syndesmosis dislocation for appropriate stabilization. When she came to the clinic yesterday, reviewed her radiographic studies, completed her examination, confirmed that she did indeed have a posterior and inferior instability pattern to her left proximal tib-fib syndesmosis causing current subluxation-dislocation type of phenomenon. Based on those clinical findings, review of her radiographic studies as well as her prior records, surgical intervention was discussed at length with her regarding an open reduction and internal fixation with insertion of 2 TightRopes to provide a dynamic stabilization as well as 1 bioabsorbable screw to provide an initial static stabilization. All of her questions were answered to her satisfaction regarding the overall procedure itself as well as the informed consent regarding the overall list of risks, benefits, potential complications, outcomes as well as postoperative management and rehabilitation. All of her questions were answered to her satisfaction. She verbalized understanding of this, is willing to accept this, and requested to proceed.

OPERATIVE COURSE: Following informed consent, the patient was identified in the preoperative holding suite. The operative site was marked. The patient was then taken to the operative site. She was placed on table in supine position. A general anesthetic was then administered. A left upper thigh tourniquet was then placed. An intraoperative time-out was completed to verify the patient's name, the operative procedure, the operative site, surgeon, preoperative antibiotics, allergies as well as surgical equipment. Once this was completed and verified, the extensive sterile preparation followed by draping was then completed to the left lower extremity. The left lower extremity was then exsanguinated with the use of Esmarch bandage. The tourniquet was then inflated to 350 mmHg. Anatomical landmarks are marked with a surgical marking pen involving the proximal fibula, the proximal tib-fib syndesmosis, the tibial tubercle, and the inferior pole of the patella. A longitudinal incision was then made overlying the lateral aspect of the left proximal leg region in line with the fibula. Sharp dissection was carried down to the level of subcutaneous tissue. All bleeding was controlled with use of electrocautery. The IT band and fascia overlying the lateral knee and proximal tib-fib articular structures was then identified. A window was then created with insertion into the IT band. The common peroneal nerve was identified along the fibular neck and was then gently freed with the use of a limited neurolysis to increase overall mobility of the nerve itself. Once this was created, a window was then created above and below the nerve region as well as identification of the fibular head for syndesmotic fixation. Once this had been fully identified and opened for direct visualization, retractors were placed into the operative field by the