



DATE OF PROCEDURE: 10/27/2015

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)  
ACL reconstruction with [ ] (29888)  
Osteochondral autograft (29866)  
Osteochondral allograft (29867)

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: [MD name]

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.



TOURNIQUET TIME: [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 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  
Patella  
Trochlea  
Medial femoral condyle  
Medial tibial plateau  
Lateral femoral condyle  
Lateral tibial plateau



Medial meniscus  
Lateral meniscus  
Medial gutter  
Lateral gutter  
Notch  
ACL  
PCL  
Posterior knee

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

A curved shaver was introduced. 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.

Chondroplasty was performed with a mechanized shaver.

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 [ ] parapatellar arthrotomy was created the patella was retracted care was taken to protect of the meniscus. The lesion was exposed by utilizing knee flexion to the appropriate angle. Sizers were then utilized to determine the appropriate size graft. A guidepin was inserted. The superior aspect was marked

Attention was then turned to harvesting the graft. The allograft was positioned in the apparatus on the back table corresponding site and size of lesion were obtained and the clamps were locked into place graft was then harvested with the coring reamer plug was cut with a reciprocating saw. A mark was made on the superior portion of the graft to maintain orientation. The graft was soaked in a saline solution.

Attention was then returned to the recipient site with the guide plan in place scoring of the cartilage was undertaken then drilling of the cartilage lesion and impactor was utilized to dilate the recipient site. Measurements were taken at the 4 quadrants and recorded.

On the back table marks were made on the corresponding 4 quadrants and the device was utilized with a reciprocating sagittal saw to make a flush cut. Length of graft on each side was remeasured and confirmed edges of the graft were slightly chamfered in order to ease graft passage.

The graft was then inserted in proper orientation into the recipient site it was not countersunk or proud but had good fit and fill of the defect. Knee was ranged and there was no crepitation. Final images were obtained

The knee was copiously lavaged. Closure the arthrotomy 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



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

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. Toe touch weightbearing until initial follow-up. Okay to unlock brace to start range of motion as tolerated.. Begin physical therapy this week. Follow up in clinic in 2 weeks for removal of sutures and to review arthroscopic findings and consider advance to progressive weightbearing locked in extension.

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