

tightropes were then completed and the excess sutures then transected. Following this, the \_\_\_\_\_ drill was utilized to drill the tricortical tunnel for the bioabsorbable screw. This was then tapped, and a 16 mm Arthrex bioabsorbable screw was then placed with good compression across the syndesmosis. Once this had been completed, final images were obtained in AP and oblique planes for documentation purposes that the syndesmosis was well reduced. Once this had been completed, the nerve was noted to again be freely mobile. There had been no damage or injury to the nerve. It had been retracted out of the operative field by the assistants. Care had been maintained to protect the nerve throughout the entire course of the surgical procedure as well as ensure that it was fully decompressed through its course as well. Following completion of this, the area was copiously irrigated with fluids. Hemostasis was well maintained. The deep fascial layers were then closed with 0 Vicryl suture. Subcutaneous tissue closed with 2-0 Vicryl. The subcuticular layer was then closed with 4-0 Monocryl and Steri-Strips were then applied at the skin level.

Attention was then turned to the distal tib-fib syndesmosis. A small incision was made overlying the lateral aspect of the fibula just above the level of the ankle joint. The Arthrex TightRope guide system was then utilized. The guide pin was then passed parallel the ankle joint with the ankle in full dorsiflexion. This was then appropriately drilled from posterolateral to anteromedial, and a single TightRope was then passed for rigid stabilization and fixation. The TightRope was then reduced with its nylon suture and the excess suture was then transected. Following this, the incisional line was then copiously irrigated with fluids. It was also closed in a similar fashion. Once this had been completed, final images are obtained which documented syndesmosis as well reduced and stabilized.

The patient subsequently undergoes harvesting of 60 mL of whole blood tissue from the right upper extremity. This was placed into an Arthrex Angel FDA cleared system processing machine. After centrifuging process, a total of 6 cc of autologous hemocyte tissue graft components with 7% hematocrit was obtained for implementation. Upon completion and removal of tissue graft, the graft tissue concentrate was brought into the operating room, and was passed off onto the field under sterile technique. Once the procedure had been completed, the graft tissue concentrate was then combined to create a plasma coagulant. The coagulant was then formed in the open receptive surgical site, was embedded into the proximal tib-fib syndesmosis, and knee high joint region to provide sealing effect of the lost tissues associated with the chronic instability and sprain pattern. A total of 6 cc of autologous hemocyte tissue graft with 7% hematocrit was then placed. Following completion of the procedure, the final dressing was then applied after injection of local anesthetic. Sterile soft tissue dressings were applied and secured in position with Ace bandage. She was then placed in a postoperative knee immobilizer locked in full extension. She tolerated the procedure very well. There were no complications. She was subsequently awakened, transferred to her bed, and taken to the recovery room in stable condition.

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