OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS:
1. Painful subtalar joint stent that appeared to be a little bit too large for her joint and needed to be down-sized, right.
2. Loose body osteophyte in the lateral anterior ankle joint, right.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION:
1. Removal of subtalar joint stent, right subtalar joint.
2. Replacement of stent with a #5 HyProCure, subtalar joint right.
3. Ankle arthroscopy, right ankle with removal of loose body osteophyte ankle joint, followed by platelet rich plasma treatment of the right ankle joint with creating a fibrin clot for the osteophyte resection area as well as just the PRP for the overall joint healing.

SURGEON: David M. Gent, D.P.M.

ANESTHESIA: General with local.
Hedim O. Ramirez, M.D.

HEMOSTASIS: Thigh tourniquet.

ESTIMATED BLOOD LOSS: Minimal.

MATERIALS: PRP with fibrin and thrombin. #5 HyProCure stent.

PATHOLOGY: None.

CONDITION: Stable.

DESCRIPTION OF PROCEDURE: The patient was brought into the operating room and placed on the operating table in the supine position. Following general anesthesia, local anesthetic was administered to the right ankle proximal to the surgical site for an ankle block. The right foot was prepped and draped in normal sterile fashion. Next, attention was directed to the right foot and ankle which was elevated and exsanguinated, utilizing an Esmarch bandage. The pneumatic thigh tourniquet was inflated to 350-mmHg pressure.

Next, attention was directed to the lateral aspect of the right ankle/foot where over the sinus tarsi the old surgical scar was incised once again in an oblique manner, and sharp and blunt dissection was performed down into the sinus tarsi with the subtalar joint stent removed, and intraoperative fluoroscopy was utilized to assist in the removal. We then placed a new subtalar joint stent, a #5,

and seated this into the correct position. We took intraoperative fluoroscopy. We were happy with the location of the placement. We then flushed this area with copious amounts of sterile saline, and then directed our attention to the ankle where a medial portal and a lateral portal were made. First of all, the lateral portal with the trocar was placed and the cannula; then the light source. We were able to tent the skin medially with the light source and visualize the neurovascular structures and make an incision around this, and then sharp and blunt dissection was performed down into the ankle joint for the medial portal. We then removed the light source laterally and placed it into the medial portal. We were able to bring it across the ankle joint and able to identify the osteophyte loose body area and damage to the ankle joint structures. We then placed in a blunt probe from the lateral portal. We were able to identify this, and we were able to then place in the reamer and remove the osteophyte at this location. We then removed the item from the portal. We then placed in the camera light source. We were able to visualize where the osteophyte had been removed, and then we were able to place the needle for placement of the fibrin injection, and we were able to inject the PRP with the fibrin and thrombin. We then removed the light source and the structures and closed up the surgical sites with 4-0 Vicryl for deep tissue reapproximation, 4-0 Vicryl for subcutaneous tissue reapproximation, and 4-0 Prolene for skin reapproximation in simple suture technique. Antibiotic ointment, Adaptic, 4x4's, cast padding, and a bivalved below knee cast were placed on the right leg. The pneumatic thigh tourniquet had been deflated. There was immediate capillary refill to digits one through five of the right foot. The patient was discharged from the operating room. General anesthesia was ceased. Following a period of postoperative monitoring, the patient will be discharged home with postoperative instructions in both written and oral form.

David M. Gent, D.P.M.

DMG/ttv
DD: 12/21/15
DT: 12/22/15

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