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

DATE OF PROCEDURE: [ ]

PREOPERATIVE DIAGNOSES:

1. [ ]
2. History of

POSTOPERATIVE DIAGNOSES:

1. [ ]
2. History of

PROCEDURE PERFORMED:

1. Open quadriceps tendon repair (27385)

COMPLICATIONS: None apparent.

SURGEON: Brian Gilmer, MD.

ASSISTANT: [Karly Dawson PAC]

ANESTHESIOLOGIST: [ ]

ANESTHESIA: [General]

COMPLEXITY: [Normal]

DEVICES AND IMPLANTS: 2x #5 Fiberwire

IMPLANT SHEET REVIEWED: Yes.

ESTIMATED BLOOD LOSS: [5mL]

SPECIMEN REMOVED: None

BLOOD ADMINISTERED: None

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TOURNIQUET TIME: [ ] minutes

INDICATIONS:

The patient is a [ ] who sustained an injury to their knee. We had a thorough discussion regarding treatment options. We discussed that the potential benefits of surgery came with increased risks. We reviewed these which include, but are not limited to anterior knee pain, weakness, loss of function, failure to return to full activity, patellofemoral arthritis, failure of repair, need for revision surgery, infection, bleeding, and poor wound healing. We discussed the rate of rerupture or rupture of the opposite side. Discussed the expected operative technique, operative and postoperative course, including restrictions, and understanding all this they asked me to proceed

DESCRIPTION OF PROCEDURE:

The patient was identified in the preoperative holding area. The surgical sites were agreed upon, confirmed, marked by the surgery team, nursing staff, and the patient themselves. They were taken to the operating room. A surgical time-out was performed. An anesthetic was administered by the anesthesia staff. They were positioned supine on the operating table with attention paid to padding all bony prominences. A bump was placed under the operative hip. Antibiotic prophylaxis was provided within 30 minutes of incision. The limb was prepped and draped in the usual sterile fashion. The nonoperative leg received mechanical DVT prophylaxis.

Attention was first turned to the patella. A standard anterior midline incision was planned. Dissection was carried through the skin and subcutaneous tissue to the level of the retinaculum. The rent in the quadriceps mechanism was immediately identified. Dissection was carried elevating skin flaps medially and laterally to provide complete visualization of the injury. The patella was lifted and the cartilage assessed. Patellar cartilage was[ ]. Trochlear cartilage was [ ].

The quadriceps tendon was freshened providing a healthy stable base of tissue for repair. A #5 FiberWire was used in a modified Kraków fashion exiting in the midportion of the tendon. This was repeated on the opposite side providing a 4 strand repair. This was vigorously pulled and the tissue was well fixed. Attention was then turned to the patella 3 drill holes were placed medially laterally and centrally utilizing the Beath pins. [Fluoroscopic imaging was obtained to confirm no intra-articular placement and parallel alignment]. Corresponding sutures were then loaded through these 3 drill tunnels and

passed distally. With the knee in hyperextension the patellar tendon was reduced and sutures tied distally on the patella. Repair was excellent. Knee was flexed to 90° and repair was stable and intact. The knee was copiously irrigated. The remainder of the retinaculum and overlying tissue was repaired with 0 Vicryl. Subcuticular closure with 2-0 Vicryl in buried interrupted fashion.

The skin was closed with interrupted 3-0 nylon. Steri-Strips were placed. Sterile dressing was placed. The patient was placed into a knee immobilizer which was locked in full extension. Patient was awakened from anesthesia and taken recovery in good condition

POSTOPERATIVE PLAN:

Day of discharge protocol with narcotics and antiemetics. Follow up in clinic in two weeks for wound check. Start range of motion 0-30°. Weightbearing as tolerated with knee brace locked in extension. Advance gradually 0-90° after first two-week visit.

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

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