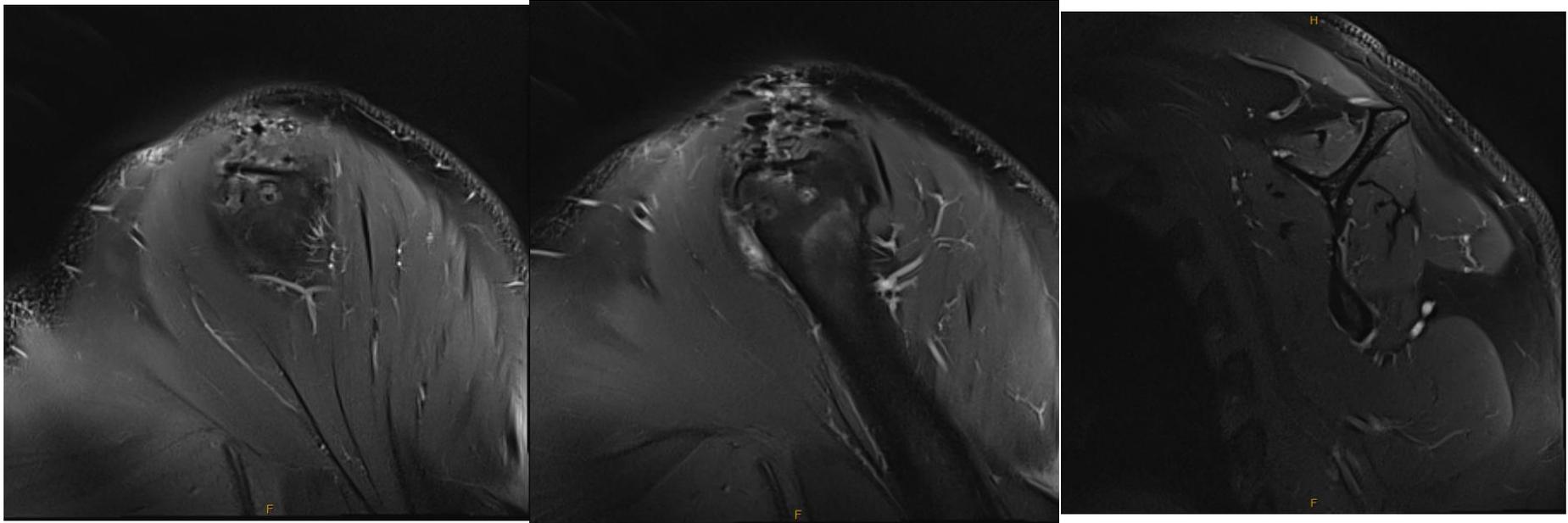
MRI Jan 2017 continued



MRI October 2017 (after second repair)



MRI october 2017 continued



No T1 Sag

EMG 2017

- Mild left suprascapular neuropathy involving only branch to infraspinatus muscle

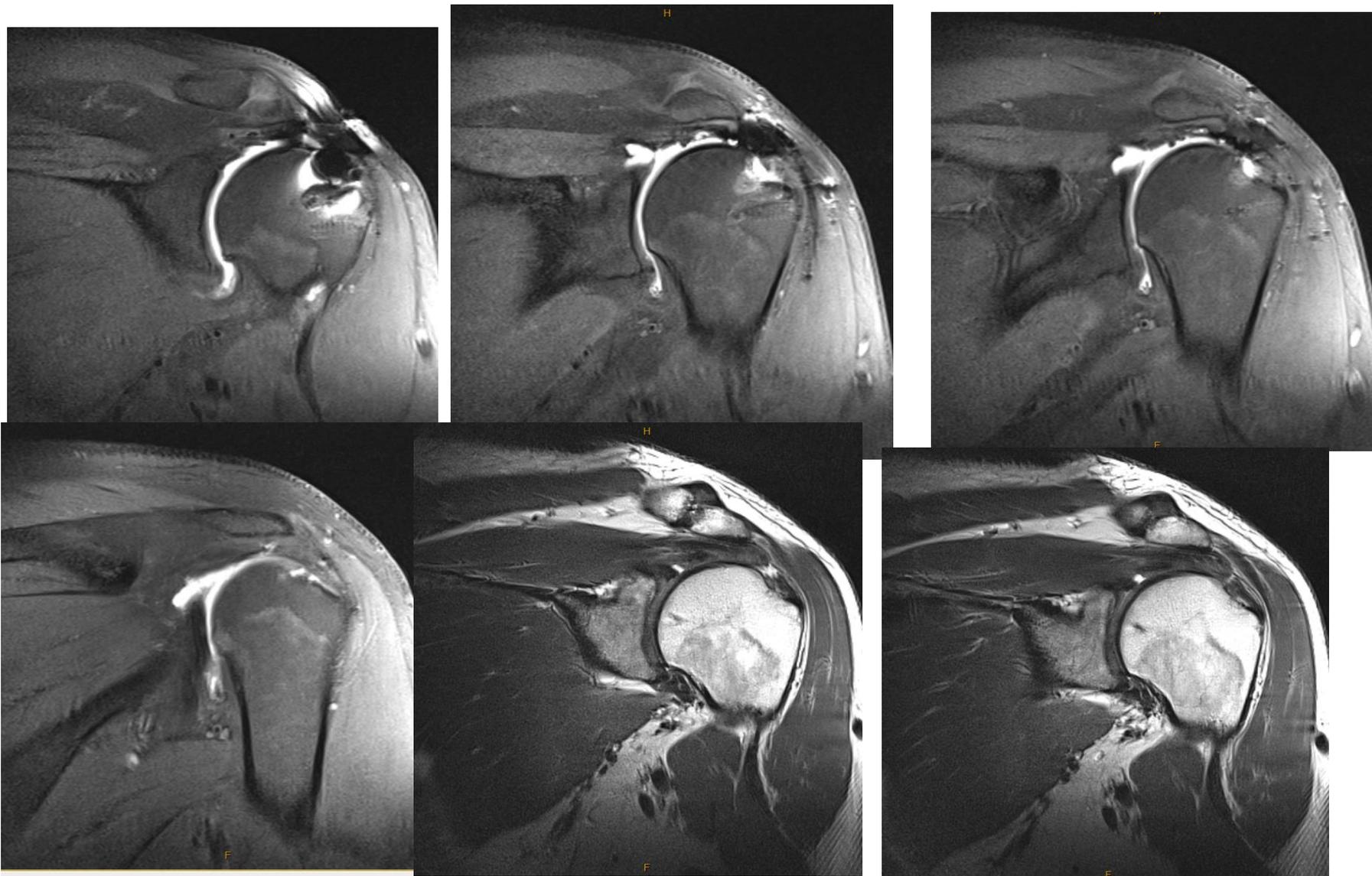
12/2017

- Left shoulder arthroscopy with capsular release and revision open rotator cuff repair (small longitudinal tear 2 cm x 1 cm)
- Found significant scar- thinned anterior supraspinatus and lots of loose sutures (pulled out 6 sutures)
- Very scarred into acromion.
- Small anterior longitudinal tear that was fixed with a single anchor

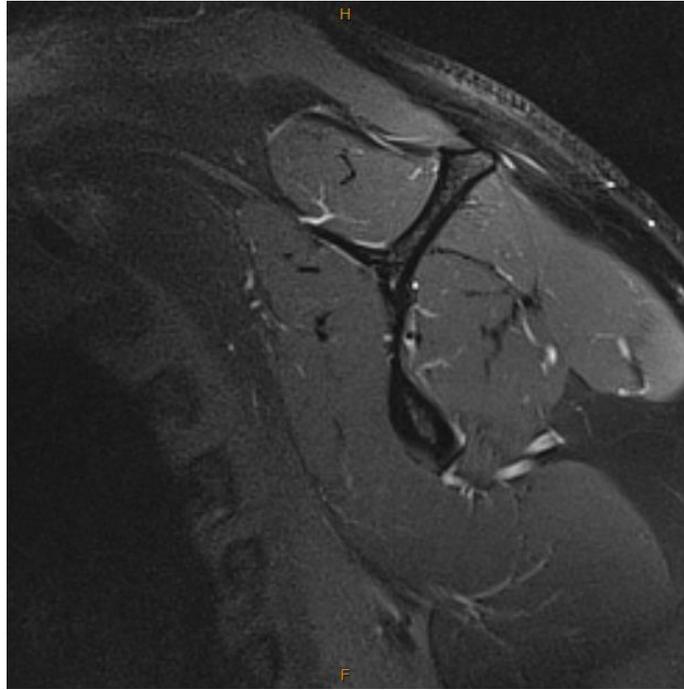
Postop (Last visit 7/2018)

- Started PT right away for ROM.
- He slowly regained his functional ROM but is weak and unable to do overhead activity (electrician) over 8 months postop
- Pain 1-2/10. Function is the problem
 - AROM FF 130 ABD 85 ER 30
 - PROM: FF 150 ABD 90 ER 40
 - Strength: 3/5 ABD 4/5 ER 5/5 Internal
- I reordered MRI and EMG – on slides to follow

MRI arthrogram June 2018



MRI June 2018 continued



Cuff overall appears grossly intact. No cysts to account for nerve compression.

EMG 2018

- **IMPRESSION:**
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- This is an abnormal study: Suprascapular neuropathy distal to suprascapular notch
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- There is electrodiagnostic evidence of a right suprascapular nerve injury distal to the suprascapular notch and innervation of the supraspinatus muscle. This is based upon the denervation potentials noted in the infraspinatus muscle only. Motor unit analysis of the left infra spinatus muscle demonstrates mild polyphasic motor units suggestive of a chronic process with reinnervation. These abnormal denervation potentials are not noted in the supraspinatus muscle, which suggests that the injury is distal to the suprascapular notch and innervation of the supraspinatus muscle. Nerve conduction studies however, of the bilateral axillary nerves and bilateral suprascapular nerves to both the infraspinatus and supraspinatus muscles demonstrate equal and symmetric latencies as well as amplitudes.

What to do?