



PREOPERATIVE DIAGNOSIS:

[] knee posterior cruciate ligament tear

POSTOPERATIVE DIAGNOSIS:

[] knee posterior cruciate ligament tear

PROCEDURE PERFORMED:

PCL reconstruction with allograft (29889)
Partial [] meniscectomy (29881)
Partial medial and lateral meniscectomies (29880)

COMPLICATIONS: None apparent.

SURGEON: Brian Gilmer, MD.

ASSISTANT: Karly Dawson, PAC.

Mrs. Dawson's expert assistance was required for manipulation of multiple arthroscopic instruments and positioning of the leg as well as retraction of soft tissue to prevent damage to vital structures. All manipulation of tissue, graft preparation, and implantation was performed by myself.

ANESTHESIOLOGIST: []

ANESTHESIA: General plus intraarticular local.

COMPLEXITY: Normal.

DEVICES AND IMPLANTS: femoral and tibial RT and ABS tightrope and corresponding cortical buttons. [8x23 mm interference screw bio interference screw]
[] peroneus longus allograft

IMPLANT SHEET REVIEWED: yes

ESTIMATED BLOOD LOSS: 5 mL

SPECIMEN REMOVED: None.

BLOOD ADMINISTERED: None.

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 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 [] positive posterior drawer, and sag with increased external rotation at 90° of flexion

The graft was previously prepared on the back table. A peroneus allograft was utilized in a continuous loop fashion according to graft link technique using O FiberWire to unite the strands. It was pretensioned to 20 pounds soaked briefly in an antibiotic solution and covered with a moist Ray-Tec and blue towel until time of implantation.

Final graft size was [] and a [] mm diameter. [] mm flip cutter was selected

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 normal
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
Lateral gutter normal
Notch mildly stenotic
ACL intact
PCL torn
Posterior knee no loose bodies

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

With a combination of the hand instruments and shaver the PCL remnant was removed from the medial wall. A posterior medial portal was established and dissection of the posterior tibia proceeded to reveal the PCL footprint and both mamillary bodies .

The tibial PCL guide was introduced at 60 degrees. A 3-5 pin followed by a flip cutter were introduced. The position was by direct arthroscopic visualization from the posterior medial portal [as well as fluoroscopically]. The flip cutter was introduced and reaming commenced to a tunnel depth of 40 mm. Care was taken with motorized shaver to ensure that there was no loose particulate matter in the knee. FiberStick suture was passed and both retrieved out the medial portal.

Attention was then turned to the femur. The femoral PCL guide was on the medial wall at the anatomic insertion site of the PCL anterolateral bundle. The condyle was measured and the appropriate anterior to posterior position was marked as described in the literature. [A 3-5 guide pin and the flip cutter were then introduced]. The position was confirmed as ideal prior to reaming without risk of blowout anteriorly. The reaming was commenced. Shavings were removed with shaver. A FiberStick was placed and parked out of the knee for later retrieval.

The graft was then shuttled into the knee and graft was first over drawn into the tibial tunnel. This allowed the entire graft into the knee. Attention was then turned to the femur where sutures were shuttled and the RT button was visualized flipping. Graft was then drawn into place with the knee at 90° of flexion with an anterior drawer. The graft had excellent suspensory fixation. 20 mm of graft was drawn into the femoral socket. Posterior visualization revealed approximately 30 mm of graft in the tibial tunnel. The ABS button was applied to the tibia with final tensioning of the graft in 80° of flexion with anterior drawer.

Position of the buttons was confirmed fluoroscopically. With use of a knot pusher knots were tied on each button. [Backup fixation on the femoral side was provided by an 8 x 23 mm interference screw placed into the femoral tunnel through the lateral portal] The knee was then taken through its full range of motion there was full range of motion of the knee and no notch impingement. At the conclusion of the procedure the tibial step-off was returned and posterior drawer had been eliminated.

POSTOPERATIVE PLAN: Date of discharge protocol with narcotics and antiemetics. Early ambulation and mechanical compression for DVT prevention, crutches as needed. Begin



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

physical therapy this week or early next 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 and time]