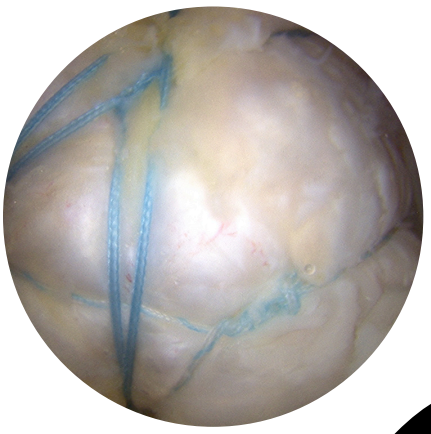
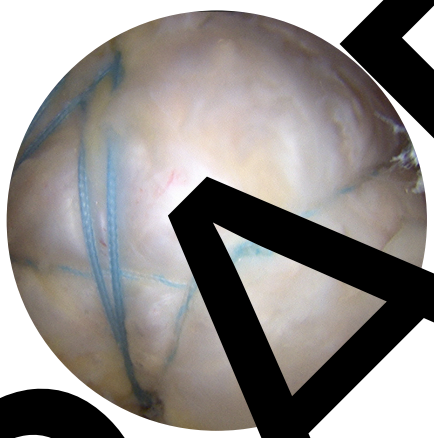
margin of the acromioclavicular joint. Attention was directed to the rotator cuff. There was a 2-tendon rotator cuff tear noted, off the anterior interval in an L shape with significant retraction. Tendon was freed of adhesions with arthroscopic elevators on both the joint and bursal surfaces. Tendon was diseased, but was able to be reduced back to its anatomic footprint on the greater tuberosity without tension. Bony bed was scarified laterally, and a fourth and final stab portal was created superiorly for anchor insertion. Two double-loaded HEALICOIL® Suture Anchors (Smith and Nephew, Andover, MA) were placed medially for medial row fixation, each loaded with two number 2 non-absorbent sutures. Tear geometry was addressed. Sutures were shuttled through the tend using suture passers for mattress repair to bone. Sutures were stored out the anterior portal for later retrieval and tying. Additio , 3 side-to-side sutures (number 2 FiberWire®, Arthrex, Naples, FL) were placed for margin convergence. Sutures were then retri from posterior to anterior, tied with a Tennessee Slider Knot, backed up with half-hitches.

Sutures were then criss-crossed, retrieved laterally, and placed through two 4.5mm Footprint anch 5m Nephew, Andover, MA) for lateral row compression. Anchor was deployed locking the sutures laterally, and then sutu is were c cellent loop and knot security was present, as well as coverage and tissue indentation (Figures 3 & 4). No further visualization of the articular contents was noted. Irrigation was undertaken. A spinal needle was introduced into the repaired t n at the midpoint of t dial and lateral rows (Figure 5). Suction of the subacromial space was undertaken, and AmnioFix wa cted into the repair site. Wo were closed and patient was awakened, placed in a sling, and transferred to recovery room an n home.





Figures 3 & 4
BridgeFix double-row rotator c epair

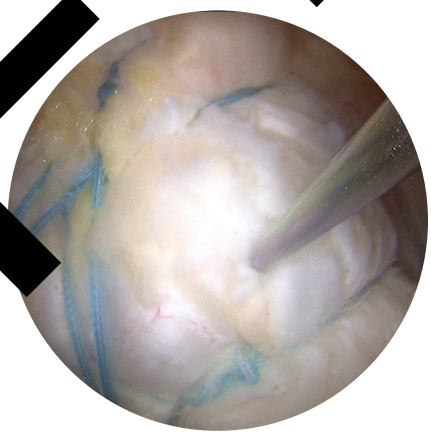


Figure 5
Injection of AmnioFix into rotator cuff repair

CLINICAL FOLLOW

Patient was placed in a sling for with instructions to work on elbow, wrist, and hand range of motion. Gentle pendulum and Codman exercises were instruc home. Patient followed up at two weeks for sutures out, discontinuation of sling, and sent for formal ph r a progre motion and strength protocol. At first post-operative visit, excellent, near normal passive range of was note a VAS pa rating of 2/10. Patient returned to clinic seven weeks post-op for follow up visit with pain s rating of 0/10. Ex tion of th lder revealed 170 forward elevation, 60 degrees external rotation with the arm at the , and internal rotation to symmetric easurements with contralateral uninjured shoulder. Rotator cuff strength testing was n t 5/5. Patient was very sa d with his results.

CONC GION

This case e is one of m that I have observed with accelerated rotator cuff healing and clinical success when augmenting my repairs wit tion of oFix at the repair site in a BridgeFix technique. AmnioFix adds less than 5 minutes to the surgical procedure and re a exposure or incision. This BridgeFix technique appears to offer increased healing rates and improved clinical outcomes. F ong-term studies are being conducted, but very promising observations are being made in patients with full-thickness rotator cu tears of all sizes. In this case example, the patient had poor tissue and a large retracted tear, two variables associated with significantly poorer outcomes. The addition of AmnioFix to the bridge repair appears to have greatly assisted in tendon attachment and regrowth.