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

PREOPERATIVE DIAGNOSIS: Right tibial plateau fracture, split depression type.

POSTOPERATIVE DIAGNOSIS:

1. [ ] tibial plateau fracture, split depression type.
2. [ ] meniscus tear.

OPERATIVE PROCEDURE:

1. Open reduction and internal fixation of unicondylar tibial plateau fracture (27535)
2. Open reduction and internal fixation of bicondylar tibial plateau fracture (27536)
3. Partial lateral meniscectomy (27332)
4. Allograft bone grafting, 30cc (20902)

COMPLICATIONS: None apparent

SURGEON: Brian Gilmer, MD

ASSISTANT: [Karly Dawson, PAC].

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: [ ]

ANESTHESIA: General

COMPLEXITY: [High

STATEMENT OF 22 MODIFIER: Significant articular comminution complicating the time required for articular reduction and complexity of the procedure. This significantly increased risk and complexity of procedure above normal. Thus, justifying use of 22 modifier.]

IMPLANTS:

1. Synthes proximal tibial plate, corresponding locking and nonlocking screws
2. [allograft bone chips.]

IMPLANT SHEET REVIEWED: Yes

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

ESTIMATED BLOOD LOSS: [ ] mL

SPECIMEN REMOVED: None

TOURNIQUET TIME: [ ] minutes.

BLOOD ADMINISTERED: None

INDICATIONS: The patient is a [ ] who sustained a tibial plateau fracture.

I discussed nonoperative management versus operative management of the fracture. I discussed alternatives including nonoperative management with immobilization. I discussed the general risks of operative intervention including damage to neurovascular structures, bleeding, persistent pain, infection, stiffness, persistent pain and need for further surgery. Additionally I discussed the risks of malunion, nonunion, and hardware complication including early failure. I discussed the risks of the mobility including development of deep venous thrombosis or other medical comorbidity or complication. I discussed the expected operative and postoperative course including immobilization weightbearing restrictions. Surgical consent was obtained placed in the patient's chart.

Discussed specifically in more detail the risks of posttraumatic arthritis, fracture collapse or failure, need for further surgery, malunion, nonunion, infection, bleeding, damage to neurovascular structures which can be temporary and/or permanent as well as compartmental syndrome. We additionally discussed the usual risks of surgery and anesthesia. Discussed that hardware may require removal later and may be symptomatic. Finally, discussed this use of allograft bone and its attendant risks of disease transmission. Understanding all of this, they elected to proceed.

DESCRIPTION OF PROCEDURE: On the date of surgery, the patient identified in the preoperative holding area. Surgical site was agreed upon, confirmed and marked by Surgery team, nursing staff and patient themself. They were taken to the Operating Room and an anesthetic was administered. They were positioned supine on the operating room table. [A Foley catheter was inserted which was removed at the conclusion of the case]. They received antibiotic prophylaxis within 30 minutes of incision and was re-dosed as needed based on duration. Limb was prepped and draped in the usual sterile fashion. They received mechanical DVT prophylaxis to the contralateral limb.

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Attention was first turned to the open approach. Standard lateral approach was planned, centered over Gerdy's tubercle. Dissection was carried through the skin and subcutaneous tissue to the level of the iliotibial band which was split proximally and distally. Herniated muscle from the anterolateral compartment was retracted posteriorly exposing the fracture fragment. A submeniscal arthrotomy was performed.

[Meniscus was inspected and found to have a tear at the junction of the posterior horn and the body which was resected openly with the use of a knife and debrided to a stable base].

Sutures were passed through the meniscus for later repair at the conclusion of the procedure. The large fragments were initially reduced using a tamp and dental pick. A clamp was then utilized to mobilize additional fragments. Provisional reduction was optimized. This was now wired into place. Plate was applied and a screw was placed for provisional reduction. The cortical window was then made posterior to the plate and a tamp was introduced to allow bone grafting of the defect with allograft bone. The articular reduction was assessed fluoroscopically and open and was optimized. Additional screws were then placed to support the subchondral bone.

All wounds were copiously irrigated. It should be noted that a femoral distractor was initially applied and then removed in standard fashion. Final fluoroscopic images were obtained. Meniscal arthrotomy was closed with 0 FiberWire, 0 Vicryl sutures were used in the iliotibial band, 2-0 Vicryl in the deep layer and 3-0 nylon in the skin. A sterile dressing was applied and a brace. Patient was awakened from anesthesia and taken to Recovery Room in good condition.

POSTOPERATIVE PLAN: Brace for 6 weeks, 0 to 90 degrees, range of motion as tolerated. Then wean from brace and advance range of motion to full. Weightbearing to begin 25% per week at 8 weeks to full by 12 weeks. Standard tibial plateau protocol. Admit to floor. Antibiotics and chemical and mechanical DVT prophylaxis with home teaching and physical therapy to begin tomorrow.

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

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