ST ROSE DOMINICAN HOSPITALS
ROSE DE LIMA CAMPUS

continued to have persistent pain in the common peroneal nerve distribution throughout the anterior and lateral compartments and the dorsum of the foot. She has met the criteria for the independent nerve compressions listed above. We had lengthy discussion regarding the anatomy, procedure, risks and benefits, the spectrum of outcomes, postoperative course and the patient has been consented for surgery.

OPERATIVE PROCEDURE: Patient was brought into the operating room and laid on the table in supine position. After induction of general anesthesia, a left upper thigh tourniquet was placed. The left leg was then prepped and draped in sterile fashion. Following time-out, Esmarch exsanguination was performed and the tourniquet insufflated to 300 mmHg.

With the knee flexed, we turned our attention to the lateral knee in the area of the fibular head and overlying fibular tunnel. The curvilinear incision was made approximately 1 cm below the fibular head. Careful dissection was carried down to the subcutaneous tissue. The first layer of the crural fascia overlying the fibular tunnel was incised from the lateral border of the lateral leg compartment to the popliteal fossa. The next layer, which was more tightly adhered over the nerve, was carefully dissected and opened along the same course. The nerve was infiltrated with fat and swollen. The nerve was circumferentially dissected and the constricting perineural fibrosis of the nerve was released.

We then turned our attention to the anterior and lateral leg compartments. The superficial and muscular fascia was incised at the level of the entrance of the common peroneal nerve. The intermuscular septum was divided. The muscle was not transected but was reflected anteriorly, exposing the dense lateral fibrous band and deep fascia compressing the common peroneal nerve at that level. The dense fibrous band was taken out en bloc above and below the ends of the nerve. The perineural fibrosis was carefully released. We then released the lateral and anterior compartments inferiorly another 12-15 cm thereby decompressing them. Then posterior to the nerve at the fusion of the posterior and lateral compartments we released the prominent rigid fascial band which was pressing posteriorly on the nerve. The nerve was then resting comfortably from the popliteal fossa into the leg compartments. The area was irrigated and 0.25% Marcaine was injected into the subcutaneous tissue. The wound was closed in a layered fashion using 5-0 PDS and 5-0 nylon sutures.

We then turned our attention to the distal lateral leg. The area of maximal tenderness at Tinel's had been marked preoperatively. A longitudinal incision was made over this area. Dissection was carried down through subcutaneous tissue. The superficial peroneal nerve was identified at its exit point from the lateral compartment. Using a pair of fine Metz scissors, the swish of