



PREOPERATIVE DIAGNOSIS:

knee anterior cruciate ligament tear

POSTOPERATIVE DIAGNOSIS:

knee anterior cruciate ligament tear

PROCEDURE PERFORMED:

ACL reconstruction with (29888)
 meniscal repair (29882)
 meniscectomy (29881)
Medial and lateral meniscectomy (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 anesthetic and narcotic

COMPLEXITY: Normal.

DEVICES AND IMPLANTS: femoral and tibial BTB and ABS tightrope and corresponding cortical buttons.

IMPLANT SHEET REVIEWED: yes

ESTIMATED BLOOD LOSS: 20 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



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.

Tourniquet was inflated to 250 mmHg.

Attention was then turned to the quadriceps harvest. A longitudinal incision was made at the superior pole of the patella. Dissection was carried through skin and subcutaneous tissue, identifying the quadriceps tendon. A piece of quadriceps 7 cm long by 10 mm wide was selected. The graft was peeled off the superior aspect of the patella, leaving intact tendon on both sides of the planned graft harvest. The portion adjacent to the patella was cut and removed prior to graft preparation. Plane was identified between the underlying capsule and dissection was carried proximally. The graft was ultimately truncated and was 70 mm in length and approximately a size 10 over its course. The wound was then copiously irrigated. [The defect in the quadriceps was not closed to avoid overtightening the extensor mechanism]. The skin was closed with 3-0 nylon sutures

On the back table the graft was prepared using FiberLoop and the respective tightrope suture passer devices in the manner we have previously described in the literature. The graft was tensioned to 20 pounds and was forcibly pulled to ensure no slippage, creep, or rupture. Once determined to be satisfactory, the graft was covered with a wet Ray-Tec and a sterile blue towel until implantation.

Final graft size was [] and a [] mm diameter. [] mm flip cutter was selected for the femur and []mm for the tibia



Diagnostic arthroscopy was then undertaken. The 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. The reaming was commenced. 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. 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



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

were then tied to secure the buttons both with the tags from the tightropes, as well as of the previously passed Fiberwires. Wounds were copiously irrigated, closed with nylon sutures except for the quad tendon which was closed previously as above, Sterile dressing was placed followed by postoperative brace. The tourniquet was deflated after closure. The patient was taken to recovery room in good condition.

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]