guide pin and into the subtalar joint with reduction of the subluxing talus to realign the joint and stabilize the rear foot. We took intraoperative fluoroscopy and were happy with the alignment and positioning.

We followed up with removal of the guide pin, flushed with copious amounts of sterile saline, and closed utilizing 3-0 Vicryl for joint capsule reapproximation over the subtalar joint. We used 4-0 Vicryl for subcutaneous tissue reapproximation and 4-0 nylon for skin reapproximation in a simple suture technique. Antibiotic ointment, Adaptic, 4x4s, cast padding, and a DVT prophylactic compression pump cooling system was applied to the left foot followed by more cast padding over the top of this and a posterior splint, 3", with Ace bandages, 3" and 4", to hold this in position. General anesthesia was ceased. The pneumatic ankle tourniquet had been deflated previously and was removed. There was immediate capillary refill to digits one through five of the left foot. The patient was taken from the operating room to the recovery room with vital signs stable and vascular status intact. No complications to surgery or anesthesia had occurred. Following a period of postoperative monitoring, the patient will be discharged home with postoperative instructions in both written and oral form. It is noted that we did hook up the ice cooling system/DVT prophylactic system and she tolerated this well.