OPERATIVE REPORT
THE ORTHOPAEDIC SURGERY CENTER

Northwest Orthopaedic Specialists
601 West 5th Avenue, Suite 500
Spokane, WA 99204

[redacted]

SURGEON: Khalid Shirzad, MD **SURGERY DATE:** 05/11/2011

SURGICAL ASSISTANT:

PREOPERATIVE DIAGNOSIS: Left hallux valgus deformity, symptomatic.

POSTOPERATIVE DIAGNOSIS: Left hallux valgus deformity, symptomatic.

OPERATIVE PROCEDURE: Left first metatarsal osteotomy (scarf osteotomy) for correction of hallux valgus deformity. (28296)

ANESTHESIA: General.
BLOOD LOSS: Less than 25 cc.
SPECIMENS REMOVED: None.
COMPLICATIONS: None apparent.
TOURNIQUET TIME: One hour and 26 minutes.

DESCRIPTION OF FINDINGS: Mild degeneration noted on the tibial sesamoid surface. The cristae had essentially worn down. The articular surface of the hallux was maintained.

DESCRIPTION OF PROCEDURE: [redacted] is a 16-year-old female who has had foot pain since she has been 8 years old. She describes a significant amount of pain along the medial eminence of the left foot. She has tried multiple nonoperative measures, including change of shoe wear, orthotics and physical therapy. However, this has not helped her pain control. At the end of March she also had sustained an injury to her great toe which caused her further pain along the plantar aspect. X-rays were reviewed and she had a small vertical line within the sesamoid. However, this appeared to be well corticated and not fragmented or jagged.

A discussion was held with regard to surgical management for this. We also discussed the prior injury that she had sustained and we could also explore the sesamoid complex too. A discussion was held with regard to risks and benefits of surgery, including numbness, tingling, infection, need for further surgery, recurrence of hallux valgus, hallux varus, nonunion and malunion. Both she and her mother understood this and her mother signed for consent as she is 16 years old.

She was seen in the preoperative area and the surgical site was marked. She was brought into the operating room and she was placed under general anesthesia with a LMA. Ancef was provided for prophylactic antibiotics. Next an ankle block was placed for postoperative pain control. The left lower extremity was then elevated and a well padded tourniquet was placed on the left thigh. The left lower extremity was then prepped and draped in standard sterile fashion. A surgical time out was held with regard to the patient, procedure and surgical site and all were in agreement. Once all antibiotics were completed the left lower extremity was elevated and exsanguinated with an Esmarch dressing. A medial-sided incision was made over the first metatarsal and proximal phalanx. Proximally it was extended to the level of the TMT joint and distally to the base of the proximal phalanx. Dissection was carried down sharply through the skin and subcutaneous tissue and full thickness flaps were elevated. The superficial nerve was identified and retracted dorsally. Next, the periosteum and the medial capsular tissue and