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

PREOPERATIVE DIAGNOSIS:

1. [ ] knee patellar instability

POSTOPERATIVE DIAGNOSIS:

1. [ ] knee patellar instability

PROCEDURE PERFORMED: [ ]knee

Tibial Tubercle Transfer (27418)
Medial Patellofemoral Ligament (MPFL) Reconstruction with allograft (27420)
3 compartment synovectomy (29876)

COMPLICATIONS: None apparent.

SURGEON: Brian Gilmer, MD.

ASSISTANT: [Bartlett White PAC.

Mr. White's expert assistance was medically necessary for manipulation of the limb, manipulation of multiple instruments at one time, as well as to prevent damage to neurovascular structures. All critical portions of procedure were performed by myself.]

ANESTHESIOLOGIST: [Jonathan Bourne M.D.]

ANESTHESIA: General plus intraarticular local anesthetic.

COMPLEXITY: Normal.

DEVICES AND IMPLANTS:
6 x 23 mm interference screw
2×4.75 mm swivel lock anchors at the patella.
Peroneal longus allograft
2x4.5 mm screws for fixation of tibial tubercle osteotomy

IMPLANT SHEET REVIEWED: N/A.

ESTIMATED BLOOD LOSS: 5 mL

SPECIMEN REMOVED: None.

BLOOD ADMINISTERED: None.

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TOURNIQUET TIME: [ ] minutes.

INDICATIONS: The patient is a [ ] year-old female with a history of knee pain which has been unresponsive to conservative management. They were seen in clinic. An MRI was obtained which revealed disruption of the medial patellofemoral ligament a [ ] TT–TG distanc. We discussed continuing 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. Consent was obtained from her mother

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.

[We additionally discussed risks associated with tibial tubercle osteotomy and medial patellofemoral ligament reconstruction including recurrent fracture stiffness need for manipulation and persistent pain or pain of a different nature.]

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 stable exam to anterior and posterior drawer, Lachman, pivot shift and varus and valgus stress. There was full range of motion.

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 synovitis
Patella [ ]
Trochlea [ ]
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 [evidence of prior patellar dislocation]
Notch synovitic
ACL normal
PCL normal
Posterior knee no loose bodies

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

[Chondroplasty was performed with a mechanized shaver of the chondral damage noted above.]

[Attention was turned to the inflamed/hypertrophic synovium of the notch, the anterior-medial and anterior- lateral compartments, and the suprapatellar pouch, and this was thoroughly debrided with a shaver.]

Attention was then turned to the open portion of the procedure.

A midline incision was made and dissection was carried through the skin and subcutaneous tissue to the level of the patella. The medial retinaculum was identified and incision was made exposing the medial aspect of the patellar facet without entering the joint capsule.

2x 2.4 mm guide pins were introduced and the anatomic locations and overdrilled with the corresponding 4.5 mm reamer to a depth of 20 mm. The graft was taken from the back table and secured with 4.75 mm push lock anchors into each tunnel. There was excellent control of the patella without fracture or cortical violation.

Attention was then turned to the femur. A perfect lateral of the knee was obtained fluoroscopically, the radiolucent guide was placed over the knee and a pin was introduced over Schottle's point. It was advanced anterior and superiorly. Its position was confirmed fluoroscopically. A acorn reamer was then passed to the far side of the femur. The pin was then utilized to pass a passing suture. A long snap was utilized to identify the anatomic layer from the medial patellar retinaculum to the femoral origin. The graft was then passed and drawn into the tunnel. The patella was translated into the trochlea and centered appropriately with approximately 5 N of tension. A nitinol wire was placed followed by 6 x 23 mm interference screw. It was inserted and confirmed fixation under direct visualization. The pin was removed. The knee was flexed to 30° at time of graft fixation. The knee was ranged and it was confirmed that there was no overtensioning and full range of motion with good tracking.

[A medial tibial incision was made and exposed. K wires were introduced from medial to lateral at a 45° angle below the tibial tubercle a preliminary cut was made with the saw with the patellar tendon retracted and protected to ensure no fracture into the tibial plateau. A osteotome was then utilized along the [ ] based plane and created a free fragment of the tibial

tubercle. This was then medialized and a pin was placed creating a correction of approximately 10 mm. The osteotomy was fixed with 2x 4.5 mm screws from anterior to posterior inserted in lag technique. The correction held and was secure. Fluoroscopically confirmed and arthroscopically confirmed. The knee was again ranged and tracking reassessed. It was excellent]

The knee was copiously lavaged. Deep closure of the patellar incision and pretibial incision was performed with 0 Vicryl then 2-0 Vicryl in the deep dermal layer followed by 3-0 nylon in the skin. Arthroscopy portal were closed with 3-0 inverted figure-of-eight sutures. Xeroform and a sterile dressing were placed. Anesthetic was administered intra-articularly for postoperative pain control. The tourniquet was deflated after application of an Ace wrap for compression. The patient was 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 and brace. Weight bearing as tolerated locked in extension. Okay to unlock brace to start range of motion as tolerated up to 0-90° in brace. Begin physical therapy this week. Follow up in clinic in 2 weeks for removal of sutures and to review arthroscopic findings.

Electronically signed by Brian B. Gilmer, MD [ ]

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