# ANJANI SINHA MEDICAL P.C.

ORTHOPEDIC SURGEON

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ANJANI SINHA, M.D., M.S.(Ortho)


## POST - OPERATIVE NOTE

Date: 02/21/20

Patient Name: Son. Hanjoo

The patient is status post arthroscopy of the (L) Shoulder / Knee on 2/13 and comes Today for postoperative follow-up.

The surgical site has healed well.

The dressing was removed.

There is no evidence of any drainage, redness, or discharge from the surgical site.

There is no swelling.

The patient is afebrile.

The patient is very happy with the results of surgery.

The patient has regained almost full mobility of the shoulder/knee.

The patient has **no / minimal** pain.

The patient has regained almost _____% of mobility.

The patient is ambulating and full weight-bearing without any support.

The patient was advised physical therapy ___ times a week for ___ weeks to regain full mobility of the **shoulder / knee**.

The patient was encouraged to call my office if there are any problems.

Otherwise, the patient is dischared from my care.

P.T & Rip

**All City Family Healthcare Center**
3632 Nostrand Ave.
Brooklyn, NY 11229
(718) 332-44092

**OPERATIVE REPORT**

**PATIENT NAME**: Son, Hanjoo **MEDICAL RECORD #**: 3095635

**SURGEON**: Anjani Sinha, M.D. **DATE OF SURGERY**: 02/13/2020

**DATE OF BIRTH:** 06/10/1970

**PREOPERATIVE DIAGNOSIS:** Right knee meniscus tear.

**POSTOPERATIVE DIAGNOSES:**

1. Right knee extensive hypertrophic synovitis.
2. Lateral and medial meniscus tear.
3. Chondral lesion.
4. Plica Syndrome.

**PROCEDURES:**

1. Arthroscopy of the right knee.
2. Extensive synovectomy.
3. Partial medial and lateral meniscectomy.
4. Coblation arthroplasty patellofemoral compartment.
5. Excision of thickened plica.

**ASSISTANT:** David Davydov, P.A.

**ANESTHESIA:** LMA.

**ANESTHESIOLOGIST:** Dov Ginsberg, M.D.

**EBL:** Minimal.

**ANTIBIOTICS:** IV Ancef.

**SECOND ASSISTANT:** Due to the complexity of the procedure and for optimal patient care, a physician assistant was needed for successful completion of all the procedures performed.

**PROCEDURE IN DETAIL:** The patient was identified in the preoperative holding area. The operative site was signed by the surgeon. Informed consent was obtained. The patient was brought to the operating room. The patient was positioned supine on the operating room table and was given Ancef intravenously. Adequate anesthesia with LMA was achieved. The right

lower extremity was prepped and draped in the usual sterile fashion. A time-out was performed and laterality was confirmed to the right knee. Standard anterolateral and anteromedial portals were made through which the arthroscope and instruments were introduced. A diagnostic arthroscopy has begun. There was extensive hypertrophic synovitis throughout the joint. The medial compartment articular cartilage of the medial femoral condyle and tibial plateau was in good condition. The medial meniscus was inspected and demonstrated a small radial tear at the anterior horn of the medial meniscus. Using the shaver, partial medial meniscectomy was performed down to a smooth stable rim. Next, the ACL was identified and probed and was noted to be stable with a negative anterior drawer sign. We then turned our attention to the lateral compartment. The articular surfaces were normal. The lateral meniscus was probed and noted to be stable but there was traumatic radial tear of the body of the lateral meniscus; using the shaver we performed a partial lateral meniscectomy, down to a smooth and stable surface. Next we accessed the patellofemoral compartment. There was a chondral lesion on the trochlea groove. This was debrided using the shaver, however there were unstable margins remaining and a coblation arthroplasty had to be performed; using an ArthroCare wand and its plasma field, we melded the unstable margins, down to a smooth and stable surface with minimal damage to the surrounding tissue. There was a thickened medial plica identified and this was excised using the shaver. There was extensive hypertrophic synovitis seen within all three compartments; using the shaver, we performed extensive synovectomies removing the extensive hypertrophic synovitis encountered in all three compartments. The arthroscope and instruments were withdrawn. The portals were closed with buried 3-0 Monocryl. Marcaine 0.25% was injected into the portal sites intra particularly. Steri-Strips and dry sterile compressive dressings were applied. The patient was awakened and brought to the recovery room in satisfactory condition.

Anjani Sinha, M.D.