MAMMOTH HOSPITAL
Elevate Your Health

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

PREOPERATIVE DIAGNOSIS:

1.

POSTOPERATIVE DIAGNOSIS:

PROCEDURE PERFORMED: [ ] knee

Partial [ ] meniscectomy (29881)
Partial medial and lateral meniscectomies (29880)
[ ] Meniscal repair (29882)
3 compartment synovectomy (29876)
Chondroplasty (29877)
Osteochondral allograft (29867)
Osteochondral autograft (29866)
ACL reconstruction (29888)
Removal of loose body through a separate incision (29874)

COMPLICATIONS: None apparent.

SURGEON: Brian Gilmer, MD.

ASSISTANT: Karly Dawson, PAC.

Ms. Dawson'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: [ ]

ANESTHESIA: [ ] General plus intraarticular local anesthetic.

COMPLEXITY: Normal.

DEVICES AND IMPLANTS: N/A.

IMPLANT SHEET REVIEWED: N/A.

ESTIMATED BLOOD LOSS: 5 mL

SPECIMEN REMOVED: None.

BLOOD ADMINISTERED: None.

Post Office Box 660 - 85 Sierra Park Road - Mammoth Lakes, CA 93546 - 760-934-3311 - Fax 760-934-1832 - www.mammothhospital.com

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 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.

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 themself. 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 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

Post Office Box 660 - 85 Sierra Park Road - Mammoth Lakes, CA 93546 - 760-934-3311 - Fax 760-934-1832 - www.mammothhospital.com

Lateral gutter normal
Notch synovitis
ACL normal
PCL normal
Posterior knee no loose bodies

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

A curved shaver was introduced into the knee. Combination of shaver and biter were then utilized to perform a meniscectomy removing enough meniscus to leave a stable base. Loose meniscal pieces were removed. Total meniscus resected at deepest depth of resection was [ ].

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.

The knee was copiously lavaged. The arthroscope was removed. The portals were closed with 3-0 inverted figure-of-eight sutures. Xeroform and a sterile dressing were placed. 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 as needed for 1-2 days. No restrictions. Begin physical therapy earlier 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 [date]. [time]

Post Office Box 660 - 85 Sierra Park Road - Mammoth Lakes, CA 93546 - 760-934-3311 - Fax 760-934-1832 - www.mammothhospital.com