Patient Name:[name]
Account number: [account number]
MR #: [MR]
Date of Birth: [mm/dd/yyyy]
Date of Visit: [Date]

PREOPERATIVE DIAGNOSIS:

[ ] knee anterior cruciate ligament tear

POSTOPERATIVE DIAGNOSIS:

[ ] knee anterior cruciate ligament tear

PROCEDURE PERFORMED:

ACL reconstruction with peroneus longus allograft (29888)
Partial [ ] meniscectomy (29881)
Partial medial and lateral meniscectomies (29880)

COMPLICATIONS: None apparent.

SURGEON: Brian Gilmer, MD.

ASSISTANT: Karly Dawson, PAC.

Mrs. Dawson's expert assistance was required for manipulation of multiple arthroscopic instruments and positioning of the leg as well as retraction of soft tissue to prevent damage to vital structures. All manipulation of tissue, graft preparation, and implantation was performed by myself.

ANESTHESIOLOGIST: [ ]

ANESTHESIA: General plus intraarticular local.

COMPLEXITY: Normal.

DEVICES AND IMPLANTS: femoral and tibial RT and ABS tightrope and corresponding cortical buttons.
[ ] peroneus longus allograft

IMPLANT SHEET REVIEWED: yes

ESTIMATED BLOOD LOSS: 5 mL

SPECIMEN REMOVED: None.

BLOOD ADMINISTERED: None.

TOURNIQUET TIME: minutes.

INDICATIONS: The patient is a [ ] with a history of knee pain which has been unresponsive to conservative management. They were seen in clinic. An MRI was obtained which revealed [ ]. We

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discussed nonoperative management versus operative management. The patient elected to proceed with operative management. For detailed discussion of risks, benefits, and alternatives, please see the orthopedic clinic notes.

We reviewed today the usual risks of arthroscopy, including bleeding, damage to neurovascular structures, postoperative stiffness, persistent pain, degenerative joint changes which may be progressive and require further treatment, wound healing complications, infection and development of a new or exacerbation of an existing medical comorbidity. We reviewed specifically the signs and symptoms of venous thromboembolic disease.

DESCRIPTION OF PROCEDURE:

On the date of surgery, the patient was identified in the preoperative holding area. Surgical site was agreed upon, confirmed, and marked by the surgery team, nursing staff and the patient herself. I marked the operative side. They were taken to the operating room and a surgical time-out was performed. They were positioned supine on the operating table with attention paid to padding all bony prominences. An anesthetic was administered by anesthesia staff. The limb was prepped and draped in the usual sterile fashion after a tourniquet was applied over soft padding. They received antibiotic prophylaxis within 30 minutes of incision and mechanical DVT prophylaxis to the nonoperative leg.

Attention was first turned to the diagnostic portion of the procedure.

Examination under anesthesia was performed which revealed [ ] positive anterior drawer, Lachman, and pivot shift.

The graft was previously prepared on the back table. A peroneus allograft was utilized in a continuous loop fashion according to graft link technique using O FiberWire to unite the strands. It was pretensioned to 20 pounds soaked briefly in an antibiotic solution and covered with a moist Ray-Tec and blue towel until time of implantation.

Final graft size was [ ] and a [ ] mm diameter. [ ] mm flip cutter was selected

Diagnostic arthroscopy was then undertaken. The tourniquet was inflated and portal sites were marked utilizing anatomic landmarks. A lateral viewing portal was established and then a medial working portal was established under direct visualization. A probe was introduced and all structures were thoroughly probed and evaluated for pathology. Results of the diagnostic arthroscopy are as follows:

Suprapatellar pouch normal
Patella normal
Trochlea normal
Medial femoral condyle normal
Medial tibial plateau normal
Lateral femoral condyle normal
Lateral tibial plateau normal

Medial meniscus normal
Lateral meniscus normal
Medial gutter normal
Lateral gutter normal
Notch mildly stenotic
ACL torn
PCL intact
Posterior knee no loose bodies

Attention was then turned to the therapeutic portion of the arthroscopic procedure.

With a combination of the hand instruments and shaver the ACL remnant was removed from the lateral wall, remaining fibers were spared where possible. The guide was placed along the lateral femoral condyle on its medial aspect. The condyle was measured and the appropriate anterior to posterior position was marked as described in the literature. The 6-9 guide was then introduced. A 3-5 guide pin and the flip cutter were then introduced. The position was confirmed as ideal prior to reaming without risk of blowout posterior or inferiorly. The reaming was commenced. Shavings were removed with shaver. A FiberStick was placed and parked out of the knee for later retrieval. Attention was then turned to the tibia.

The guide was introduced at 60 degrees. A 3-5 pin followed by a flip cutter were again introduced. The position was confirmed as anterior to the PCL and in line with the posterior aspect of the anterior horn of the lateral meniscus as has been described for anatomic tibial tunnel position. The flip cutter was introduced and again some remaining fibers were preserved and kept intact. Care was taken with motorized shaver to ensure that there was no loose particulate matter in the knee. FiberStick suture was passed and both retrieved out the medial portal. The graft was then shuttled into the knee and the button was visualized flipping. The graft had excellent suspensory fixation. 20 mm of graft was then drawn via the tightrope into the femoral socket. The sutures were shuttled through the tibial tunnel and dunked appropriately, demonstrating 20 mm in the tibial tunnel. The ABS button was applied with the remaining sutures from the graft.

Position of the buttons was confirmed fluoroscopically. The knee was then taken through its full range of motion and final tightening was performed with tensioning in zero degrees with a reverse Lachman. There was full range of motion of the knee. At the conclusion of the procedure the Lachman had been eliminated. A gentle pivot-shift demonstrated elimination of this abnormality as well. Knots were then tied to secure the buttons both with the tags from the tightropes.

POSTOPERATIVE PLAN: Date of discharge protocol with narcotics and antiemetics. Early ambulation and mechanical compression for DVT prevention, crutches as needed. Begin physical therapy this week or early next week. Follow up in clinic in 2 weeks for removal of sutures and to review arthroscopic findings.

Electronically signed by Brian B. Gilmer, MD [date]. [time]

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