



PREOPERATIVE DIAGNOSIS:

[]

POSTOPERATIVE DIAGNOSIS:

[]

PROCEDURE PERFORMED:

Application of uniplanar external fixator for temporizing treatment of []

COMPLICATIONS: none

SURGEON: Brian Gilmer, MD.

ASSISTANT: [Karly Dawson, PAC]

Ms. Dawson's expert assistance was medically necessary for manipulation of the limb and management of multiple instruments at one time. All critical portions of the procedure were performed by myself.

ANESTHESIOLOGIST: [MD name]

ANESTHESIA: [General]

COMPLEXITY: Normal

DEVICES: Synthes large external fixator with 5 mm Schanz pins and corresponding bars and clamps

IMPLANT SHEET REVIEWED: N/A

ESTIMATED BLOOD LOSS: [Five mL].

SPECIMEN REMOVED: None.

BLOOD ADMINISTERED: None.

TOURNIQUET TIME: N/A

INDICATIONS: Patient is a [] who sustained an injury while []. For detailed description of the discussion regarding risks and benefits alternatives please see the consultation note. We discussed temporizing fixation and stabilization of the fracture followed by definitive fixation in a staged fashion. Reviewed the risks and benefits of external fixation including pin track infection pin site irritation damage to neurovascular structures which can be temporary and/or permanent, development of compartmental syndrome requiring return to the operating room for fasciotomies,



as well as usual risks of surgery and anesthesia.

Understanding all of this, they asked me to proceed.

DESCRIPTION OF PROCEDURE:

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

Attention was first turned to the femoral pin sites. These were localized utilizing fluoroscopy. Stab incision was made blunt dissection was carried down directly to the anterior aspect of the femur. The triple sleeve was introduced and a 3.5 drill was followed by a 5 mm Schanz pin. Attention was then turned distally. The tibial crest was palpated incision was made just medially. Dissection was carried to the bone. The triple sleeve was used, followed by a 3.5 mm drill and a 5 mm Schanz pin. A secondary pin was then placed parallel adjacent to the prior pin. Proximally and distally bicortical fixation was confirmed by tactile feedback and fluoroscopy images.

A provisional reduction was obtained after simulating a provisional frame. This was assessed fluoroscopically and the reduction was optimized. An additional pin was then placed based off of this bar using a triple sleeve and similar technique as noted above. All pins were inserted through the sheath as to avoid damage to soft tissue and vital structures. An additional bar and corresponding clamps was then applied to improve fixation strength and stability.

Pin sites were then copiously irrigated dressed with bio patches and sterile fluff gauze. A loose dressing was applied. Compartments were assessed and were soft at the conclusion of the procedure.

Patient was awakened from their and aesthetic and taken to the recovery room in good condition.

POSTOPERATIVE PLAN:

Admit to orthopedics floor.

Observation for development of compartmental syndrome with frequent neurovascular and compartment checks.

[CT scan obtained status post application of fixator]

Mobilize with physical therapy postoperative day one

24 hours of antibiotic prophylaxis

Chemical and mechanical DVT prophylaxis to begin in the a.m.

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