SHOULDERtips

PATIENT POSITIONING

1. Position the patient seated in a low-back chair with the shoulder to be scoped extended downward. Ensure there is room to abduct and externally rotate the arm as desired.

PREPARING THE ENVIRONMENT

1. To keep the patient calm and comfortable, place system/cart slightly behind the patient. Once you have the views you desire, the cart can easily be wheeled to a place where both you and the patient can see the screen and discuss the findings.

2. Set up all analgesia supplies and PrepPak components behind the patient. The less the patient sees, the lower the anxiety level – resulting in a relaxed and easy way to manipulate shoulder.

ANALGEISA ADMINISTRATION

1. Use a 25-gauge spinal needle to administer ~15cc of 1% lidocaine
   - 2-3cc in the subcutaneous tissue
   - 6-7cc saturating the soft tissue/posterior rotator cuff musculature. Fan out to ensure wide anesthetized pathway for cannula insertion
   - 3-4cc in the joint capsule
2. Administer posteriorly to test angle/trajectory into the joint

Option: Add 2cc of bicarbonate to neutralize the pH of the lidocaine

ANALGEISA "MARINATING" PERIOD

1. Allow a full ten (10) minutes for the analgesia to activate prior to cannula insertion

2. Mark the desired insertion site with a marking pen

Hint: If you have multiple shoulder VSI's scheduled in a row, there is no need to sit and wait:

- Bring two patients into their exam rooms (one patient per room)
- Anesthetize patient #1 and explain/discuss the procedure
- Anesthetize patient #2 and explain, discuss the procedure
- Return to patient #1 and perform VSI exam and discuss next steps
- Return to patient #2 and perform VSI exam and discuss next steps
- Repeat with next set of two patients

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SCOPE INSERTION

1. Enter the joint using a posterior approach. The cannula should be directed from posterior to anterior, parallel to the floor, aimed toward the coracoid process. No traction is needed.

2. Insertion location: 2cm–3cm distal/inferior and 2cm–3cm medial to the posterolateral corner of the acromion. As a secondary check, pinch the humeral head between your thumb and third finger to find the joint line. In practice, these two insertion points should align.

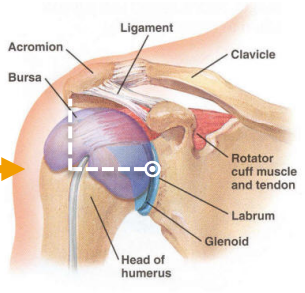
   Hint: When in doubt, direct the cannula slightly medial toward the inferior tip of the coracoid.

3. Insert the cannula with the sharp trocar angled toward the inferior tip of the coracoid. You should feel one "pop" as you insert the trocar through the skin. Once the capsule is felt, rotate the sharp trocar to begin capsular perforation and switch to the blunt trocar as desired.

   Hint: Use a 90°-to-0°-to-90° twisting rotation to help ease through the soft tissue and capsular perforation.

4. Once switched out to the blunt trocar a second noticeable "pop" will occur as you enter the capsule.

   Hint: Move the cannula with the blunt trocar in place up & down and left-to-right to ensure you are between the glenoid and humeral head (and not in the subacromial space) . The cannula should be inserted to a depth of 60mm-65mm.

Position	Angle	Depth
Posterior Beach Chair (seated in a low back office chair) 2-3cm below the lateral/ inferior edge of the acromion and 2-3cm medially	Straight back toward inferior tip of coracoid parallel to the floor Posterior Approach Target Point 	60-65mm Tangible Pop: Push 0.5cm and check mobility (lateral & medial, inferior & superior) to confirm intra-articular placement

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FIRST VIEW

- Blurry/Whiteout: Back up until the biceps and superior glenoid humeral joint are in view. If biceps cannot be identified and depth of cannula indicates outside the capsule, you may need to reposition inferior.

- Start Dry: Attach an "air filled" 10cc syringe to the the Luer Loc® on the cannula/camera hand piece. Deploy a single 10cc burst of air to help "distend" the joint initially. Control any bubbles by pushing bursts of air through the cannula. Abduction and external rotation should allow bubbles or fluid to fall into the pocket.

- Once location is visually confirmed, careful manipulation of the arm will allow greater anatomical views;
  - Internal & External rotation to confirm humeral head and Hill Sachs
  - External rotation abduction to see the rotator cuff and margin
  - Range of Motion to view view biceps/groove
  - Range of Motion to view anterior and posterior inferior glenoid

PERSONAL NOTES & TIPS

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