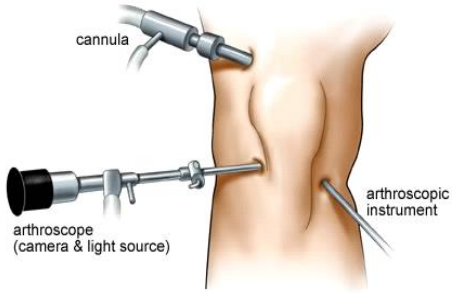
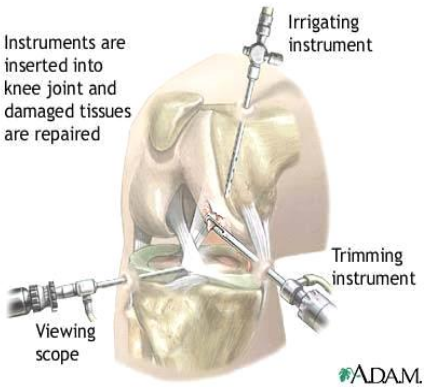
Examining Scopes: Practical Exercise

Operative Report A - Patient has been c/o of knee pain for several months.



PROCEDURE: The patient was brought down to the operating room and transferred from a stretcher to the OR table. She was then induced under a spinal anesthetic by CRNA XXXXX. The patient was placed into the supine position and the lower extremity was then prepped and draped in normal sterile fashion for knee surgery. A proximal thigh tourniquet was placed and an Esmarch bandage was used to exsanguinate the limb. The tourniquet was then inflated to approximately 100 to 150 mm of mmHg above systolic pressure. The knee was examined for range of motion and laxity.



An 11-blade stab incision was made along the anterolateral aspect for the anterolateral portal. A Dell trocar was then inserted, and the arthroscope was then introduced. Once it was confirmed to be within the joint proper, the knee was distended with sterile saline solution, a pump lavage system at 55 mm of mmHg, and medium flow.

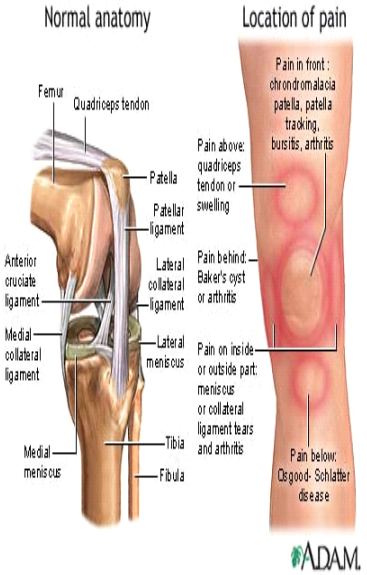
A systematic tour about the knee was performed beginning in the suprapatellar pouch, followed by the patellofemoral region, lateral gutter, posterolateral corner, and then the lateral compartment. Next, the intercondylar notch region was examined and finally, the medial compartment and medial gutter. The knee was found to be entirely normal. Arthroscope was removed, the arthroscopy portals were reapproximated using 4-0 nylon in interrupted fashion. Patient sent in stable condition to Recovery room, home later today.

Examining Scopes: Practical Exercise

Operative Report B - PREOPERATIVE DIAGNOSIS: Patient has been c/o of knee pain for several months.

PROCEDURE: The patient was brought down to the operating room and transferred from a stretcher to the OR table. She was then induced under a spinal anesthetic by CRNA XXXXX. The patient was placed into the supine position and the lower extremity was then prepped and draped in normal sterile fashion for knee surgery. A proximal thigh tourniquet was placed and an Esmarch bandage was used to exsanguinate the limb. The tourniquet was then inflated to approximately 100 to 150 mm of Hg above systolic pressure. The knee was examined for range of motion and laxity.

Skin incision was made from proximal patella to below the tibial plateau. We proceeded through the subcutaneous tissues and muscle, the joint capsule was entered, using knee retractors were able to visual much of the medial, lateral and patella compartments. Just a little fraying noted, nothing that would cause any problems. The remainder of the visualized knee joint was found to be completely normal. Hemovac drain was put in place. Deep tissues closed with absorbable suture and skin was closed with 4-0 nylon. Compression dressed and knee immobilizer placed and patient sent to Recovery. Patient will be able to go home in three days.



Examining Scopes: Practical Exercise

Operative Report C - PREOPERATIVE DIAGNOSIS: Acute left knee medial meniscal tear and chondromalacia of the patella.

POSTOPERATIVE DIAGNOSES: 1. Posterior horn tear around medial meniscus.

PROCEDURE: Left knee arthroscopy with partial medial meniscectomy.

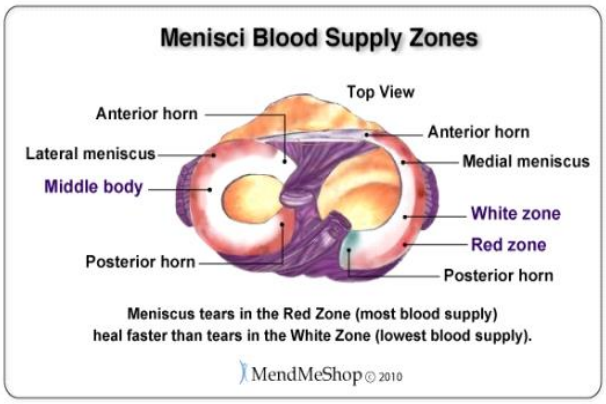
ANESTHESIA: Spinal.

TOURNIQUET TIME: 32 minutes.

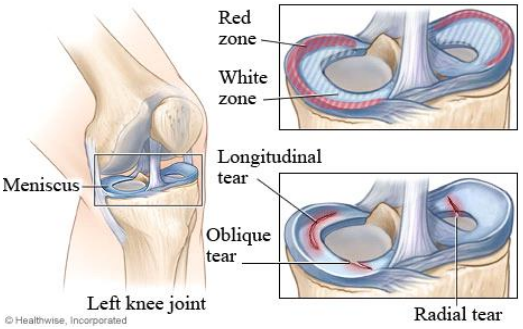
BLOOD LOSS: Minimal.

VS: 900 cc

PROCEDURE: The patient was brought down to the operating room and transferred from a stretcher to the OR table. She was then induced under a spinal anesthetic by CRNA XXXXX. The patient was placed into the supine position and the lower extremity was then prepped and draped in normal sterile fashion for knee arthroscopy. A proximal thigh tourniquet was placed and an Esmarch bandage was used to exsanguinate the limb. The tourniquet was then inflated to approximately 100 to 150 mm of mmHg above systolic pressure. The knee was examined for range of motion and laxity.



An 11-blade stab incision was made along the anterolateral aspect for the anterolateral portal. A Dell trocar was then inserted and the arthroscope was then introduced. Once it was confirmed to be within the joint proper, the knee was distended with sterile saline solution, a pump lavage system at 55 mm of mmHg, and medium flow.



A systematic tour about the knee was performed beginning in the suprapatellar pouch, followed by the

patellofemoral region, lateral gutter, posterolateral corner, and then the lateral compartment. Next, the intercondylar notch region was examined and finally, the medial compartment and medial gutter. A posterior horn tear of the medial meniscus in the white-white zone to white-red zone, which was complex in nature and was irreparable, was debrided back to stable margins using an arthroscopy meniscal biter and a 4.0 shaver. After removal of the meniscal tear careful examination of all articular cartilage surfaces of the tibial, femoral, and patella were probed. The cruciate ligaments also were probed. Some minimal fraying but these chondromalacia changes were all stable and did not require any chondroplasty.

Arthroscope was removed, the arthroscopy portals were reapproximated using 4-0 nylon in interrupted fashion. Patient sent in stable condition to Recovery room.

Examining Scopes: Practical Exercise

Operative Report D - PREOPERATIVE DIAGNOSIS: Left knee medial meniscal tear and chondromalacia of the patella.

POSTOPERATIVE DIAGNOSES:
1. Posterior horn tear of medial meniscus.

2. Minimal chondromalacia changes

PROCEDURE: Arthrotomy with partial meniscectomy of the left knee

PROCEDURE: The patient was brought down to the operating room, general anesthesia was delivered by anesthesiologists, patient was positioned and the knee and prepped and draped in the usual fashion. Tourniquet in place. Skin incision was made from proximal patella to below the tibial plateau. We proceeded through the subcutaneous tissues and muscle, the joint capsule was entered, using knee retractors I was able to visual much of the medial, lateral and patella compartments. Just a little fraying noted, nothing that would cause any problems. We carefully identified the medial meniscal tear and use instruments we were able to remove the torn portion of the cartilage. The remained of the visualized knee joint was found to be completely normal. Hemovac drain was put in place. Deep tissues closed with absorbable suture and skin was closed with 4-0 nylon. EBL = 200CCs. Compression dressed and knee immobilizer placed and patient sent to Recovery. Patient will be able to go home in three days.

Examining Scopes: Practical Exercise

Operative Report E - PREOPERATIVE DIAGNOSIS: Left knee medial meniscal tear and chondromalacia of the patella.

POSTOPERATIVE DIAGNOSES:
1. Posterior horn tear around medial meniscus.
2. Chondromalacia changes of grade III in medial compartment of the left knee.

PROCEDURE: Left knee arthroscopy with partial medial meniscectomy and medial compartment chondroplasty.

ANESTHESIA: Spinal.

TOURNIQUET TIME: 32 minutes.

BLOOD LOSS: Minimal.

IVS: 900 cc

PROCEDURE: The patient was brought down to the operating room and transferred from a stretcher to the OR table. She was then induced under a spinal anesthetic by CRNA XXXXX.

The patient was placed into the supine position and the lower extremity was then prepped and draped in normal sterile fashion for knee arthroscopy. A proximal thigh tourniquet was placed and an Esmarch bandage was used to exsanguinate the limb. The tourniquet was then inflated to approximately 100 to 150 mm of mmHg above systolic pressure. The knee was examined for range of motion and laxity.

An 11-blade stab incision was made along the anterolateral aspect for the anterolateral portal. A Dell trocar was then inserted and the arthroscope was then introduced. Once it was confirmed to be within the joint proper, the knee was distended with sterile saline solution, a pump lavage system at 55 mm of mmHg, and medium flow.

A systematic tour about the knee was performed beginning in the suprapatellar pouch, followed by the patellofemoral region, lateral gutter, posterolateral corner, and then the lateral compartment. Next, the intercondylar notch region was examined and finally, the medial compartment and medial gutter. A posterior horn tear of the medial meniscus in the white-white zone to white-red zone, which was complex in nature and was irreparable, was debrided back to stable margins using an arthroscopy meniscal biter and a 4.0 shaver. After removal of the meniscal tear attention was turned back to the medial compartment where the articular surfaces were found to be frayed and craters noted. Using the Chondroshaver resurfacing was accomplished where possible. Arthroscope was removed, the arthroscopy portals were reapproximated using 4-0 nylon in interrupted fashion. Patient was sent to Recovery in good condition.