BRIGHAM CITY COMMUNITY HOSPITAL 950 SOUTH MEDICAL DRIVE BRIGHAM CITY, UT 84302

OPERATIVE REPORT.

PATIENT NAME: WHITAKER, LARRY SEX/AGE: M /68

DATE OF BIRTH: 12/05/46 UNIT #: G000048824

PT LOC/ROOM: G.MDS G.101 ACCOUNT #: G00702739749

ADMISSION DATE: 07/20/15 DATE OF SERVICE: 07/20/15

DISCHARGE DATE:

SIGNING PHYSICIAN: Daniel D Higbee, DO

SURGEON: DANIEL HIGBEE, DO

ASSISTANT: KAY C. JOHNSON, PA-C

PREOPERATIVE DIAGNOSIS: Right hip degenerative joint disease.

POSTOPERATIVE DIAGNOSIS: Right hip degenerative joint disease.

PROCEDURE PERFORMED: Right anterior total hip arthroplasty.

ANESTHESIA: General with 100 mL of cocktail solution injected locally at closure and perioperative cheilectomy block.

PREOPERATIVE FINDINGS AND COMMENTS: This 68-year-old male has had a long time severe DJD in his right hip. He has continued to progress with pain and difficulty walking due to pain for several years and the pain has gotten bad enough now that he has difficulty with all activities of daily living to only walk short distances less than 100 feet without to stop for pain. He failed conservative therapy as he was treated at the VA for his right hip disease. After discussing treatment options with the patient, we discussed operative versus nonoperative options going forward. He decided he wanted to go ahead with the right anterior total hip arthroplasty. He understood the risks and benefits of this procedure as I described them to him and signed consent for the surgery in my clinic. A complete preoperative workup was performed to ensure that the patient was medically stable for this elective procedure.

DESCRIPTION OF PROCEDURE: The patient was taken preoperatively and marked his right hip with my initials and yes, he confirmed this as the operative hip. He was noted to be neurovascularly intact in the right lower extremity with no skin changes over the right hip. He was then moved to the OR and received 2-3 g of vancomycin prior to being moved to the OR due to history of MRSA infection. Once in the OR, the patient was placed under general anesthesia without complications and positioned in a spine position on the Hana operating table. His right hip was prepped and draped in sterile fashion after which I made an 8 cm incision over the anterior interval to the hip. The incision was made with a 10 blade and dissection was carried down bluntly to the fascia. The fascia was then incised in line with the incision, and I bluntly developed the plane between the tensor fascia and sartorius muscle fibers. Retractors were placed around the capsule of the hip. The circumflex vessels were cauterized and the hip capsule was exposed after removing the pericapsular fat pad. The hip capsule was then incised in an L-type fashion, the femoral neck was exposed.

PATIENT NAME WHITAKER, LARRY ACCOUNT #: G00702739749

Retractors were placed around the neck. I then found my appropriate neck cut level using the C-arm and the neck cut was made using the precision oscillating saw. I used a napkin ring technique to remove a portion of the neck and then removed the head with the corkscrew device. The acetabulum was then exposed. The labrum and pulvinar were excised and I then brought the C-arm in and found the level view of the pelvis. I then began reaming in a stepwise fashion beginning with a size 47 reamer and once I had reached the size 53 reamer, I was happy with the purchase around the edges of the cup, it had excellent bleeding bone within the cup over 90% of the cup surface and was out to the rim on my reaming, I had also medialized appropriately. Once I had completed reaming, I washed the acetabulum copiously with sterile saline and then impacted my size 54 limited hole acetabular shell in the appropriate position using C-arm as a guide to maintain 20 degrees of anteversion and 45 degrees of abduction. With the acetabulum was down to the appropriate level, I placed the E poly standard liner for 36 head and impacted this. It was noted to be locked in place. I then exposed the proximal femur and began broaching in a stepwise fashion. The proximal femur while lateralizing until it was at the lateral cortex of the femur, but still noted that my stem x-ray was in a slightly varus position. I noted that the contralateral stem was in the same position from his previous total hip, was performed at the VA and decided that this was due to the patient's anatomy. I lateralize this as far as I possibly could during the procedure as I continued to go up in my size stem. Once I had reached a size 13 stem, I noted that I had excellent purchase in the proximal femur. When was unable to advance the stem any further, I then trialed with a high offset stem and a standard head and noted that I was a few millimeters short with this head, I removed the trials and decided that the 13 was the appropriate size stem on C-arm images. This trial was removed. I washed the femur copiously with sterile saline and placed the size 13 high offset stem as I was happy with the offset. This was impacted down to the appropriate level and was noted to sit a few millimeters proud with the porous coating. After completing with the stem to the appropriate level, I trialed again with a +3 head and noted that equal leg lengths bilaterally with this has. I removed the +3 head and washed the stem with sterile saline and dried it carefully and then placed the final +3ceramic head and impacted this down. It was noted to be locked in place. I then reduced the hip again and took final x-rays of the hip with the head reduced. I noted that had equal leg lengths and was happy with the position of the hip. The hip was then washed again copiously with sterile saline and I injected my 100 mL solution through the soft tissues using 90 mL of the solution. I then washed again copiously with sterile saline and closed the capsule with #1 Vicryl, and then closed the fascia with a #1 Vicryl and closed the skin with 2-0 and #3-0 Monocryl in subcuticular fashion. Sterile dressing was applied, and the patient was brought out of general anesthesia without complications and transferred to PACU in stable condition. His blood loss for the case was 700 mL. We gave 490 Baxter Cell Saver leaving net loss of 210 mL of blood. There were no complications. There was no specimen saved. Implants were the size as stated.

DISPOSITION: The patient will stay in-house for inpatient medical management, pain control, anticoagulation, physical therapy, and 24 hours of antibiotics.

DDH/ss Conf #: 374011 DID: 2293891 D: 07/20/2015 15:48:24 T: 07/20/2015 22:54:54

PATIENT NAME WHITAKER, LARRY ACCOUNT #: G00702739749

REPORT ID: 0720-0067

PATIENT NAME WHITAKER, LARRY

ACCOUNT #: G00702739749