OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Ankle instability, high ankle sprain, ligament laxity, tibia-fibula region.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION: Left ankle Arthrex TightRope ankle stabilization.

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

ANESTHESIA: General with local.
David J. Bobiak, CRNA/ARNP

HEMOSTASIS: None.

MATERIALS: Arthrex TightRope system.

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 left ankle proximal to the surgical site. The left foot was prepped and draped in normal sterile fashion with a thigh tourniquet placed on the left leg. Next, attention was directed to the leg. Intraoperative fluoroscopy was performed to assess the left leg for the placement of the implant. We then placed markers at the location where we liked this to be performed. We then made a stab incision on the posterolateral aspect of the ankle and through a guide pin from posterolateral through the fibula to anteromedial on the tibia, this crossed across the location of the tibia-fibula ligament proximal to the ankle joint. We then used this guide pin for drilling with the appropriate drill bit provided with the TightRope surgery. Following this, then we called for the Arthrex TightRope system. We passed the needle through the drilled portion of the bone from posterolateral to anteromedial, passing through the fibula and across into the tibia. We then passed the needle through the medial leg, and we were able to pull this up and through the skin. We then had the ability to pull the washers all the way through from the fibula across the tibia and then able to lock this in on the medial aspect of the medial anterior aspect of the tibia just proximal to the medial malleolus and the groove so that it would lock down in the location that would be less irritating. We then followed the appropriate technique for lassoing this down and sliding this down with the slide technique on the lateral aspect so that the washer was able to come down and into contact with the fibula. We dorsiflexed the ankle while we tightened down the TightRope, pulling the bones into a stable

presentation and then relaxed to foot. We removed the suture material that was exposed and had been used for the ratcheting effect and flushed with copious amounts of sterile saline. We cleaned the leg and then sutured close the lateral stab incision with 4-0 nylon in a simple suture technique. Antibiotic ointment, Adaptic, 4 x 4's, and Kling wrap were applied. Then the patient's TENS unit was applied on the medial and lateral aspects of the calf muscle and lower leg and then the dorsal and plantar aspect of the left foot. Cast padding was continued and a posterior splint was applied with a sugar tong presentation. We made sure that the leads for the TENS unit were able to be visualized through the dressing. It was noted that we did not require the thigh tourniquet during the procedure.

Anesthesia was ceased. The patient was taken from the operating room to the recovery room with vital signs stable and vascular status intact. The posterior splint of sugar tong splinting was in good position and good condition. The patient was taken to the recovery room. Following a period of postoperative monitoring, the patient will be discharged home with postoperative instructions in both written and oral form. She has all of her pain medications already at this point.

David M. Gent, D.P.M.

DMG/ttv
DD: 7/11/14
DT: 7/11/14