



PREOPERATIVE DIAGNOSIS:

Right knee anterior cruciate ligament tear (844.2)

POSTOPERATIVE DIAGNOSIS:

[] knee anterior cruciate ligament tear (844.2)

PROCEDURE PERFORMED:

ACL repair (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: 2x4.75 mm swivel lock anchors and corresponding #2 FiberWire suture [and fiber tape internal brace]

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 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.

Discussed risks specific to ACL surgery including failure requiring revision to a graft. Discussed risk of hardware complications and fracture. Discussed risk of inability to complete technical repair and need for conversion to reconstruction. Discussed associated meniscal pathology and chance for long-term degenerative change despite restoration of stability.

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.

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 normal
ACL torn
PCL intact
Posterior knee no loose bodies

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

The ACL stump was identified and lightly debrided. An anterior synovectomy was performed to improve visualization. It was determined that the tissue quality was adequate and the tear was a femoral avulsion allowing enough ligament for primary repair.

The lateral femoral wall was prepared with the shaver and reduced to bleeding bone with a curet to stimulate healing. A suture passing cannula was placed in the medial portal. A #2 FiberWire was then woven from the base of the ligament extending out its femoral stump through the posterior lateral bundle. This was repeated for the anterior medial bundle. Suture was tightened and light debridement of the frayed stump was completed.

A separate low anterior medial portal was created and a half pipe was introduced for suture management. The sutures from the posterior lateral bundle were taken into the low anterior medial portal a punch was introduced for the 4.75 mm swivel lock anchor followed by a tap. The anchor was loaded and the bundle was repaired to the wall and its anatomic origin. This was then repeated for the anterior medial bundle in its anatomic position. The knee was flexed to allow restoration of the normal anatomy.

[the anteromedial bundle was loaded with fibertape for internal brace. Using the ACL guide a 35 guide pin was introduced into the tibial footprint. A fiber stick was then introduced and the fiber tape limbs were retrieved. These were tied over in ABS button on the anterior medial cortex of the tibia. This was tied with the knee in full extension to prevent overconstraining the knee.

The ligament was tested to probe and brought into full extension there was no entrapment or over constraint of the knee and there was elimination of the Lachman and anterior drawer. Remaining suture tails were cut.

All incisions were copiously irrigated and closed with 3-0 nylon. Xeroform, 4 x 4's, ABD, and web roll dressing were then applied followed by a large Ace wrap. Patient was then awakened from anesthesia and 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]

Ortho Operative Note



Patient Name: []
Account number: []
MR #: []
Date of Birth: []
Date of Visit: []