ligaments were incised longitudinally and full thickness flaps were elevated dorsally and plantarly. The capsular attachments to the sesamoids were left intact. Next, the oscillating saw was used and the medial eminence was removed 1 mm medial to the sulcus in line with the metatarsal shaft. Then, using an intraarticular approach the lateral sesamoid ligament was released, allowing reduction of the sesamoid complex, and then the lateral capsule was pie-crusted with a freer elevator. This allowed for about 45 degrees of varus correction at the MP joint. Next, a guidewire was placed with 20 degrees of inclination 5 mm proximal to the dorsal articular surface and 3 mm plantar to the dorsal surface. A proximal guidepin was then placed 10 mm distal to the TMT joint and 3 mm dorsal from the plantar surface. This was placed in an oblique fashion. An oscillating saw was then used to create the dorsal and plantar proximal cuts at an angle of 60 degrees and then a reciprocating saw was used to create the transverse cut from medial to lateral parallel to the two pins. The pins were then removed and the cuts were completed. An osteotome was then used to free the lateral soft tissues. Once the two segments were freed I was able to both translate and rotate the plantar articular section. Fluoroscopic imaging was then obtained and this showed correction of the intermetatarsal angle and with a clamp on the capsular tissue this showed correction of the hallux valgus deformity to neutral. Next, the fragments were fixed with 2.7 mm screws proximally and then given the amount of translation and the remaining bone a 2.0 mm screw was decided to be used distally. All screws were placed in lag fashion. After screw placement there was excellent fixation and fluoroscopic imaging was obtained and noted to have satisfactory alignment. Next, the oscillating saw was used and the medial overhanging bone was trimmed down and this was used as bone graft at the distal osteotomy site where the metatarsal had been lengthened slightly. Next, we explored the tibial sesamoid. There were no areas suggestive of a nonunion. The cartilage was intact. There was no evidence of injury to the sesamoid complex. She did have some wear over the sesamoid articular surface, though. Next, the medial capsular tissue was reapproximated and the excessive tissue was trimmed. Then, while maintaining the MP joint in slight varus and supination the capsular tissue was closed with 0 Vicryl sutures. The rest of the fascial layer was closed with 4-0 Vicryl. The tourniquet was then deflated. The wound was re-irrigated. She did receive a second gram of Ancef at this time. Coagulation was obtained with electrocautery. The subcutaneous layer was then closed with 4-0 Vicryl and the skin was closed with 4-0 nylon. The incisions were then dressing with Xeroform and 4x4s and Kerlix with a bunion wrap maintaining slight varus alignment. This was then all wrapped with an ace wrap.

She was then reversed from anesthesia and taken to the PACU in stable condition.

Postoperative plan: She will maintain her dressings for one week. She will return to clinic next Tuesday and at that time we will remove her dressings and rewrap her. After that she will come back the following week and if appropriate her sutures will be removed. She can weight bear as tolerated with a postop wedge shoe.

Digitally authenticated by
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