ESC

1301 4th Ave NW
Suite 201
Issaquah, WA 98027

OPERATIVE REPORT

PHYSICIAN: Thomas Trumble, M.D.

PREOPERATIVE DIAGNOSES:

1. Rupture of lateral collateral ligament of the elbow with traumatic avulsion, S53.432A.
2. Lateral epicondylitis with rupture of extensor carpi radialis brevis insertion, M77.12.
3. Triangular fibrocartilage complex tear of left wrist, S63.392.
4. Lateral epicondylitis of right elbow, M77.11.

POSTOPERATIVE DIAGNOSES:

1. Rupture of lateral collateral ligament of the elbow with traumatic evulsio, S53.432A.
2. Lateral epicondylitis with rupture of extensor carpi radialis brevis insertion, M77.12.
3. Triangular fibrocartilage complex tear of left wrist, S63.392.
4. Lateral epicondylitis of right elbow, M77.11.

PROCEDURES PERFORMED:

1. Reconstruction of lateral collateral ligament, left elbow with local tissue and Fiber Arthrex FiberTape with Arthrex PushLock anchor, 24343.22 complex.
2. Lateral epicondylectomy with decompression and stabilization of extensor carpi radialis brevis, 24358.
3. Elbow arthroscopy for evaluation and synovectomy.
4. Injection of left elbow under fluoroscopic guidance with platelet-rich plasma, 20610.
5. Injection of right elbow under fluoroscopic guidance with platelet-rich plasma, 20610 and 77002.
6. Injection of left wrist with platelet-rich plasma under fluoroscopic guidance, 20605 and 77002.

ASSISTANT: Keith Lemay, PA-C.; and Derek Omori, PA-C.

IT/SN/sndovmt004/FSI-18786684
D: 02/18/16 12:33 A CST
T: 02/19/16 03:41 A CST

ANESTHESIA: General.

PREPARATION: Iodine paint and intravenous antibiotic.

DESCRIPTION OF PROCEDURE: After proper level of anesthesia was obtained, the patient was prepped and draped in the usual fashion. A safety check was performed. The right elbow was injected after sterile prep and drape with 3 mL of PRP that was obtained after blood draw with 60 mL of blood, it was dull and spun down to 9 mL of PRP, 3 mL was injected under fluoroscopic guidance into the right elbow. Subsequently 3 mL were injected into the left wrist under fluoroscopic guidance and also 3 mL was injected into left elbow at the end of the repair procedure. The arm was elevated and exsanguinated with the use of Esmarch bandage, and the tourniquet was inflated to 250-mmHg pressure. A lateral portal incision was made after injection the joint with 30 mL of saline.

An anterior lateral and posterior lateral portals were established, center on the radial head, it was then possible to insert the arthroscope using the blunt trocar and cannula into the lateral superior portal taking care under fluoroscopic guidance, stay close to the radiocapitellar articular to protect the radial nerve. In the similar fashion a posterior lateral portal was established, possibly inspected the joint, it was noted to be only mild amount of synovitis. Synovectomy was completed with a synovial rongeur. The lateral collateral ligament was nearly completely evulsed off of the bone and there was noted to be rupture of the ECRB. It was felt that this would be more amenable to open repair. The arthroscope was removed and fluid was allowed to egress from the joint. A curved incision was made along the medial aspect of the joint. The skin flaps are carefully mobilized and elevated. Sensory branches were protected. The interval within the EDC and ECRL was mobilized and split longitudinally with 15-blace. The ECRL was then elevated with retractor. The ECRB was noted to have a generative ruptures debrided and also incorporating the LCL repair. The lateral collateral ligament near to 80% peel back lesion of the lateral epicondyle, this was repaired using the Arthrex FiberTape, this was passed in a buried fashion through the body of the LCL ligament. The bone surface obturated with the rongeur and epicondylectomy was completed, there was also possibly include the ECRB with the LCL repair with the FiberTape and this could then be inserted with the Arthrex PushLock anchor after predrilling into the center point of rotation of the LCL under fluoroscopic guidance. The FiberTape was then loaded onto the PushLock anchor and this then tensioned, the elbow was placed in

valgus in 30 degrees of flexion to obtain maximal tightening and shortening, this traumatically corrected the instability of the LCL that was present both by dress inspection as well as with fluoroscopic stress use. The anchor was inserted, deployed, and secured. The FiberTape was trimmed. Buried 0 Vicryl sutures were then ____. The interval between the ECRL and EDC in a running locking fashion. The ECRB, I then reconstructed and anchored both the EDC inferiorly and the ECRL superiorly with buried 0 Vicryl sutures. The wounds were irrigated with saline. The tourniquet was released. Bleeding was controlled with Gelfoam, thrombin and electrocautery. The wounds were then closed with buried 3-0 Monocryl sutures and Prolene sutures. A bulky dressing was applied with a fiberglass splint. The right arm was also splinted as well for the patient's comfort. The left wrist was incorporated the splint and the patient's gel pad that she brought with her was used to help protect the skin with the splinting process.

Keith Lemay, PA-C; and Derek Omori, PA-C were required to assist due to the complex elbow reconstruction using the PRP injection. A PRP injection was performed to the left elbow under fluoroscopic guidance at the end of the procedure and the wounds were then closed as described above. This was also incorporated with PRP injections to the right elbow and the left wrist combined with epicondylectomy and ECRB stabilization.

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