has been bothered by hypermobility involving the lower extremities which has required insertion of a subtalar implant via surgeon in Seattle, Washington. This has corrected most of her foot issues involving the right lower extremity had now completely resolved; however, symptoms on the left lower extremity following her stabilization procedure performed by myself as well as the Hypocare to the bilateral lower extremities. She had contacted my practice with continued complaints of pain overlying the right lower extremity due to her feeling of instability. She had undergone several modes of conservative measures including bracing, physical therapy, taping as well as evaluations by alternate physicians. Her radiographic studies including MRIs of the ankle and knee did not demonstrate evidence of gross structural abnormalities, but clinically she had signs of instability. The patient was seen yesterday in the office by my PA, who also examined the patient today preoperatively, and identified that she did have significant instability involving the right proximal tib-fib syndesmosis as well as a mild instability involving the distal tib-fib syndesmosis. Based on her findings, she had been scheduled for operative intervention today. Due to the fact that she had undergone the same procedure before, she is well versed in the overall postoperative management and rehabilitation course. Informed consent was also obtained, and she verbalized understanding of this, willing to accept this, and requested to proceed.

OPERATIVE COURSE: Following informed consent, the patient was identified in preoperative holding suite. The patient operative site was marked. The patient was then taken the operative suite at which time, she was placed on the table in supine position. A general anesthetic was then administered. Following this, all pressure points were well padded. A thigh-high tourniquet was placed along the right lower extremity. The left lower extremity was placed into mechanical DVT prophylaxis. The intraoperative time-out was then completed to verify the patient's name, the operative procedure, the operative site, surgeon, preoperative antibiotics, allergies, as well as surgical equipment. Once this was completed and verified, the extensive sterile preparation followed by draping was then completed to the right lower extremity. A surgical marking pen was then utilized to mark surgical landmarks involving the tibial tubercle, the proximal fibula across syndesmosis as well as the ankle syndesmosis. Following this, the leg was exsanguinated with use of Esmarch bandage. The tourniquet was inflated to 350 mmHg.

A longitudinal incision was made overlying the lateral aspect of the knee in line with the proximal fibula. Sharp dissection was carried down to the level of subcutaneous tissue. All bleeding was controlled with use of electrocautery. The lower portion of the IT band and fascia were then opened longitudinally to expose the fibula. The common peroneal nerve was easily identified. This was directly noted, and was decompressed and followed along the posterolateral corner of the knee as well as extends all the way down into the anterolateral compartment structures. Care was maintained to avoid any type of traction or compression injury to the nerve itself. Once the nerve had been fully decompressed to more fascial slings, the nerve was then freely mobile throughout the course of its direction. Following this, the periosteum was then opened and reflected off the lateral fibula proximal and distal to the nerve itself. Initially, the guide pin for the static bio-absorbable screw was then placed. This was placed in posterolateral to anteromedial, parallel to the knee joint. This was confirmed under fluoroscopy. Following this, two TightRope guide pins were then placed, one involving the tibial head and one just distal to the static stabilization screw pin. Again, these were done in slightly diverging fashion to allow for compressive effect of the proximal tib-fib syndesmosis. As these were appropriately positioned, they were confirmed under radiographic fluoroscopy intraoperatively. These were then appropriately drilled, and both tightropes were then passed. The button was then passed and flipped along the anteromedial cortex of the proximal tibia. The knotless tightropes were then reduced down to appropriate fit. Care was maintained involving the proximal tightropes and not providing any type of compression effect to the fibular head due to the overall decreased density of the bone in this region due to the chronic instability pattern. The distal one was noted to be up against firm cortical bone. Once the syndesmosis was reduced with the ankle in full dorsiflexion, the final tightening effect of the