

**THE HOSPITAL FOR SPECIAL SURGERY
OPERATIVE RECORD**Patient Name: ████████████████████████████Date: 12/03/2009MR# 708402**ATTENDING SURGEON:**██, M.D.
██, M.D.**ASSISTANT:**██, M.D.**PRELIMINARY DIAGNOSES:**

1. SECOND METATARSALGIA.
2. POSSIBLE SMALL NEUROMA.

POSTOPERATIVE DIAGNOSES:

1. SECOND METATARSALGIA WITH CENTRAL PLANTAR PLATE INJURY.
2. POSSIBLE SMALL NEUROMA.

NAME OF OPERATION:

1. SECOND METATARSOPHALANGEAL JOINT ARTHROPLASTY (PLANTAR PLATE REPAIR).
2. SECOND METATARSAL SHORTENING OSTEOTOMY (3 MM).
3. SECOND WEB SPACE NEUROPLASTY.

ANESTHESIA:

ANKLE BLOCK ANESTHESIA.

POSITION:

SUPINE.

ANTIBIOTIC:

ANCEF ONE GRAM INTRAVENOUSLY PRIOR TO THE USE OF THE TOURNIQUET.

TOURNIQUET TIME:

ANKLE TOURNIQUET OVER COPIOUS WEBRIL PADDING FOR 54 MINUTES.

IMPLANTS:

A 2.0 PLATE WITH THREE APPROPRIATE LENGTH SCREWS.

SPECIMEN:

NONE.

INDICATIONS:

THE HOSPITAL FOR SPECIAL SURGERY

OPERATIVE RECORD

Patient Name: ~~████████████████~~Date: 12/03/2009MR# 708402

The patient has had pain at the second metatarsophalangeal joint for quite some time. She has failed nonoperative treatment consisting of shoe wear modifications, orthotics, activity modifications and the like. Preoperative MRI scan really did not show any injury to the plantar plate. The patient was continued to have point focal pain in the metatarsal head region. The patient and I have elected to proceed with operative intervention. The goal is to go ahead and give her reduction in her pain so that she may be able to wear shoe wear and function.

PROCEDURE:

The patient was brought to the Operating Room and was placed supine on the operating room table. After instillation of adequate ankle block anesthesia, the left lower extremity was prepped and draped in a normal sterile fashion. We exsanguinated the foot with an Esmarch bandage used over copious Webril padding at the level of the ankle for 54 minutes.

We made a hockey stick shaped incision over the second metatarsophalangeal joint region. This was carried down through the subcutaneous tissue with blunt dissection. Care was taken to Bovie the small crossing veins. We identified the extensor digitorum longus/extensor digitorum brevis interval and sharply incised this longitudinally from the proximal phalanx across the metatarsal metatarsophalangeal joint. We were then able to visualize a side of the joint. There was not any copious synovium.

The metatarsal head itself had a small, grade II change in the distal end of it. There was also a central defect in the plantar plate and although this was near the insertion, the medial and lateral structures were still intact.

We went ahead and used a combination of a small curette as well as a periosteal elevator and rongeur to roughen up this edge. We then went

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ahead and used a 0.062 Kirschner wire to drill holes going from dorsal and through the phalanx, coming out just at the plantar proximal border of the phalanx where suture material would be passed later.

We then, by distracting the joint, were able to take a 3-0 Ethibond stitch and then suture in a U-type fashion into the plantar plate. We were then able, with 28-gauge wire, to pass the sutures from inside the joint, out the dorsal aspect of the proximal phalanx through the two drill holes. With this, we then went ahead and we were able to tie this down, advancing the plantar plate to the roughened area. The joint was not unstable prior and it was not unstable at this time.

We then went ahead and turned our attention to the metatarsal itself. We then, protecting on either side with baby Bennett retractors, went ahead and performed a Weil type of osteotomy parallel to the plantar aspect of the foot. We translated this approximately 3 mm, making it shorter than the first, but not overly short compared to the third. We then pinned this into position, felt plantarly and felt as though the metatarsal was not prominent. We then went ahead and fashioned, after trimming off the overhanging edge, fashioned a 2.0 plate, 4-hole, to go ahead and place dorsal to plantar screws, taking care not to perforate the metatarsal head to gain fixation.

We then went ahead and took the toe through a range of motion, which was smooth. There was no hypermobility. We then went ahead and inspected the plantar plate repair, which was still in good position and holding.

At this time we then went ahead and let down the tourniquet. We achieved hemostasis and copiously irrigated the wound and then closed the skin with 4-0 Monocryl and 4-0 nylon. The sponge and needle counts were correct. The toe was pink immediately. The foot was then placed into a well padded foot dressing and the patient was transferred to the Recovery Room in stable condition.

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OPERATIVE RECORD**

Patient Name: [REDACTED]

Date: 1/27/2010

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ATTENDING SURGEON:

[REDACTED], M.D.

OPERATING SURGEON:

[REDACTED], M.D.

ASSISTANT:

[REDACTED], P.A.

PRELIMINARY DIAGNOSES:

1. SCARRING OF DORSAL CAPSULE
LEFT SECOND METATARSAL LEADING
TO METATARSOPHALANGEAL
CONTRACTURE.
2. LEFT IMPINGING HARDWARE.

POSTOPERATIVE DIAGNOSES:

1. SCARRING OF DORSAL CAPSULE
LEFT SECOND METATARSAL LEADING
TO METATARSOPHALANGEAL
CONTRACTURE.
2. LEFT IMPINGING HARDWARE.

NAME OF OPERATION:

1. LEFT FOOT HARDWARE REMOVAL,
DEEP.
2. LEFT SECOND
METATARSOPHALANGEAL
CAPSULOTOMY AND TENOLYSIS.

ANESTHESIA:

ANKLE BLOCK ANESTHESIA.

PREPARATION:

BETADINE SCRUB.

ANTIBIOTIC:

ANCEF ONE GRAM INTRAVENOUSLY
PRIOR TO THE USE OF THE
TOURNIQUET.

TOURNIQUET TIME:

ANKLE Tourniquet over copious
WEBRIL PADDING for 20 MINUTES.
HARDWARE AND SCAR TISSUE.

SPECIMEN:

NONE.

IMPLANTS:

SUPINE.

POSITION:

INDICATIONS:

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Patient Name: [REDACTED]

Date: 1/27/2010

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The patient is status post surgery to help with repair of plantar plate with metatarsal shortening. Postoperatively, the patient has developed quite a bit of scar tissue leading to contracture as well as blockage with motion. After a discussion with the patient regarding the risks and benefits of the surgical procedure to include, continued pain, reformation of scar tissue, deformity of the toe, increased pain, nerve injury, wound healing problems and the like, the patient and I have elected to proceed with operative intervention.

PROCEDURE:

The patient was brought to the Operating Room and was placed supine on the operating room table. After the instillation of adequate ankle block anesthesia, the left lower extremity was prepped and draped in a normal sterile fashion. We then exsanguinated the extremity and used the Esmarch as a tourniquet over copious Webril padding at the level of the ankle for 20 minutes.

We exploited the prior surgical incision, immediately encountering a fair amount of dense scar tissue, encapsulating the capsule and the extensor tendon. We carefully released the extensor tendon with blunt dissection and identified the dorsal aspect of the metatarsophalangeal capsule. We then sharply removed the dorsal capsule as well as tissue over the metatarsal head area, exposing the plate. The plate was then easily removed and sent for specimen. The scar tissue was also collected and sent for specimen.

We then went ahead and identified that the osteotomy was healed and was stable. We then also went ahead and released part of the collateral ligaments more on the medial side than on the lateral side to be able to get the toe to sit in a better position.

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After performing all of this, the toe was able to sit in a more plantigrade type of position. There was a full range of motion of the joint to about 45 degrees of dorsiflexion with no impingement.

At this time, we went ahead and let the tourniquet down after 20 minutes. We waited approximately ten minutes, achieving hemostasis until the wound was dry and then went ahead and copiously irrigated again. We closed the wound with 4-0 Monocryl and 4-0 nylon. The toe was pink after letting down the tourniquet.

The patient tolerated the procedure well. She was then placed in a bulky foot dressing and then transferred to the recovery room stretcher and then to the Recovery Room in stable condition. The toe was pink up on transference.

The sponge and needle counts were correct.

CC: [REDACTED], M.D.

..

DATE

[REDACTED], M.D.

Dictated by: [REDACTED], M.D.

Dict Date: 1/28/2010 Typed by: PMC/pw/10482

Trans Date: 01/29/2010

[REDACTED]
[REDACTED] Street
New York, NY 10021

[REDACTED] Department of Orthopedic Pathology

[REDACTED], M.D., Director
Phone: [REDACTED]

PATHOLOGY CONSULTATION REPORT

Patient Name: [REDACTED]

Case Number: S2010-001431

Date of Birth: 08 13 1960

Medical Record #: 708402

Gender: F Age: 49

Account Number: 74000077

Location: AMS

Accession Date: 01 28 2010

Pathologist: [REDACTED]

Operative Date: 01 27 2010

Physicians

Clinical Information

Status post left foot, retain painful hardware, status post left foot hammertoes

OPERATION PERFORMED: Left foot removal of hardware, left second metatarso-phalangeal capsulotomy

Final Anatomic Diagnosis

1. FOOT, SOFT TISSUE, LEFT

Dermal Scar, Hypertrophic (Skin Scar)

- with a Granulomatous Reaction to Suture Material

2. BONE, FOOT, LEFT

Fixation Device: - Metallic Plate - Metallic Screws - 3

Gross Anatomic Description

1. Specimen Label: Left foot scar tissue

In formalin: The specimen consists of multiple pieces of tan, focally brown soft tissue measuring in aggregate approximately 1.5 cm in greatest dimension. The entire specimen is submitted.

2. Specimen Label: Left foot removed hardware

In formalin: The specimen consists of one metallic plate measuring approximately 2.5 cm in length and three metallic screws, each measuring approximately 1.3 cm in length. Tissues are not present. The hardware is submitted to Biomechanics.

PR/fc

Material Submitted

Code Description	Code	Type Description	Type	Count
1. Undesignated	U	Soft Tissue, Routine	STR	1

Microscopic Description

- The section is of fragments of skin and superficial subcutaneous tissue showing dermal scarring with vascular hyperplasia and interstitial mucoid degeneration as well as a slight degree of perivascular chronic inflammation. A sparse mononuclear and giant cell reaction to particulate debris from polyfilamentous suture material is also present. Organizing hematoma with nonspecific granulation tissue is also present. Inflammation of the type and degree usually associated with infection is not identified.
- Microscopic description was not performed.

[REDACTED] M.D.
(Case signed 01 29 2010)