## M60.0 Infective myositis

1. Patient presented with severe pain, swelling, and erythema in the left lower extremity. MRI revealed evidence of infective myositis involving the quadriceps muscle. A surgical incision was made, and purulent material was drained. Cultures confirmed the presence of Staphylococcus aureus. The muscle was thoroughly irrigated, and a negative pressure wound therapy device was applied. Intravenous antibiotics were initiated, and the patient was closely monitored for signs of systemic infection. Follow-up imaging showed resolution of the infection, and the patient's symptoms significantly improved.

2. This operative note describes the management of infective myositis affecting the right biceps muscle. The patient presented with localized tenderness, warmth, and swelling. Surgical exploration revealed purulent fluid within the muscle compartment. A thorough debridement was performed, removing necrotic tissue. Cultures confirmed the presence of Streptococcus pyogenes. The wound was irrigated with saline and closed in layers. Intravenous antibiotics were administered, and the patient was placed on strict bed rest. Follow-up examinations demonstrated a favorable response to treatment with reduced pain, swelling, and improved range of motion.

3. The patient underwent surgical intervention for infective myositis involving the left gastrocnemius muscle. On examination, there was significant muscle tenderness, induration, and erythema. A longitudinal incision was made, allowing for drainage of purulent material. Cultures grew Methicillin-resistant Staphylococcus aureus (MRSA). Extensive irrigation with sterile saline was performed, followed by the application of a negative pressure wound therapy system. Intravenous antibiotics were initiated, targeting MRSA. The patient showed clinical improvement, with decreased pain and swelling observed during subsequent follow-up visits.

4. Operative intervention was performed for infective myositis affecting the right pectoralis major muscle. The patient complained of severe pain, redness, and limited range of motion. A transverse incision was made over the affected area, revealing purulent material within the muscle fibers. Cultures confirmed the presence of Enterococcus faecalis. Extensive debridement and irrigation were performed, followed by primary closure. Intravenous antibiotics targeting Enterococcus were administered, and the patient was closely monitored for signs of systemic infection. Subsequent examinations showed marked improvement, with reduced pain and restoration of normal muscle function.

5. This operative note describes the management of infective myositis involving the left deltoid muscle. The patient presented with localized pain, swelling, and warmth. Surgical exploration revealed a collection of pus within the muscle compartment. Purulent material was drained, and cultures grew Escherichia coli. Thorough irrigation was performed using sterile saline, and the wound was left open for secondary healing. Intravenous antibiotics were administered to target E. coli. Follow-up examinations demonstrated significant improvement, with reduced pain, decreased swelling, and improved shoulder range of motion.

6. Patient underwent surgery for infective myositis involving the right hamstring muscles. On examination, there was significant muscle tenderness, edema, and erythema. A longitudinal incision was made over the affected area, and purulent material was drained. Cultures grew Pseudomonas aeruginosa. Extensive debridement and irrigation were performed, followed by the application of a negative pressure wound therapy system. Intravenous antibiotics targeting Pseudomonas were initiated. The patient showed progressive improvement, with reduced pain, improved muscle function, and resolution of the infection.

7. The patient underwent operative intervention for infective myositis affecting the left adductor muscles. The patient presented with severe pain, swelling, and limited range of motion. A medial approach was utilized, allowing for thorough debridement of necrotic tissue and drainage of purulent material. Cultures confirmed the presence of Group A Streptococcus. The wound was copiously irrigated, and a drain was placed. Intravenous antibiotics targeting Group A Streptococcus were administered. The patient's symptoms gradually resolved, and subsequent follow-up examinations revealed improved muscle function and decreased pain.

8. This operative note documents the management of infective myositis involving the right trapezius muscle. The patient complained of intense pain, swelling, and limited neck and shoulder movement. A transverse incision was made, providing access to the affected area. Purulent material was drained, and cultures confirmed the presence of Haemophilus influenzae. Thorough irrigation with saline was performed, and the wound was closed primarily. Intravenous antibiotics targeting H. influenzae were initiated. The patient exhibited significant improvement, with decreased pain, improved range of motion, and resolution of local signs of infection.

9. Operative intervention was performed for infective myositis affecting the left gluteus maximus muscle. The patient presented with severe pain, swelling, and erythema. A curvilinear incision was made, and a significant amount of purulent material was drained. Cultures grew Streptococcus pneumoniae. Thorough irrigation was performed, and the wound was left open for secondary healing. Intravenous antibiotics targeting S. pneumoniae were administered. The patient demonstrated progressive improvement, with reduced pain, improved muscle function, and resolution of local signs of infection.

10. This operative note describes the management of infective myositis involving the right gastrocnemius muscle. The patient presented with severe pain, swelling, and erythema. Surgical exploration revealed a deep-seated abscess within the muscle compartment. Incision and drainage were performed, and cultures grew Klebsiella pneumoniae. The wound was thoroughly irrigated, and a drain was placed. Intravenous antibiotics targeting K. pneumoniae were initiated. The patient's symptoms gradually improved, with decreased pain, reduced swelling, and improved mobility of the affected limb. Follow-up imaging demonstrated resolution of the infection.

1. Patient underwent surgery for infective myositis involving the left intercostal muscles. The patient complained of severe pain, tenderness, and difficulty breathing. A thoracotomy was performed, revealing a localized abscess. Purulent material was drained, and cultures confirmed the presence of Streptococcus pneumoniae. Thorough irrigation was carried out, and a chest tube was inserted. Intravenous antibiotics targeting S. pneumoniae were administered. The patient demonstrated gradual improvement, with reduced pain, improved respiratory function, and resolution of the infection.

2. Operative intervention was performed for infective myositis affecting the right temporalis muscle. The patient presented with localized pain, swelling, and trismus. A transverse incision was made over the affected area, and purulent material was drained. Cultures grew Fusobacterium necrophorum. Thorough irrigation was performed using saline, and the wound was left open for secondary healing. Intravenous antibiotics targeting F. necrophorum were initiated. The patient showed progressive improvement, with reduced pain, improved jaw movement, and resolution of the infection.

3. The patient underwent surgical management for infective myositis involving the right iliopsoas muscle. On examination, there was significant muscle tenderness, hip flexion limitation, and systemic signs of infection. A surgical approach was used, allowing for drainage of purulent material and extensive debridement. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). The wound was thoroughly irrigated, and a drain was placed. Intravenous antibiotics targeting MRSA were administered. The patient demonstrated gradual improvement, with reduced pain, improved range of motion, and resolution of systemic symptoms.

4. This operative note describes the management of infective myositis affecting the left rhomboid muscles. The patient presented with localized pain, swelling, and limited shoulder movement. A longitudinal incision was made, providing access to the affected area. Purulent material was drained, and cultures confirmed the presence of Actinomyces israelii. Thorough irrigation with saline was performed, and the wound was closed primarily. Intravenous antibiotics targeting A. israelii were initiated. The patient exhibited significant improvement, with decreased pain, improved range of motion, and resolution of local signs of infection.

5. Operative intervention was performed for infective myositis involving the right quadratus lumborum muscle. The patient presented with severe back pain, localized tenderness, and restricted movement. A transverse incision was made, revealing a deep abscess. Purulent material was drained, and cultures grew Escherichia coli. Thorough irrigation with saline was performed, and a drain was inserted. Intravenous antibiotics targeting E. coli were administered. The patient demonstrated progressive improvement, with reduced pain, improved mobility, and resolution of the infection.

6. Patient underwent surgery for infective myositis involving the left orbicularis oculi muscle. On examination, there was significant muscle tenderness, eyelid swelling, and erythema. An incision was made along the eyelid crease, allowing for drainage of purulent material. Cultures grew Streptococcus pyogenes. Extensive irrigation with sterile saline was performed, and the wound was closed primarily. Intravenous antibiotics targeting S. pyogenes were initiated. The patient showed clinical improvement, with reduced pain, decreased swelling, and restored eyelid function.

7. The patient underwent operative intervention for infective myositis affecting the right triceps brachii muscle. The patient complained of severe pain, swelling, and limited elbow extension. A longitudinal incision was made, providing access to the affected area. Purulent material was drained, and cultures confirmed the presence of Pseudomonas aeruginosa. Thorough irrigation was performed using sterile saline, and the wound was closed in layers. Intravenous antibiotics targeting Pseudomonas were administered. The patient exhibited significant improvement, with decreased pain, improved range of motion, and resolution of local signs of infection.

8. This operative note documents the management of infective myositis involving the left sternocleidomastoid muscle. The patient presented with localized pain, swelling, and difficulty turning the head. A transverse incision was made over the affected area, and purulent material was drained. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, and the wound was closed primarily. Intravenous antibiotics targeting S. epidermidis were initiated. The patient demonstrated significant improvement, with decreased pain, improved neck movement, and resolution of local signs of infection.

9. Operative intervention was performed for infective myositis affecting the right gluteus medius muscle. The patient presented with severe pain, swelling, and difficulty walking. A curvilinear incision was made, and purulent material was drained. Cultures grew Klebsiella pneumoniae. Thorough irrigation was performed, and a drain was placed. Intravenous antibiotics targeting K. pneumoniae were administered. The patient showed progressive improvement, with reduced pain, improved muscle function, and resolution of the infection.

10. This operative note describes the management of infective myositis involving the left masseter muscle. The patient presented with localized pain, swelling, and trismus. A transoral approach was used, allowing for drainage of purulent material and thorough debridement. Cultures confirmed the presence of Prevotella intermedia. The wound was copiously irrigated with saline, and the patient was placed on a liquid diet. Intravenous antibiotics targeting P. intermedia were initiated. The patient demonstrated gradual improvement, with reduced pain, improved jaw movement, and resolution of the infection.

1. The patient underwent surgical intervention for infective myositis involving the left quadriceps muscle. General anesthesia was induced with intravenous propofol (150 mg) and fentanyl (100 mcg). Maintenance was achieved with sevoflurane (1-2%) and remifentanil infusion (0.1-0.2 mcg/kg/min). A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, and a negative pressure wound therapy system was applied. Intravenous antibiotics targeting MRSA were administered. The patient tolerated the procedure well, and postoperative recovery was uneventful.

2. Operative intervention was performed for infective myositis affecting the right biceps muscle. The patient received regional anesthesia with ultrasound-guided brachial plexus block using 30 mL of 0.5% ropivacaine. A transverse incision was made over the affected area, and purulent material was drained. Cultures confirmed the presence of Streptococcus pyogenes. Thorough irrigation was performed, and the wound was closed in layers. Intravenous antibiotics targeting S. pyogenes were administered. The patient remained hemodynamically stable throughout the procedure, and sensory-motor blockade was adequate.

3. Patient underwent surgery for infective myositis involving the left gastrocnemius muscle. The procedure was performed under monitored anesthesia care (MAC) using midazolam (2 mg) and fentanyl (50 mcg) for conscious sedation. A longitudinal incision was made, and purulent material was drained. Cultures grew Staphylococcus aureus. Extensive irrigation with sterile saline was performed, and a drain was inserted. Intravenous antibiotics targeting S. aureus were initiated. The patient was cooperative and comfortable throughout the procedure, and vital signs remained stable.

4. This operative note describes the management of infective myositis affecting the right pectoralis major muscle. The patient received general anesthesia induced with propofol (100 mg) and remifentanil (0.5 mcg/kg). Maintenance was achieved with desflurane (3-4%) and remifentanil infusion (0.1-0.2 mcg/kg/min). A transverse incision was made over the affected area, revealing purulent material within the muscle fibers. Cultures confirmed the presence of Enterococcus faecalis. Extensive debridement and irrigation were performed, followed by primary closure. Intravenous antibiotics targeting Enterococcus were administered. The patient remained stable throughout the procedure, and adequate depth of anesthesia was maintained.

5. The patient underwent operative intervention for infective myositis involving the left deltoid muscle. Regional anesthesia was administered with ultrasound-guided interscalene brachial plexus block using 20 mL of 0.5% bupivacaine. A curvilinear incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of Escherichia coli. Thorough irrigation was performed using sterile saline, and the wound was left open for secondary healing. Intravenous antibiotics targeting E. coli were initiated. The patient remained comfortable and had excellent sensory blockade throughout the procedure.

6. Operative intervention was performed for infective myositis affecting the right hamstring muscles. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). Maintenance was achieved with a combination of sevoflurane (1-2%) and a remifentanil infusion (0.05-0.1 mcg/kg/min). A longitudinal incision was made over the affected area, and purulent material was drained. Cultures grew Pseudomonas aeruginosa. Thorough irrigation with sterile saline was performed, followed by the application of a negative pressure wound therapy system. Intravenous antibiotics targeting Pseudomonas were administered. The patient's vital signs remained stable, and anesthesia depth was appropriate throughout the procedure.

7. The patient underwent surgical management for infective myositis involving the left adductor muscles. The procedure was performed under spinal anesthesia using hyperbaric bupivacaine (10 mg) injected at the L3-L4 interspace. A medial approach was utilized, allowing for drainage of purulent material and extensive debridement. Cultures confirmed the presence of Group A Streptococcus. The wound was irrigated with saline and closed in layers. Intravenous antibiotics targeting Group A Streptococcus were administered. The patient remained comfortable and had adequate sensory and motor blockade during the procedure.

8. This operative note documents the management of infective myositis involving the right trapezius muscle. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). Maintenance was achieved with sevoflurane (1-2%) and a remifentanil infusion (0.1-0.2 mcg/kg/min). A transverse incision was made over the affected area, and purulent material was drained. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, and the wound was closed primarily. Intravenous antibiotics targeting S. epidermidis were administered. The patient's vital signs were stable, and anesthesia was maintained at an appropriate level.

9. Operative intervention was performed for infective myositis affecting the left gluteus maximus muscle. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). Maintenance was achieved with a combination of sevoflurane (1-2%) and a remifentanil infusion (0.05-0.1 mcg/kg/min). A curvilinear incision was made, and purulent material was drained. Cultures grew Klebsiella pneumoniae. Thorough irrigation was performed, and a drain was placed. Intravenous antibiotics targeting K. pneumoniae were administered. The patient remained hemodynamically stable, and anesthesia depth was appropriate throughout the procedure.

10. This operative note describes the management of infective myositis involving the right gastrocnemius muscle. The patient received spinal anesthesia with hyperbaric bupivacaine (12 mg) injected at the L4-L5 interspace. A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, and a negative pressure wound therapy system was applied. Intravenous antibiotics targeting MRSA were administered. The patient remained comfortable and had appropriate sensory and motor blockade during the procedure.

1. The patient underwent surgical intervention for infective myositis involving the left quadriceps muscle with associated bone erosion. General anesthesia was induced with intravenous propofol (150 mg) and fentanyl (100 mcg). Maintenance was achieved with sevoflurane (1-2%) and remifentanil infusion (0.1-0.2 mcg/kg/min). A longitudinal incision was made, allowing for drainage of purulent material and debridement of the eroded bone. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, and a negative pressure wound therapy system was applied. Intravenous antibiotics targeting MRSA were administered. The patient tolerated the procedure well, and postoperative recovery was uneventful.

2. Operative intervention was performed for infective myositis involving the right biceps muscle with associated bone erosion. The patient received regional anesthesia with ultrasound-guided brachial plexus block using 30 mL of 0.5% ropivacaine. A transverse incision was made over the affected area, and purulent material was drained. Cultures confirmed the presence of Streptococcus pyogenes. Thorough irrigation was performed, and the eroded bone was debrided. The wound was closed in layers. Intravenous antibiotics targeting S. pyogenes were administered. The patient remained hemodynamically stable throughout the procedure, and sensory-motor blockade was adequate.

3. Patient underwent surgery for infective myositis involving the left gastrocnemius muscle with associated bone erosion. The procedure was performed under monitored anesthesia care (MAC) using midazolam (2 mg) and fentanyl (50 mcg) for conscious sedation. A longitudinal incision was made, and purulent material was drained. Cultures grew Staphylococcus aureus. Extensive irrigation with sterile saline was performed, and the eroded bone was debrided. The wound was closed in layers. Intravenous antibiotics targeting S. aureus were initiated. The patient was cooperative and comfortable throughout the procedure, and vital signs remained stable.

4. This operative note describes the management of infective myositis involving the right pectoralis major muscle with associated bone erosion. The patient received general anesthesia induced with propofol (100 mg) and remifentanil (0.5 mcg/kg). Maintenance was achieved with desflurane (3-4%) and remifentanil infusion (0.1-0.2 mcg/kg/min). A transverse incision was made over the affected area, revealing purulent material within the muscle fibers. Cultures confirmed the presence of Enterococcus faecalis. Extensive debridement and irrigation were performed, including debridement of the eroded bone. The wound was closed in layers. Intravenous antibiotics targeting Enterococcus were administered. The patient remained stable throughout the procedure, and adequate depth of anesthesia was maintained.

5. The patient underwent operative intervention for infective myositis involving the left deltoid muscle with associated bone erosion. Regional anesthesia was administered with ultrasound-guided interscalene brachial plexus block using 20 mL of 0.5% bupivacaine. A curvilinear incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of Escherichia coli. Thorough irrigation was performed using sterile saline, and the eroded bone was debrided. The wound was closed in layers. Intravenous antibiotics targeting E. coli were initiated. The patient remained comfortable and had excellent sensory blockade throughout the procedure.

6. Operative intervention was performed for infective myositis affecting the right hamstring muscles with associated bone erosion. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). Maintenance was achieved with a combination of sevoflurane (1-2%) and a remifentanil infusion (0.05-0.1 mcg/kg/min). A longitudinal incision was made over the affected area, and purulent material was drained. Cultures grew Pseudomonas aeruginosa. Thorough irrigation with sterile saline was performed, including debridement of the eroded bone. The wound was closed in layers. Intravenous antibiotics targeting Pseudomonas were administered. The patient's vital signs remained stable, and anesthesia depth was appropriate throughout the procedure.

7. The patient underwent surgical management for infective myositis involving the left adductor muscles with associated bone erosion. The procedure was performed under spinal anesthesia using hyperbaric bupivacaine (10 mg) injected at the L3-L4 interspace. A medial approach was utilized, allowing for drainage of purulent material and extensive debridement, including the eroded bone. Cultures confirmed the presence of Group A Streptococcus. The wound was irrigated with saline and closed in layers. Intravenous antibiotics targeting Group A Streptococcus were administered. The patient remained comfortable and had adequate sensory and motor blockade during the procedure.

8. This operative note documents the management of infective myositis involving the right trapezius muscle with associated bone erosion. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). Maintenance was achieved with sevoflurane (1-2%) and a remifentanil infusion (0.1-0.2 mcg/kg/min). A transverse incision was made over the affected area, and purulent material was drained. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, including debridement of the eroded bone. The wound was closed primarily. Intravenous antibiotics targeting S. epidermidis were administered. The patient's vital signs were stable, and anesthesia was maintained at an appropriate level.

9. Operative intervention was performed for infective myositis affecting the left gluteus maximus muscle with associated bone erosion. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). Maintenance was achieved with a combination of sevoflurane (1-2%) and a remifentanil infusion (0.05-0.1 mcg/kg/min). A curvilinear incision was made, and purulent material was drained. Cultures grew Klebsiella pneumoniae. Thorough irrigation was performed, including debridement of the eroded bone, and a drain was placed. Intravenous antibiotics targeting K. pneumoniae were administered. The patient remained hemodynamically stable, and anesthesia depth was appropriate throughout the procedure.

10. This operative note describes the management of infective myositis involving the right gastrocnemius muscle with associated bone erosion. The patient received spinal anesthesia with hyperbaric bupivacaine (12 mg) injected at the L4-L5 interspace. A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, including debridement of the eroded bone, and a negative pressure wound therapy system was applied. Intravenous antibiotics targeting MRSA were administered. The patient remained comfortable and had appropriate sensory and motor blockade during the procedure.

1. The patient underwent urgent surgical intervention for infective myositis involving the left quadriceps muscle with severe bone pain. General anesthesia was induced with intravenous propofol (150 mg) and fentanyl (100 mcg). Maintenance was achieved with sevoflurane (1-2%) and remifentanil infusion (0.1-0.2 mcg/kg/min). A longitudinal incision was made, allowing for drainage of purulent material and debridement of the infected muscle and bone. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, and a negative pressure wound therapy system was applied. Intravenous antibiotics targeting MRSA were administered. The patient tolerated the procedure well, and postoperative pain management was optimized.

2. Operative intervention was performed for infective myositis involving the right biceps muscle with severe bone pain. The patient received regional anesthesia with ultrasound-guided brachial plexus block using 30 mL of 0.5% ropivacaine. A transverse incision was made over the affected area, and purulent material was drained. Cultures confirmed the presence of Streptococcus pyogenes. Thorough irrigation was performed, and the infected bone was debrided. The wound was closed in layers. Intravenous antibiotics targeting S. pyogenes were administered. The patient remained hemodynamically stable throughout the procedure, and comprehensive pain management was implemented.

3. Patient underwent surgery for infective myositis involving the left gastrocnemius muscle with severe bone pain. The procedure was performed under monitored anesthesia care (MAC) using midazolam (2 mg) and fentanyl (50 mcg) for conscious sedation. A longitudinal incision was made, and purulent material was drained. Cultures grew Staphylococcus aureus. Extensive irrigation with sterile saline was performed, and the infected bone was meticulously debrided. The wound was closed in layers. Intravenous antibiotics targeting S. aureus were initiated. The patient was cooperative and comfortable throughout the procedure, and multidisciplinary pain management strategies were employed.

4. This operative note describes the management of infective myositis involving the right pectoralis major muscle with severe bone pain. The patient received general anesthesia induced with propofol (100 mg) and remifentanil (0.5 mcg/kg). Maintenance was achieved with desflurane (3-4%) and remifentanil infusion (0.1-0.2 mcg/kg/min). A transverse incision was made over the affected area, revealing purulent material within the muscle fibers. Cultures confirmed the presence of Enterococcus faecalis. Extensive debridement and irrigation were performed, including meticulous debridement of the infected bone. The wound was closed in layers. Intravenous antibiotics targeting Enterococcus were administered. The patient remained stable throughout the procedure, and optimal pain control measures were implemented.

5. The patient underwent operative intervention for infective myositis involving the left deltoid muscle with severe bone pain. Regional anesthesia was administered with ultrasound-guided interscalene brachial plexus block using 20 mL of 0.5% bupivacaine. A curvilinear incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of Escherichia coli. Thorough irrigation was performed using sterile saline, and the infected bone was meticulously debrided. The wound was closed in layers. Intravenous antibiotics targeting E. coli were initiated.

The patient remained comfortable and had excellent pain control throughout the procedure.

6. Operative intervention was performed for infective myositis affecting the right hamstring muscles with severe bone pain. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). Maintenance was achieved with a combination of sevoflurane (1-2%) and a remifentanil infusion (0.05-0.1 mcg/kg/min). A longitudinal incision was made over the affected area, and purulent material was drained. Cultures grew Pseudomonas aeruginosa. Thorough irrigation with sterile saline was performed, including meticulous debridement of the infected bone. The wound was closed in layers. Intravenous antibiotics targeting Pseudomonas were administered. The patient's vital signs remained stable, and comprehensive pain management was provided.

7. The patient underwent surgical management for infective myositis involving the left adductor muscles with severe bone pain. The procedure was performed under spinal anesthesia using hyperbaric bupivacaine (10 mg) injected at the L3-L4 interspace. A medial approach was utilized, allowing for drainage of purulent material and extensive debridement, including meticulous debridement of the infected bone. Cultures confirmed the presence of Group A Streptococcus. The wound was irrigated with saline and closed in layers. Intravenous antibiotics targeting Group A Streptococcus were administered. The patient remained comfortable and had adequate sensory and motor blockade during the procedure. Pain control measures were optimized postoperatively.

8. This operative note documents the management of infective myositis involving the right trapezius muscle with severe bone pain. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). Maintenance was achieved with sevoflurane (1-2%) and a remifentanil infusion (0.1-0.2 mcg/kg/min). A transverse incision was made over the affected area, and purulent material was drained. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, including meticulous debridement of the infected bone. The wound was closed primarily. Intravenous antibiotics targeting S. epidermidis were administered. The patient's vital signs were stable, and comprehensive pain management was provided.

9. Operative intervention was performed for infective myositis affecting the left gluteus maximus muscle with severe bone pain. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). Maintenance was achieved with a combination of sevoflurane (1-2%) and a remifentanil infusion (0.05-0.1 mcg/kg/min). A curvilinear incision was made, and purulent material was drained. Cultures grew Klebsiella pneumoniae. Thorough irrigation was performed, including meticulous debridement of the infected bone, and a drain was placed. Intravenous antibiotics targeting K. pneumoniae were administered. The patient remained hemodynamically stable, and anesthesia depth was appropriate throughout the procedure. Optimal pain management strategies were employed intraoperatively and postoperatively.

10. This operative note describes the management of infective myositis involving the right gastrocnemius muscle with severe bone pain. The patient received spinal anesthesia with hyperbaric bupivacaine (12 mg) injected at the L4-L5 interspace. A longitudinal incision was made, allowing for drainage of purulent material. Culturesconfirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, including meticulous debridement of the infected bone, and a negative pressure wound therapy system was applied. Intravenous antibiotics targeting MRSA were administered. The patient tolerated the procedure well, and comprehensive pain control measures were implemented both intraoperatively and postoperatively.

1. The patient underwent urgent surgical intervention for severe infective myositis involving the left quadriceps muscle. General anesthesia was induced using intravenous propofol (150 mg) and fentanyl (100 mcg). A curvilinear incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement were performed, including meticulous removal of infected muscle tissue. The wound was closed in layers. Intravenous antibiotics targeting MRSA were initiated. The patient tolerated the procedure well, and appropriate postoperative care was provided.

2. Operative intervention was performed for infective myositis involving the right hamstring muscles. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). A longitudinal incision was made, allowing for drainage of purulent material. Cultures grew Pseudomonas aeruginosa. Thorough irrigation with sterile saline was performed, including extensive debridement of infected muscle and necrotic tissue. The wound was closed primarily. Intravenous antibiotics targeting Pseudomonas were administered. The patient's vital signs remained stable, and appropriate surgical postoperative management was implemented.

3. This operative note documents the surgical management of infective myositis involving the left adductor muscles. The procedure was performed under spinal anesthesia using hyperbaric bupivacaine (10 mg) injected at the L3-L4 interspace. A medial approach was utilized, allowing for drainage of purulent material and extensive debridement of the infected muscles. Cultures confirmed the presence of Group A Streptococcus. The wound was thoroughly irrigated and closed in layers. Intravenous antibiotics targeting Group A Streptococcus were administered. The patient remained comfortable and had adequate sensory and motor blockade during the surgical intervention.

4. The patient underwent surgical intervention for infective myositis involving the right trapezius muscle. General anesthesia was induced using intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, including surgical debridement of infected muscle tissue. The wound was closed primarily. Intravenous antibiotics targeting S. epidermidis were administered. The patient's vital signs remained stable throughout the surgical procedure, and appropriate postoperative care was provided.

5. Operative intervention was performed for infective myositis affecting the left gluteus maximus muscle. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A curvilinear incision was made, and purulent material was drained. Cultures grew Klebsiella pneumoniae. Thorough irrigation was performed, including surgical debridement of the infected muscle tissue, and a drain was placed. Intravenous antibiotics targeting K. pneumoniae were administered. The patient remained hemodynamically stable, and appropriate surgical postoperative management was implemented.

6. This operative note describes the surgical management of infective myositis involving the right gastrocnemius muscle. The patient received spinal anesthesia with hyperbaric bupivacaine (12 mg) injected at the L4-L5 interspace. A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, including surgical debridement of the infected muscle tissue, and a negative pressure wound therapy system was applied. Intravenous antibiotics targeting MRSA were administered. The patient tolerated the surgical intervention well, and appropriate postoperative care was provided.

7. The patient underwent urgent surgical intervention for infective myositis involving the left deltoid muscle. General anesthesia was induced using intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A curvilinear incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and surgical debridement were performed, including removal of necrotic muscle tissue. The wound was closed in layers. Intravenous antibiotics targeting MRSA were initiated. The patient tolerated the surgical procedure well, and appropriate postoperative pain management strategies were implemented.

8. Operative intervention was performed for infective myositis involving the right pectoralis major muscle. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures grew Streptococcus pyogenes. Thorough irrigation with sterile saline was performed, including surgical debridement of the infected muscle tissue. The wound was closed primarily. Intravenous antibiotics targeting S. pyogenes were administered. The patient remained stable throughout the surgical procedure, and appropriate postoperative care was provided.

9. This operative note documents the surgical management of infective myositis involving the left biceps muscle. The procedure was performed under regional anesthesia with ultrasound-guided brachial plexus block using 30 mL of 0.5% ropivacaine. A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of Staphylococcus aureus. Thorough irrigation and surgical debridement were performed, including meticulous removal of infected muscle tissue. The wound was closed in layers. Intravenous antibiotics targeting S. aureus were administered. The patient remained comfortable and had appropriate sensory and motor blockade during the surgical intervention.

10. Operative intervention was performed for infective myositis affecting the right biceps muscle. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of Escherichia coli. Thorough irrigation with saline was performed, including surgical debridement of the infected muscle tissue. The wound was closed primarily. Intravenous antibiotics targeting E. coli were administered. The patient's vital signs remained stable throughout the surgical procedure, and appropriate postoperative care was provided.

1. The patient underwent surgical intervention for severe infective myositis involving the left quadriceps muscle. General anesthesia was induced with intravenous propofol (150 mg) and fentanyl (100 mcg). A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement were performed, including meticulous removal of infected muscle tissue. The wound was closed in layers. Intravenous antibiotics targeting MRSA were initiated, and the patient was closely monitored for postoperative complications.

2. Operative intervention was performed for infective myositis involving the right hamstring muscles with associated severe pain. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures grew Pseudomonas aeruginosa. Thorough irrigation with sterile saline was performed, including extensive debridement of infected muscle and necrotic tissue. The wound was closed primarily. Intravenous antibiotics targeting Pseudomonas were administered, and the patient's pain was managed with a multimodal approach.

3. This operative note documents the surgical management of infective myositis involving the left adductor muscles with severe bone erosion. The procedure was performed under spinal anesthesia using hyperbaric bupivacaine (10 mg) injected at the L3-L4 interspace. A medial approach was utilized, allowing for drainage of purulent material and extensive debridement of the infected muscles. Cultures confirmed the presence of Group A Streptococcus. The wound was thoroughly irrigated and closed in layers. Intravenous antibiotics targeting Group A Streptococcus were administered, and postoperative imaging was planned to assess bone erosion.

4. The patient underwent surgical intervention for infective myositis involving the right trapezius muscle with severe bone erosion. General anesthesia was induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A curvilinear incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, including surgical debridement of infected muscle tissue. The wound was closed primarily. Intravenous antibiotics targeting S. epidermidis were administered, and a consult with an orthopedic surgeon was requested to evaluate the extent of bone erosion.

5. Operative intervention was performed for infective myositis affecting the left gluteus maximus muscle with severe bone erosion. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A curvilinear incision was made, and purulent material was drained. Cultures grew Klebsiella pneumoniae. Thorough irrigation was performed, including surgical debridement of the infected muscle tissue and necrotic bone. The wound was closed, and intravenous antibiotics targeting K. pneumoniae were administered. Postoperatively, the patient was referred to the orthopedic department for further evaluation and management of the bone erosion.

6. This operative note describes the surgical management of infective myositis involving the right gastrocnemius muscle with severe bone erosion. The patient received spinal anesthesia with hyperbaric bupivacaine (12 mg) injected at the L4-L5 interspace. A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, including surgical debridement of the infected muscle tissue and extensive evaluation of the bone erosion. The wound was closed, and intravenous antibiotics targeting MRSA were administered. A follow-up appointment with the orthopedic team was scheduled to assess bone healing.

7. The patient underwent urgent surgical intervention for infective myositis involving the left deltoid muscle with severe bone pain. General anesthesia was induced using intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A curvilinear incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and surgical debridement were performed, including removal of necrotic muscle tissue. The extent of bone erosion was assessed intraoperatively. The wound was closed, and intravenous antibiotics targeting MRSA were administered. Orthopedic consultation was requested for further evaluation of bone involvement.

8. Operative intervention was performed for infective myositis involving the right pectoralis major muscle with severe bone pain and erosion. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures grew Streptococcus pyogenes. Thorough irrigation with sterile saline was performed, including surgical debridement of the infected muscle tissue and careful assessment of the bone erosion. The wound was closed primarily. Intravenous antibiotics targeting S. pyogenes were administered, and a consultation with the orthopedic team was scheduled for further management of the bone erosion.

9. This operative note documents the surgical management of infective myositis involving the left biceps muscle with severe bone pain. The procedure was performed under regional anesthesia with ultrasound-guided brachial plexus block using 30 mL of 0.5% ropivacaine. A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of Staphylococcus aureus. Thorough irrigation and surgical debridement were performed, including meticulous removal of infected muscle tissue and evaluation of the bone erosion. The wound was closed in layers. Intravenous antibiotics targeting S. aureus were administered, and orthopedic follow-up was recommended.

10. Operative intervention was performed for infective myositis affecting the right biceps muscle with severe bone pain and erosion. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of Escherichia coli. Thorough irrigation with saline was performed, including surgical debridement of the infected muscle tissue and evaluation of the extent of bone erosion. The wound was closed primarily. Intravenous antibiotics targeting E. coli were administered, and consultation with an orthopedic specialist was arranged to address the bone erosion and optimize patient outcomes.

1. The patient underwent urgent surgical intervention for infective myositis with severe infection involving the right hip joint. General anesthesia was induced using intravenous propofol (150 mg) and fentanyl (100 mcg). A modified anterior approach was employed, allowing for adequate exposure and drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement of the infected joint were performed, followed by intravenous administration of MRSA-targeting antibiotics. The patient's vital signs remained stable throughout the procedure, and orthopedic consultation was obtained for further management of the joint infection.

2. Operative intervention was performed for severe infective myositis involving the left shoulder joint. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). A deltopectoral approach was utilized, providing adequate exposure and allowing for drainage of purulent material. Cultures grew Streptococcus pyogenes. Thorough irrigation of the joint was performed, followed by extensive debridement of infected tissues. Intravenous antibiotics targeting S. pyogenes were administered. The patient's pain was managed with a combination of systemic analgesics and local anesthetic infiltration.

3. This operative note documents the surgical management of severe infective myositis involving the right knee joint. The procedure was performed under spinal anesthesia with hyperbaric bupivacaine (12 mg) injected at the L3-L4 interspace. A medial parapatellar approach was utilized, providing adequate exposure for drainage of purulent material from the joint. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement were performed, followed by intravenous administration of MRSA-targeting antibiotics. The patient's vital signs remained stable, and a multidisciplinary approach involving orthopedics and infectious disease specialists was initiated for further joint management.

4. The patient underwent surgical intervention for severe infective myositis involving the left ankle joint. General anesthesia was induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A medial approach was utilized, allowing for drainage of purulent material from the joint. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation and debridement of infected tissues were performed, followed by intravenous administration of antibiotics targeting S. epidermidis. The patient's pain was managed with a combination of systemic analgesics and regional anesthesia techniques.

5. Operative intervention was performed for severe infective myositis affecting the right elbow joint. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). An olecranon approach was utilized, providing adequate exposure for drainage of purulent material from the joint. Cultures grew Pseudomonas aeruginosa. Thorough irrigation was performed, followed by debridement of infected tissues. Intravenous antibiotics targeting P. aeruginosa were administered. The patient's pain was managed with a multimodal approach involving systemic analgesics and regional anesthesia techniques.

6. This operative note describes the surgical management of severe infective myositis involving the left wrist joint. The procedure was performed under regional anesthesia using an ultrasound-guided wrist block with 15 mL of 0.5% ropivacaine. A dorsal approach was utilized, allowing for drainage of purulent material from the joint. Cultures

confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement of infected tissues were performed, followed by intravenous administration of MRSA-targeting antibiotics. The patient's pain was effectively managed with the regional anesthesia technique.

7. The patient underwent surgical intervention for severe infective myositis involving the right temporomandibular joint. General anesthesia was induced using intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). An intraoral approach was utilized, allowing for adequate exposure and drainage of purulent material from the joint. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement were performed, followed by intravenous administration of MRSA-targeting antibiotics. The patient's vital signs remained stable throughout the procedure, and a consultation with a maxillofacial surgeon was obtained for further joint management.

8. Operative intervention was performed for severe infective myositis involving the left temporomandibular joint. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). An intraoral approach was employed, allowing for drainage of purulent material from the joint. Cultures grew Streptococcus pyogenes. Thorough irrigation and debridement were performed, followed by intravenous administration of antibiotics targeting S. pyogenes. The patient's pain was managed with systemic analgesics and local anesthetic infiltration techniques.

9. This operative note documents the surgical management of severe infective myositis involving the right hip joint. The procedure was performed under spinal anesthesia with hyperbaric bupivacaine (12 mg) injected at the L4-L5 interspace. A modified lateral approach was employed, providing adequate exposure and allowing for drainage of purulent material from the joint. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement were performed, followed by intravenous administration of MRSA-targeting antibiotics. The patient's vital signs remained stable, and orthopedic consultation was obtained for further joint management.

10. Operative intervention was performed for severe infective myositis affecting the left temporomandibular joint. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). An extraoral approach was utilized, providing adequate exposure and allowing for drainage of purulent material from the joint. Cultures grew Klebsiella pneumoniae. Thorough irrigation and debridement were performed, followed by intravenous administration of antibiotics targeting K. pneumoniae. The patient's vital signs were closely monitored throughout the procedure, and a consultation with a maxillofacial surgeon was obtained for further joint management.

1. The patient underwent surgical intervention for infective myositis involving the right quadriceps muscle with severe inflammation. General anesthesia was induced using intravenous propofol (150 mg) and fentanyl (100 mcg). A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement were performed, including meticulous removal of inflamed muscle tissue. The wound was closed in layers. Intravenous antibiotics targeting MRSA were initiated, and postoperative anti-inflammatory medications were prescribed to manage the inflammation.

2. Operative intervention was performed for infective myositis involving the left hamstring muscles with moderate inflammation. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures grew Streptococcus pyogenes. Thorough irrigation with sterile saline was performed, including surgical debridement of the inflamed muscle tissue. The wound was closed primarily. Intravenous antibiotics targeting S. pyogenes were administered, and postoperative anti-inflammatory agents were prescribed to address the inflammation.

3. This operative note documents the surgical management of infective myositis involving the right adductor muscles with mild inflammation. The procedure was performed under spinal anesthesia with hyperbaric bupivacaine (10 mg) injected at the L3-L4 interspace. A medial approach was utilized, allowing for drainage of purulent material and limited debridement of the inflamed muscles. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). The wound was thoroughly irrigated and closed in layers. Intravenous antibiotics targeting MRSA were administered, and postoperative anti-inflammatory medications were prescribed to address the mild inflammation.

4. The patient underwent surgical intervention for infective myositis involving the left trapezius muscle with severe inflammation. General anesthesia was induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A curvilinear incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, including surgical debridement of the inflamed muscle tissue. The wound was closed primarily. Intravenous antibiotics targeting S. epidermidis were administered, and postoperative anti-inflammatory agents were prescribed to manage the severe inflammation.

5. Operative intervention was performed for infective myositis affecting the left gluteus maximus muscle with moderate inflammation. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A curvilinear incision was made, and purulent material was drained. Cultures grew Pseudomonas aeruginosa. Thorough irrigation was performed, including surgical debridement of the inflamed muscle tissue. The wound was closed, and intravenous antibiotics targeting P. aeruginosa were administered. Postoperatively, anti-inflammatory medications were prescribed to manage the inflammation.

6. This operative note describes the surgical management of infective myositis involving the right gastrocnemius muscle with mild inflammation. The procedure was performed under regional anesthesia with ultrasound-guided sciatic nerve block using 20 mL of 0.5% ropivacaine. A longitudinal incision was made, allowing for drainage of purulent material and limited debridement of the inflamed muscle tissue. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). The wound was thoroughly irrigated and closed primarily. Intravenous antibiotics targeting MRSA were administered, and postoperative anti-inflammatory medications were prescribed to address the mild inflammation.

7. The patient underwent surgical intervention for infective myositis involving the left deltoid muscle with moderate inflammation. General anesthesia was induced using intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A transverse incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of Streptococcus pyogenes. Thorough irrigation and debridement were performed, including meticulous removal of inflamed muscle tissue. The wound was closed in layers. Intravenous antibiotics targeting S. pyogenes were initiated, and postoperative anti-inflammatory medications were prescribed to manage the moderate inflammation.

8. Operative intervention was performed for infective myositis involving the right pectoralis major muscle with severe inflammation. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures grew Escherichia coli. Thorough irrigation with sterile saline was performed, including surgical debridement of the inflamed muscle tissue. The wound was closed primarily. Intravenous antibiotics targeting E. coli were administered, and postoperative anti-inflammatory agents were prescribed to address the severe inflammation.

9. This operative note documents the surgical management of infective myositis involving the left biceps muscle with mild inflammation. The procedure was performed under regional anesthesia using an ultrasound-guided brachial plexus block with 25 mL of 0.5% ropivacaine. A longitudinal incision was made, allowing for drainage of purulent material and limited debridement of the inflamed muscle tissue. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). The wound was thoroughly irrigated and closed in layers. Intravenous antibiotics targeting MRSA were administered, and postoperative anti-inflammatory medications were prescribed to address the mild inflammation.

10. Operative intervention was performed for infective myositis affecting the right biceps muscle with moderate inflammation. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A longitudinal incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation with saline was performed, including surgical debridement of the inflamed muscle tissue. The wound was closed, and intravenous antibiotics targeting S. epidermidis were administered. Postoperatively, anti-inflammatory medications were prescribed to manage the moderate inflammation.

1. The patient underwent urgent surgical intervention for severe infective myositis involving the right quadriceps muscle. General anesthesia was induced using intravenous propofol (150 mg) and fentanyl (100 mcg). A longitudinal incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation and debridement were performed, and the wound was left open for delayed primary closure. Intravenous antibiotics targeting MRSA were administered. The patient's follow-up will involve daily wound dressing changes and close monitoring for signs of infection.

2. Operative intervention was performed for moderate infective myositis involving the left hamstring muscles. The patient received general anesthesia induced with sevoflurane (1.5%) and intravenous fentanyl (100 mcg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures grew Streptococcus pyogenes. Thorough irrigation and debridement were performed, and the wound was closed primarily. Intravenous antibiotics targeting S. pyogenes were initiated. The patient's follow-up will involve regular outpatient visits for wound inspection, suture removal, and assessment of antibiotic response.

3. This operative note documents the surgical management of mild infective myositis involving the right adductor muscles. The procedure was performed under spinal anesthesia with hyperbaric bupivacaine (10 mg) injected at the L3-L4 interspace. A medial approach was utilized, allowing for drainage of purulent material and limited debridement. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, and the wound was closed primarily. Intravenous antibiotics targeting MRSA were administered. The patient's follow-up will involve a postoperative visit to assess wound healing and response to antibiotics.

4. The patient underwent surgical intervention for severe infective myositis involving the left trapezius muscle. General anesthesia was induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A curvilinear incision was made over the affected area, allowing for drainage of purulent material. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation and debridement were performed, and a drain was placed. Intravenous antibiotics targeting S. epidermidis were administered. The patient's follow-up will involve regular outpatient visits for drain removal, wound assessment, and adjustment of antibiotics based on culture and sensitivity results.

5. Operative intervention was performed for mild infective myositis affecting the left gluteus maximus muscle. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A curvilinear incision was made, and purulent material was drained. Cultures grew Pseudomonas aeruginosa. Thorough irrigation was performed, and the wound was closed primarily. Intravenous antibiotics targeting P. aeruginosa were administered. The patient's follow-up will involve regular outpatient visits to monitor wound healing and response to antibiotics, with a plan for further assessment and adjustment if needed.

6. This operative note describes the surgical management of severe infective myositis involving the right gastrocnemius muscle. The procedure was performed under regional anesthesia with ultrasound-guided sciatic nerve block using 20 mL of 0.5% ropivacaine. A longitudinal incision was made, allowing for drainage of purulent material and extensive debridement. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, and the wound was left open for delayed primary closure. Intravenous antibiotics targeting MRSA were administered. The patient's follow-up will involve frequent wound dressing changes, serial debridement if necessary, and close monitoring for signs of infection.

7. Operative intervention was performed for moderate infective myositis involving the left deltoid muscle. The patient received general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A transverse incision was made, allowing for drainage of purulent material. Cultures confirmed the presence of Streptococcus pyogenes. Thorough irrigation and debridement were performed, and the wound was closed primarily. Intravenous antibiotics targeting S. pyogenes were initiated. The patient's follow-up will involve regular outpatient visits to assess wound healing, monitor for any signs of recurrence or complications, and adjust antibiotics if necessary.

8. This operative note documents the surgical management of mild infective myositis involving the right biceps muscle. The procedure was performed under regional anesthesia using an ultrasound-guided brachial plexus block with 25 mL of 0.5% ropivacaine. A longitudinal incision was made, allowing for drainage of purulent material and limited debridement. Cultures confirmed the presence of methicillin-resistant Staphylococcus aureus (MRSA). Thorough irrigation was performed, and the wound was closed primarily. Intravenous antibiotics targeting MRSA were administered. The patient's follow-up will involve regular outpatient visits for wound assessment, suture removal, and adjustment of antibiotics based on culture and sensitivity results.

9. Operative intervention was performed for moderate infective myositis affecting the left pectoralis major muscle. The patient received general anesthesia induced with sevoflurane (1.5-2%) and intravenous fentanyl (100 mcg). A transverse incision was made over the affected area, allowing for drainage of purulent material. Cultures grew Escherichia coli. Thorough irrigation was performed, and the wound was closed primarily. Intravenous antibiotics targeting E. coli were administered. The patient's follow-up will involve regular outpatient visits for wound inspection, monitoring of antibiotic response, and adjustment of treatment if necessary.

10. This operative note describes the surgical management of severe infective myositis involving the left biceps muscle. The procedure was performed under general anesthesia induced with intravenous propofol (100 mg) and remifentanil (0.5 mcg/kg). A longitudinal incision was made over the affected area, allowing for drainage of purulent material and extensive debridement. Cultures confirmed the presence of Staphylococcus epidermidis. Thorough irrigation was performed, and the wound was left open for delayed primary closure. Intravenous antibiotics targeting S. epidermidis were administered. The patient's follow-up will involve regular wound care, frequent debridement if necessary, and close monitoring for signs of infection or wound complications.

## M60.1 Interstitial myositis

1. Patient: Ms. A, a 45-year-old female presenting with chronic thigh pain and muscle weakness. Operative Procedure: Bilateral muscle biopsy performed. Intraoperative findings: Grossly enlarged and inflamed interstitial tissues with infiltration of inflammatory cells. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Prescribed immunosuppressive therapy, pain management, and physical therapy. Prognosis discussed, and follow-up scheduled in two weeks.

2. Patient: Mr. B, a 32-year-old male with persistent shoulder pain and limited range of motion. Operative Procedure: Arthroscopic examination and synovial tissue biopsy performed. Intraoperative findings: Interstitial myositis characterized by synovial inflammation, fibrosis, and lymphocytic infiltration. Diagnosis: Interstitial myositis confirmed. Postoperative care: Administered intra-articular corticosteroid injection, advised rest, and initiated physical therapy. Follow-up scheduled in four weeks to assess response.

3. Patient: Mrs. C, a 55-year-old female complaining of muscle stiffness and pain in her legs. Operative Procedure: Open muscle biopsy of bilateral quadriceps performed. Intraoperative findings: Evidence of interstitial myositis, including interstitial fibrosis, necrotic muscle fibers, and infiltration of lymphocytes. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Initiated systemic immunosuppressive therapy and referred to rheumatology for further management. Patient educated about potential side effects and long-term monitoring.

4. Patient: Mr. D, a 28-year-old male athlete with recurrent calf muscle pain. Operative Procedure: Percutaneous muscle biopsy of the affected calf performed. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltration, perimysial fibrosis, and increased vascularity. Diagnosis: Interstitial myositis confirmed. Postoperative care: Prescribed nonsteroidal anti-inflammatory drugs (NSAIDs), advised rest, and recommended gradual return to activity. Follow-up scheduled in six weeks to monitor response.

5. Patient: Ms. E, a 62-year-old female experiencing progressive weakness in her arms. Operative Procedure: Open muscle biopsy of the biceps brachii muscle performed. Intraoperative findings: Interstitial myositis identified with lymphocytic infiltration, muscle fiber necrosis, and increased endomysial connective tissue. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated systemic corticosteroid therapy, provided occupational therapy for adaptive techniques, and arranged regular follow-up for treatment optimization.

6. Patient: Mr. F, a 50-year-old male presenting with chronic lower back pain and difficulty walking. Operative Procedure: Open muscle biopsy of the erector spinae performed. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber degeneration, and increased perimysial collagen deposition. Diagnosis: Interstitial myositis confirmed. Postoperative care: Administered corticosteroid injections at the biopsy site, recommended physical therapy, and scheduled follow-up in four weeks for treatment assessment.

7. Patient: Mrs. G, a 42-year-old female with persistent hand and wrist pain. Operative Procedure: Arthroscopic biopsy of the wrist synovium performed. Intraoperative findings: Interstitial myositis evidenced by synovial inflammation, lymphocytic infiltration, and increased vascularity. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered localized corticosteroid injection, advised splinting, and referred for hand therapy. Follow-up scheduled in six weeks for symptom reassessment.

8. Patient: Mr. H, a 30-year-old male presenting with progressive thigh weakness and difficulty climbing stairs. Operative Procedure: Muscle biopsy of the vastus lateralis performed. Intraoperative findings: Interstitial myositis identified with perivascular lymphocytic infiltrates, myofiber necrosis, and increased interstitial fibrosis. Diagnosis: Interstitial myositis confirmed. Postoperative care: Initiated immunosuppressive therapy, provided gait training, and arranged regular follow-up for clinical evaluation and medication adjustments.

9. Patient: Ms. I, a 55-year-old female experiencing recurrent muscle pain and fatigue. Operative Procedure: Muscle biopsy of the deltoid muscle performed. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, and increased endomysial connective tissue. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated corticosteroid therapy, recommended regular exercise, and scheduled follow-up visits for treatment monitoring and symptom management.

10. Patient: Mr. J, a 48-year-old male with chronic knee pain and swelling. Operative Procedure: Arthroscopic biopsy of the knee synovium performed. Intraoperative findings: Interstitial myositis evidenced by synovial hyperplasia, lymphocytic infiltration, and increased angiogenesis. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered intra-articular corticosteroid injection, advised rest and joint protection, and referred for physical therapy. Follow-up scheduled in eight weeks to assess treatment response and consider further interventions if necessary.

1. Patient: Ms. K, a 37-year-old female presenting with recurrent muscle pain and weakness in the calves. Operative Procedure: Bilateral calf muscle biopsy performed. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, muscle fiber degeneration, and increased endomysial collagen. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, recommended low-impact exercises, and scheduled regular follow-up for treatment monitoring and adjustment.

2. Patient: Mr. L, a 60-year-old male with persistent shoulder and neck pain. Operative Procedure: Open muscle biopsy of the trapezius muscle performed. Intraoperative findings: Interstitial myositis evidenced by lymphocytic infiltration, perimysial fibrosis, and increased vascularity. Diagnosis: Interstitial myositis confirmed. Postoperative care: Prescribed nonsteroidal anti-inflammatory drugs (NSAIDs), recommended gentle stretching exercises, and scheduled follow-up in six weeks for symptom assessment.

3. Patient: Mrs. M, a 43-year-old female experiencing progressive weakness in her hands and fingers. Operative Procedure: Muscle biopsy of the flexor digitorum superficialis performed. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, and increased interstitial fibrosis. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Initiated corticosteroid therapy, provided hand therapy for motor skill preservation, and arranged regular follow-up visits for treatment evaluation.

4. Patient: Mr. N, a 55-year-old male presenting with chronic hip pain and difficulty walking. Operative Procedure: Open muscle biopsy of the gluteus medius performed. Intraoperative findings: Interstitial myositis identified with perivascular lymphocytic infiltrates, myofiber necrosis, and increased endomysial collagen deposition. Diagnosis: Interstitial myositis confirmed. Postoperative care: Initiated immunosuppressive therapy, recommended assistive devices for ambulation, and scheduled follow-up in four weeks for treatment response assessment.

5. Patient: Ms. O, a 32-year-old female with persistent muscle pain and fatigue. Operative Procedure: Muscle biopsy of the gastrocnemius performed. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, and increased endomysial connective tissue. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated corticosteroid therapy, recommended gentle exercises and pacing techniques, and scheduled regular follow-up visits for treatment monitoring and symptom management.

6. Patient: Mr. P, a 48-year-old male experiencing recurrent muscle weakness and stiffness. Operative Procedure: Muscle biopsy of the quadriceps performed. Intraoperative findings: Interstitial myositis evidenced by perivascular lymphocytic infiltrates, muscle fiber degeneration, and increased perimysial collagen deposition. Diagnosis: Interstitial myositis confirmed. Postoperative care: Administered immunosuppressive therapy, provided physical therapy for muscle strengthening, and arranged regular follow-up for treatment optimization.

7. Patient: Mrs. Q, a 42-year-old female with chronic hand and wrist pain. Operative Procedure: Arthroscopic biopsy of the wrist synovium performed. Intraoperative findings: Interstitial myositis identified with synovial inflammation, lymphocytic infiltration, and increased vascularity. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered localized corticosteroid injection, advised rest, and referred for hand therapy. Follow-up scheduled in six weeks for symptom reassessment.

8. Patient: Mr. R, a 58-year-old male presenting with progressive weakness and atrophy in his legs. Operative Procedure: Open muscle biopsy of the tibialis anterior performed. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, and increased interstitial fibrosis. Diagnosis: Interstitial myositis confirmed. Postoperative care: Initiated immunosuppressive therapy, provided gait training with assistive devices, and scheduled regular follow-up for treatment monitoring.

9. Patient: Ms. S, a 40-year-old female with recurrent muscle pain and fatigue. Operative Procedure: Muscle biopsy of the deltoid performed. Intraoperative findings: Interstitial myositis evidenced by perifascicular atrophy, lymphocytic infiltrates, and increased endomysial collagen deposition. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated corticosteroid therapy, recommended low-impact exercises, and scheduled regular follow-up visits for treatment evaluation and symptom management.

10. Patient: Mr. T, a 53-year-old male with chronic knee pain and swelling. Operative Procedure: Arthroscopic biopsy of the knee synovium performed. Intraoperative findings: Interstitial myositis characterized by synovial hyperplasia, lymphocytic infiltration, and increased angiogenesis. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered intra-articular corticosteroid injection, advised rest, and referred for physical therapy. Follow-up scheduled in eight weeks to assess treatment response and consider additional interventions if required.

1. Patient: Ms. U, a 42-year-old female presenting with chronic thigh pain and muscle weakness. Operative Procedure: Bilateral muscle biopsy performed under local anesthesia with minimal sedation. Intraoperative findings: Grossly enlarged and inflamed interstitial tissues with infiltration of inflammatory cells. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Prescribed immunosuppressive therapy, pain management, and physical therapy. Prognosis discussed, and follow-up scheduled in two weeks.

2. Patient: Mr. V, a 32-year-old male with persistent shoulder pain and limited range of motion. Operative Procedure: Arthroscopic examination and synovial tissue biopsy performed under regional anesthesia. Intraoperative findings: Interstitial myositis characterized by synovial inflammation, fibrosis, and lymphocytic infiltration. Diagnosis: Interstitial myositis confirmed. Postoperative care: Administered regional anesthesia block for pain control, advised rest, and initiated physical therapy. Follow-up scheduled in four weeks to assess response.

3. Patient: Mrs. W, a 55-year-old female complaining of muscle stiffness and pain in her legs. Operative Procedure: Open muscle biopsy of bilateral quadriceps performed under general anesthesia. Intraoperative findings: Evidence of interstitial myositis, including interstitial fibrosis, necrotic muscle fibers, and infiltration of lymphocytes. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Initiated systemic immunosuppressive therapy and referred to rheumatology for further management. Patient educated about potential side effects and long-term monitoring.

4. Patient: Mr. X, a 28-year-old male athlete with recurrent calf muscle pain. Operative Procedure: Percutaneous muscle biopsy of the affected calf performed under conscious sedation. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltration, perimysial fibrosis, and increased vascularity. Diagnosis: Interstitial myositis confirmed. Postoperative care: Prescribed nonsteroidal anti-inflammatory drugs (NSAIDs), advised rest, and recommended gradual return to activity. Follow-up scheduled in six weeks to monitor response.

5. Patient: Ms. Y, a 62-year-old female experiencing progressive weakness in her arms. Operative Procedure: Open muscle biopsy of the biceps brachii muscle performed under monitored anesthesia care. Intraoperative findings: Interstitial myositis identified with lymphocytic infiltration, muscle fiber necrosis, and increased endomysial connective tissue. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated systemic corticosteroid therapy, provided occupational therapy for adaptive techniques, and arranged regular follow-up for treatment optimization.

6. Patient: Mr. Z, a 50-year-old male presenting with chronic lower back pain and difficulty walking. Operative Procedure: Open muscle biopsy of the erector spinae performed under spinal anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber degeneration, and increased perimysial collagen deposition. Diagnosis: Interstitial myositis confirmed. Postoperative care: Administered local anesthetic epidural for postoperative pain control, recommended physical therapy, and scheduled follow-up in four weeks for treatment assessment.

7. Patient: Ms. AA, a 46-year-old female with persistent hand and wrist pain. Operative Procedure: Arthroscopic biopsy of the wrist synovium performed under intravenous sedation. Intraoperative findings: Interstitial myositis evidenced by synovial inflammation, lymphocytic infiltration, and increased vascularity. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered localized corticosteroid injection, advised splinting, and referred for hand therapy. Follow-up scheduled in six weeks for symptom reassessment.

8. Patient: Mr. BB, a 39-year-old male presenting with progressive thigh weakness and difficulty climbing stairs. Operative Procedure: Muscle biopsy of the vastus lateralis performed under general anesthesia with muscle relaxants. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, and increased interstitial fibrosis. Diagnosis: Interstitial myositis confirmed. Postoperative care: Initiated immunosuppressive therapy, provided gait training, and arranged regular follow-up for clinical evaluation and medication adjustments.

9. Patient: Ms. CC, a 48-year-old female experiencing recurrent muscle pain and fatigue. Operative Procedure: Muscle biopsy of the deltoid performed under local anesthesia with moderate sedation. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, and increased endomysial connective tissue. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated corticosteroid therapy, recommended regular exercise, and scheduled follow-up visits for treatment monitoring and adjustment.

10. Patient: Mr. DD, a 54-year-old male with chronic knee pain and swelling. Operative Procedure: Arthroscopic biopsy of the knee synovium performed under spinal anesthesia. Intraoperative findings: Interstitial myositis characterized by synovial hyperplasia, lymphocytic infiltration, and increased angiogenesis. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered intra-articular corticosteroid injection, advised rest, and referred for physical therapy. Follow-up scheduled in eight weeks to assess treatment response and consider further interventions if necessary.

1. Patient: Ms. EE, a 36-year-old female with recurrent muscle pain and weakness. Operative Procedure: Muscle biopsy of the quadriceps performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and evidence of bone erosion. Diagnosis: Interstitial myositis with associated bone erosion confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, recommended weight-bearing exercises, and scheduled regular follow-up visits for treatment monitoring.

2. Patient: Mr. FF, a 45-year-old male presenting with chronic shoulder pain and limited mobility. Operative Procedure: Open muscle biopsy of the deltoid performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by perimysial fibrosis, lymphocytic infiltration, and bone erosion adjacent to the affected muscle. Diagnosis: Interstitial myositis with associated bone erosion confirmed histopathologically. Postoperative care: Administered regional anesthesia block for pain control, initiated corticosteroid therapy, and referred to orthopedics for evaluation of bone erosion.

3. Patient: Mrs. GG, a 52-year-old female with progressive weakness and joint pain. Operative Procedure: Muscle biopsy of the gastrocnemius performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, perifascicular atrophy, increased interstitial fibrosis, and bone erosion observed on imaging. Diagnosis: Interstitial myositis with associated bone erosion confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, recommended low-impact exercises, and scheduled regular follow-up visits for treatment evaluation.

4. Patient: Mr. HH, a 60-year-old male complaining of chronic hip pain and difficulty walking. Operative Procedure: Open muscle biopsy of the gluteus medius performed under spinal anesthesia. Intraoperative findings: Interstitial myositis identified with perivascular lymphocytic infiltrates, muscle fiber degeneration, increased perimysial collagen deposition, and evidence of bone erosion on imaging. Diagnosis: Interstitial myositis with associated bone erosion confirmed. Postoperative care: Administered local anesthetic epidural for postoperative pain control, initiated immunosuppressive therapy, and referred to orthopedics for management of bone erosion.

5. Patient: Ms. II, a 38-year-old female with persistent muscle pain and fatigue. Operative Procedure: Muscle biopsy of the biceps brachii performed under local anesthesia with minimal sedation. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial connective tissue, and bone erosion noted on imaging. Diagnosis: Interstitial myositis with associated bone erosion confirmed histopathologically. Postoperative care: Initiated corticosteroid therapy, recommended gentle exercises, and scheduled regular follow-up visits for treatment monitoring and symptom management.

6. Patient: Mr. JJ, a 49-year-old male presenting with chronic lower back pain and radiating leg discomfort. Operative Procedure: Open muscle biopsy of the erector spinae performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber necrosis, increased perimysial collagen deposition, and evidence of bone erosion adjacent to the affected muscle. Diagnosis: Interstitial myositis with associated bone erosion confirmed. Postoperative care: Initiated systemic corticosteroid therapy, provided physical therapy for pain management, and arranged regular follow-up for treatment optimization.

7. Patient: Mrs. KK, a 43-year-old female with persistent hand and wrist pain. Operative Procedure: Arthroscopic biopsy of the wrist synovium performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by synovial inflammation, lymphocytic infiltration, increased vascularity, and bone erosion detected on imaging. Diagnosis: Interstitial myositis with associated bone erosion confirmed histologically. Postoperative care: Administered localized corticosteroid injection, advised rest, and referred to orthopedics for evaluation and management of bone erosion. Follow-up scheduled in six weeks for symptom reassessment.

8. Patient: Mr. LL, a 52-year-old male presenting with progressive weakness and muscle atrophy in the legs. Operative Procedure: Muscle biopsy of the tibialis anterior performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and evidence of bone erosion adjacent to the affected muscle. Diagnosis: Interstitial myositis with associated bone erosion confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, provided physical therapy for muscle strengthening, and scheduled regular follow-up for treatment monitoring.

9. Patient: Ms. MM, a 41-year-old female experiencing recurrent muscle pain and fatigue. Operative Procedure: Muscle biopsy of the trapezius performed under local anesthesia with moderate sedation. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial collagen deposition, and bone erosion observed on imaging. Diagnosis: Interstitial myositis with associated bone erosion confirmed histopathologically. Postoperative care: Initiated corticosteroid therapy, recommended low-impact exercises, and scheduled regular follow-up visits for treatment evaluation and symptom management.

10. Patient: Mr. NN, a 55-year-old male with chronic knee pain and swelling. Operative Procedure: Arthroscopic biopsy of the knee synovium performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by synovial hyperplasia, lymphocytic infiltration, increased angiogenesis, and bone erosion detected on imaging. Diagnosis: Interstitial myositis with associated bone erosion confirmed histologically. Postoperative care: Administered intra-articular corticosteroid injection, advised rest, referred to orthopedics for management of bone erosion, and scheduled follow-up in eight weeks to assess treatment response.

1. Patient: Ms. OO, a 38-year-old female presenting with severe muscle pain and debilitating bone pain. Operative Procedure: Muscle biopsy of the quadriceps performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and severe bone pain observed upon palpation. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histologically. Postoperative care: Initiated aggressive pain management, prescribed immunosuppressive therapy, and scheduled regular follow-up visits for treatment monitoring and pain control.

2. Patient: Mr. PP, a 49-year-old male with chronic shoulder pain and excruciating bone pain. Operative Procedure: Open muscle biopsy of the deltoid performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by perimysial fibrosis, lymphocytic infiltration, and severe bone pain upon movement. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histopathologically. Postoperative care: Administered regional anesthesia block for pain control, initiated corticosteroid therapy, and referred to orthopedics for evaluation and management of severe bone pain.

3. Patient: Mrs. QQ, a 54-year-old female with progressive weakness, joint pain, and severe bone pain. Operative Procedure: Muscle biopsy of the gastrocnemius performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, perifascicular atrophy, increased interstitial fibrosis, and severe bone pain reported by the patient. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histologically. Postoperative care: Initiated intensive pain management, prescribed immunosuppressive therapy, recommended low-impact exercises, and scheduled regular follow-up visits for treatment evaluation and pain control.

4. Patient: Mr. RR, a 60-year-old male complaining of chronic hip pain, difficulty walking, and severe bone pain. Operative Procedure: Open muscle biopsy of the gluteus medius performed under spinal anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber degeneration, increased perimysial collagen deposition, and severe bone pain upon palpation. Diagnosis: Interstitial myositis with associated severe bone pain confirmed. Postoperative care: Administered local anesthetic epidural for postoperative pain control, initiated immunosuppressive therapy, and referred to orthopedics for management of severe bone pain.

5. Patient: Ms. SS, a 42-year-old female with persistent muscle pain, fatigue, and excruciating bone pain. Operative Procedure: Muscle biopsy of the biceps brachii performed under local anesthesia with minimal sedation. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial connective tissue, and severe bone pain reported by the patient. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histologically. Postoperative care: Initiated intensive pain management, prescribed corticosteroid therapy, recommended gentle exercises, and scheduled regular follow-up visits for treatment monitoring and pain control.

6. Patient: Mr. TT, a 49-year-old male presenting with chronic lower back pain, radiating leg discomfort, and severe bone pain. Operative Procedure: Open muscle biopsy of the erector spinae performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber necrosis, increased perimysial collagen deposition, and severe bone pain reported by the patient. Diagnosis: Interstitial myositis with associated severe bone pain confirmed. Postoperative care: Initiated aggressive pain management, prescribed systemic corticosteroid therapy, provided physical therapy for pain management, and arranged regular follow-up for treatment optimization and pain control.

7. Patient: Mrs. UU, a 44-year-old female with severe hand and wrist pain accompanied by excruciating bone pain. Operative Procedure: Arthroscopic biopsy of the wrist synovium performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by synovial inflammation, lymphocytic infiltration, increased vascularity, and severe bone pain reported by the patient. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histologically. Postoperative care: Administered localized corticosteroid injection for pain relief, prescribed aggressive pain management, advised rest, and referred to orthopedics for evaluation and management of severe bone pain. Follow-up scheduled in six weeks for symptom reassessment and pain control.

8. Patient: Mr. VV, a 51-year-old male presenting with progressive weakness and muscle atrophy in the legs, accompanied by severe bone pain. Operative Procedure: Muscle biopsy of the tibialis anterior performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and severe bone pain reported by the patient. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histologically. Postoperative care: Initiated aggressive pain management, prescribed immunosuppressive therapy, provided physical therapy for muscle strengthening, and scheduled regular follow-up visits for treatment monitoring and pain control.

9. Patient: Ms. WW, a 39-year-old female experiencing recurrent muscle pain, fatigue, and severe bone pain. Operative Procedure: Muscle biopsy of the trapezius performed under local anesthesia with moderate sedation. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial collagen deposition, and severe bone pain reported by the patient. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histopathologically. Postoperative care: Initiated intensive pain management, prescribed corticosteroid therapy, recommended low-impact exercises, and scheduled regular follow-up visits for treatment evaluation and pain control.

10. Patient: Mr. XX, a 56-year-old male with chronic knee pain, swelling, and severe bone pain. Operative Procedure: Arthroscopic biopsy of the knee synovium performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by synovial hyperplasia, lymphocytic infiltration, increased angiogenesis, and severe bone pain reported by the patient. Diagnosis: Interstitial myositis with associated severe bone pain confirmed histologically. Postoperative care: Administered intra-articular corticosteroid injection for pain relief, initiated aggressive pain management, advised rest, referred to orthopedics for management of severe bone pain, and scheduled follow-up in eight weeks to assess treatment response and pain control.

1. Patient: Ms. YY, a 42-year-old female presenting with severe muscle pain and limited mobility. Operative Procedure: Surgical excision of affected muscle bundles performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and the need for surgical intervention due to the severity of the condition. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for wound healing and treatment monitoring.

2. Patient: Mr. ZZ, a 50-year-old male with chronic shoulder pain and severe muscle weakness. Operative Procedure: Open muscle biopsy and debridement of affected muscle performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by perimysial fibrosis, lymphocytic infiltration, and the need for surgical intervention to alleviate muscle compression and improve function. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered regional anesthesia block for pain control, initiated corticosteroid therapy, and provided postoperative physical therapy for rehabilitation.

3. Patient: Mrs. AA, a 47-year-old female with progressive weakness, joint pain, and debilitating muscle pain. Operative Procedure: Surgical debridement and release of affected muscles performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, perifascicular atrophy, increased interstitial fibrosis, and the need for surgical intervention to address muscle contractures and improve mobility. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for surgical wound evaluation and treatment monitoring.

4. Patient: Mr. BB, a 55-year-old male complaining of chronic hip pain, difficulty walking, and severe muscle weakness. Operative Procedure: Total hip arthroplasty performed under spinal anesthesia. Intraoperative findings: Interstitial myositis evidenced by lymphocytic infiltrates, muscle fiber degeneration, increased perimysial collagen deposition, and the need for surgical intervention to address joint degeneration and muscle involvement. Diagnosis: Interstitial myositis confirmed with intraoperative evaluation. Postoperative care: Administered local anesthetic epidural for postoperative pain control, initiated immunosuppressive therapy, and provided postoperative rehabilitation for joint and muscle recovery.

5. Patient: Ms. CC, a 41-year-old female with persistent muscle pain, fatigue, and severe muscle weakness. Operative Procedure: Surgical release of affected muscles and tendon transfers performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial connective tissue, and the need for surgical intervention to improve muscle balance and function. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Initiated corticosteroid therapy, provided postoperative pain management, and scheduled regular follow-up visits for wound healing and treatment monitoring.

6. Patient: Mr. DD, a 49-year-old male presenting with chronic lower back pain, radiating leg discomfort, and severe muscle weakness. Operative Procedure: Spinal decompression surgery performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber necrosis, increased perimysial collagen deposition, and the need for surgical intervention to relieve nerve compression and improve symptoms. Diagnosis: Interstitial myositis confirmed intraoperatively. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for surgical site evaluation and treatment monitoring.

7. Patient: Mrs. EE, a 44-year-old female with severe hand and wrist pain accompanied by muscle weakness. Operative Procedure: Arthroscopic synovectomy and tendon release performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by synovial inflammation, lymphocytic infiltration, increased vascularity, and the need for surgical intervention to alleviate joint inflammation and improve hand function. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Administered localized corticosteroid injection, provided postoperative pain management, and referred to hand therapy for rehabilitation.

8. Patient: Mr. FF, a 51-year-old male presenting with progressive weakness and muscle atrophy in the legs. Operative Procedure: Muscle biopsy and myectomy performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and the need for surgical intervention to remove affected muscle tissue and improve muscle function. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for wound healing and treatment monitoring.

9. Patient: Ms. GG, a 39-year-old female experiencing recurrent muscle pain, fatigue, and severe muscle weakness. Operative Procedure: Surgical excision of affected muscle bundles and fasciotomy performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial collagen deposition, and the need for surgical intervention to release muscle compartments and alleviate muscle compression. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Initiated intensive pain management, prescribed corticosteroid therapy, provided postoperative physical therapy, and scheduled regular follow-up visits for wound healing and treatment monitoring.

10. Patient: Mr. HH, a 56-year-old male with chronic knee pain, swelling, and severe muscle weakness. Operative Procedure: Arthroscopic synovectomy and muscle debridement performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by synovial hyperplasia, lymphocytic infiltration, increased angiogenesis, and the need for surgical intervention to remove inflamed synovial tissue and improve joint and muscle function. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Administered intra-articular corticosteroid injection, initiated immunosuppressive therapy, provided postoperative pain management, and scheduled follow-up in eight weeks to assess treatment response and surgical site healing.

1. Patient: Ms. II, a 45-year-old female presenting with severe muscle pain and muscle contractures. Operative Procedure: Surgical release of affected muscles and joint mobilization performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and the need for surgical intervention to improve range of motion and alleviate muscle contractures. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for rehabilitation and treatment monitoring.

2. Patient: Mr. JJ, a 52-year-old male with chronic shoulder pain, muscle weakness, and limited mobility. Operative Procedure: Open muscle biopsy and rotator cuff repair performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by perimysial fibrosis, lymphocytic infiltration, and the need for surgical intervention to address muscle damage and repair the torn rotator cuff. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Administered regional anesthesia block for pain control, initiated corticosteroid therapy, provided postoperative physical therapy, and scheduled regular follow-up visits for rehabilitation and treatment monitoring.

3. Patient: Mrs. KK, a 48-year-old female with progressive weakness, muscle atrophy, and severe muscle pain. Operative Procedure: Surgical excision of affected muscle bundles and tendon transfers performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, perifascicular atrophy, increased interstitial fibrosis, and the need for surgical intervention to restore muscle balance and improve function. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for wound healing and treatment monitoring.

4. Patient: Mr. LL, a 57-year-old male complaining of chronic hip pain, limited mobility, and severe muscle weakness. Operative Procedure: Total hip replacement surgery performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber degeneration, increased perimysial collagen deposition, and the need for surgical intervention to address joint deterioration and restore hip function. Diagnosis: Interstitial myositis confirmed with intraoperative evaluation. Postoperative care: Administered local anesthetic epidural for postoperative pain control, initiated immunosuppressive therapy, and provided postoperative rehabilitation for joint and muscle recovery.

5. Patient: Ms. MM, a 43-year-old female with persistent muscle pain, fatigue, and severe muscle weakness. Operative Procedure: Surgical release of affected muscles and tendon lengthening performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial connective tissue, and the need for surgical intervention to alleviate muscle tightness and improve range of motion. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Initiated corticosteroid therapy, provided postoperative pain management, and scheduled regular follow-up visits for rehabilitation and treatment monitoring.

6. Patient: Mr. NN, a 50-year-old male presenting with chronic lower back pain, radiating leg discomfort, and severe muscle weakness. Operative Procedure: Spinal fusion surgery performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by lymphocytic infiltrates, muscle fiber necrosis, increased perimysial collagen deposition, and the need for surgical intervention to stabilize the spine and alleviate nerve compression. Diagnosis: Interstitial myositis confirmed intraoperatively. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for surgical site evaluation and treatment monitoring.

7. Patient: Mrs. OO, a 46-year-old female with severe hand and wrist pain accompanied by muscle weakness. Operative Procedure: Arthroscopic synovectomy, tendon repair, and joint stabilization performed under regional anesthesia. Intraoperative findings: Interstitial myositis evidenced by synovial inflammation, lymphocytic infiltration, increased vascularity, and the need for surgical intervention to address joint instability and improve hand function. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Administered localized corticosteroid injection, provided postoperative pain management, and referred to hand therapy for rehabilitation.

8. Patient: Mr. PP, a 53-year-old male presenting with progressive weakness and muscle atrophy in the legs. Operative Procedure: Muscle biopsy and myoplasty performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perivascular lymphocytic infiltrates, myofiber necrosis, increased interstitial fibrosis, and the need for surgical intervention to reconstruct affected muscle tissue and improve muscle strength. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Initiated immunosuppressive therapy, provided postoperative pain management, and scheduled regular follow-up visits for wound healing and treatment monitoring.

9. Patient: Ms. QQ, a 41-year-old female experiencing recurrent muscle pain, fatigue, and severe muscle weakness. Operative Procedure: Surgical excision of affected muscle bundles and fasciotomy performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by perifascicular atrophy, lymphocytic infiltrates, increased endomysial collagen deposition, and the need for surgical intervention to release muscle compartments and alleviate muscle compression. Diagnosis: Interstitial myositis confirmed histopathologically. Postoperative care: Initiated intensive pain management, prescribed corticosteroid therapy, provided postoperative physical therapy, and scheduled regular follow-up visits for wound healing and treatment monitoring.

10. Patient: Mr. RR, a 58-year-old male with chronic knee pain, swelling, and severe muscle weakness. Operative Procedure: Arthroscopic synovectomy, meniscal repair, and muscle debridement performed under general anesthesia. Intraoperative findings: Interstitial myositis characterized by synovial hyperplasia, lymphocytic infiltration, increased angiogenesis, and the need for surgical intervention to remove inflamed synovial tissue, repair the meniscus, and improve joint and muscle function. Diagnosis: Interstitial myositis confirmed histologically. Postoperative care: Administered intra-articular corticosteroid injection, initiated immunosuppressive therapy, provided postoperative pain management, and scheduled follow-up in eight weeks to assess treatment response and surgical site healing.

1. Patient: Ms. SS, a 49-year-old female presenting with severe muscle pain, limited range of motion, and signs of infection in the knee joint. Operative Procedure: Surgical debridement and joint irrigation performed under general anesthesia. Intraoperative findings: Interstitial myositis accompanied by bacterial infection manifested as purulent joint fluid, erythema, and edema, necessitating surgical intervention to remove infected tissue and alleviate symptoms. Diagnosis: Interstitial myositis with septic arthritis confirmed intraoperatively. Postoperative care: Administered intravenous antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and wound healing.

2. Patient: Mr. TT, a 55-year-old male with chronic hip pain, muscle weakness, and signs of infection in the hip joint. Operative Procedure: Open joint debridement and drainage performed under general anesthesia. Intraoperative findings: Interstitial myositis accompanied by deep joint infection evidenced by purulent material, synovial inflammation, and joint destruction, necessitating surgical intervention to clear the infection and restore joint function. Diagnosis: Interstitial myositis with septic arthritis confirmed histopathologically. Postoperative care: Administered intravenous antibiotics, initiated immunosuppressive therapy, and provided postoperative rehabilitation for joint recovery.

3. Patient: Mrs. UU, a 47-year-old female with progressive muscle weakness, joint pain, and signs of infection in the shoulder joint. Operative Procedure: Arthroscopic irrigation and debridement of the infected joint performed under regional anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis evidenced by synovial inflammation, purulent joint fluid, and joint erosion, necessitating surgical intervention to remove infected tissue and promote healing. Diagnosis: Interstitial myositis with septic arthritis confirmed intraoperatively. Postoperative care: Administered intra-articular antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and joint rehabilitation.

4. Patient: Mr. VV, a 52-year-old male complaining of severe elbow pain, muscle weakness, and signs of infection in the elbow joint. Operative Procedure: Open joint exploration and debridement performed under general anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis characterized by joint effusion, purulent material, and joint destruction, necessitating surgical intervention to clear the infection and improve joint mobility. Diagnosis: Interstitial myositis with septic arthritis confirmed histologically. Postoperative care: Administered intravenous antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and joint function assessment.

5. Patient: Ms. WW, a 44-year-old female with chronic ankle pain, limited mobility, and signs of infection in the ankle joint. Operative Procedure: Arthroscopic debridement and irrigation of the infected joint performed under regional anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis evidenced by synovial inflammation, purulent joint fluid, and joint cartilage damage, necessitating surgical intervention to address the infection and improve joint function. Diagnosis: Interstitial myositis with septic arthritis confirmed intraoperatively. Postoperative care: Administered intra-articular antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and joint rehabilitation.

6. Patient: Mr. XX, a 51-year-old male presenting with severe muscle pain, joint stiffness, and signs of infection in the wrist joint. Operative Procedure: Open joint debridement and lavage performed under general anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis characterized by synovial inflammation, purulent joint fluid, and joint erosion, necessitating surgical intervention to remove infected tissue and improve joint mobility. Diagnosis: Interstitial myositis with septic arthritis confirmed histopathologically. Postoperative care: Administered intravenous antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and joint rehabilitation.

7. Patient: Mrs. YY, a 48-year-old female with chronic finger pain, limited range of motion, and signs of infection in the finger joint. Operative Procedure: Arthroscopic debridement and irrigation of the infected joint performed under regional anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis evidenced by synovial inflammation, purulent joint fluid, and joint destruction, necessitating surgical intervention to clear the infection and improve finger function. Diagnosis: Interstitial myositis with septic arthritis confirmed intraoperatively. Postoperative care: Administered intra-articular antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and finger rehabilitation.

8. Patient: Mr. ZZ, a 53-year-old male complaining of severe knee pain, muscle weakness, and signs of infection in the knee joint. Operative Procedure: Open joint debridement and irrigation performed under general anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis characterized by synovial inflammation, purulent joint fluid, and joint deterioration, necessitating surgical intervention to remove infected tissue and promote joint healing. Diagnosis: Interstitial myositis with septic arthritis confirmed histologically. Postoperative care: Administered intravenous antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and joint function assessment.

9. Patient: Ms. AA, a 46-year-old female with progressive muscle weakness, joint pain, and signs of infection in the shoulder joint. Operative Procedure: Arthroscopic debridement and lavage of the infected joint performed under regional anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis evidenced by synovial inflammation, purulent joint fluid, and joint erosion, necessitating surgical intervention to clear the infection and improve shoulder function. Diagnosis: Interstitial myositis with septic arthritis confirmed intraoperatively. Postoperative care: Administered intra-articular antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and shoulder rehabilitation.

10. Patient: Mr. BB, a 49-year-old male with chronic elbow pain, limited range of motion, and signs of infection in the elbow joint. Operative Procedure: Open joint exploration and debridement performed under general anesthesia. Intraoperative findings: Interstitial myositis with septic arthritis characterized by joint effusion, purulent material, and joint destruction, necessitating surgical intervention to clear the infection and improve elbow mobility. Diagnosis: Interstitial myositis with septic arthritis confirmed histopathologically. Postoperative care: Administered intravenous antibiotics, provided postoperative pain management, and scheduled regular follow-up visits for infection monitoring and joint function assessment.

1. Patient: Ms. CC, a 47-year-old female with severe muscle pain, joint stiffness, and marked inflammation in the knee joint. Operative Procedure: Arthroscopic synovectomy and joint irrigation performed under regional anesthesia. Intraoperative findings: Interstitial myositis with intense synovial inflammation, characterized by hyperemia, increased vascularity, and synovial hypertrophy, requiring surgical intervention to address the inflammatory response and restore joint function. Diagnosis: Interstitial myositis with synovitis confirmed histologically. Postoperative care: Administered intra-articular corticosteroid injection, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and joint rehabilitation.

2. Patient: Mr. DD, a 55-year-old male presenting with progressive muscle weakness, joint pain, and significant inflammation in the shoulder joint. Operative Procedure: Open joint debridement and lavage performed under general anesthesia. Intraoperative findings: Interstitial myositis with marked synovial inflammation, manifested as thickened synovium, synovial proliferation, and intense inflammatory cell infiltration, necessitating surgical intervention to reduce inflammation and improve shoulder function. Diagnosis: Interstitial myositis with synovitis confirmed intraoperatively. Postoperative care: Administered systemic corticosteroid therapy, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and shoulder rehabilitation.

3. Patient: Mrs. EE, a 48-year-old female with chronic ankle pain, muscle weakness, and significant inflammation in the ankle joint. Operative Procedure: Arthroscopic synovectomy and joint debridement performed under regional anesthesia. Intraoperative findings: Interstitial myositis with pronounced synovial inflammation, characterized by synovial hyperplasia, inflammatory cell infiltrates, and pannus formation, necessitating surgical intervention to address the inflammatory process and improve joint mobility. Diagnosis: Interstitial myositis with synovitis confirmed histopathologically. Postoperative care: Administered nonsteroidal anti-inflammatory drugs (NSAIDs), provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and joint rehabilitation.

4. Patient: Mr. FF, a 52-year-old male complaining of severe elbow pain, muscle weakness, and marked inflammation in the elbow joint. Operative Procedure: Open joint debridement and synovial biopsy performed under general anesthesia. Intraoperative findings: Interstitial myositis with significant synovial inflammation, evidenced by synovial hypertrophy, vascular proliferation, and inflammatory cell infiltration, necessitating surgical intervention to address the inflammatory process and improve elbow function. Diagnosis: Interstitial myositis with synovitis confirmed histologically. Postoperative care: Administered intra-articular corticosteroid injection, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and joint rehabilitation.

5. Patient: Ms. GG, a 44-year-old female with chronic finger pain, limited mobility, and marked inflammation in the finger joint. Operative Procedure: Arthroscopic synovectomy and joint irrigation performed under regional anesthesia. Intraoperative findings: Interstitial myositis with pronounced synovial inflammation, characterized by synovial hyperemia, hypertrophy, and inflammatory cell infiltrates, necessitating surgical intervention to address the inflammatory response and improve finger function. Diagnosis: Interstitial myositis with synovitis confirmed intraoperatively. Postoperative care: Administered localized corticosteroid injection, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and finger rehabilitation.

6. Patient: Mr. HH, a 51-year-old male presenting with severe muscle pain, joint stiffness, and marked inflammation in the wrist joint. Operative Procedure: Open joint debridement and synovial biopsy performed under general anesthesia. Intraoperative findings: Interstitial myositis with intense synovial inflammation, evidenced by synovial edema, increased vascularity, and inflammatory cell infiltration, necessitating surgical intervention to address the inflammatory process and improve wrist function. Diagnosis: Interstitial myositis with synovitis confirmed histopathologically. Postoperative care: Administered systemic corticosteroid therapy, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and joint rehabilitation.

7. Patient: Mrs. II, a 46-year-old female with progressive muscle weakness, joint pain, and marked inflammation in the shoulder joint. Operative Procedure: Arthroscopic synovectomy and joint irrigation performed under regional anesthesia. Intraoperative findings: Interstitial myositis with pronounced synovial inflammation, characterized by synovial hypertrophy, intense hyperemia, and inflammatory cell infiltration, necessitating surgical intervention to address the inflammatory response and improve shoulder function. Diagnosis: Interstitial myositis with synovitis confirmed intraoperatively. Postoperative care: Administered intra-articular corticosteroid injection, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and shoulder rehabilitation.

8. Patient: Mr. JJ, a 55-year-old male with chronic hip pain, muscle weakness, and marked inflammation in the hip joint. Operative Procedure: Open joint debridement and lavage performed under general anesthesia. Intraoperative findings: Interstitial myositis with significant synovial inflammation, manifested as synovial hyperplasia, increased vascularity, and inflammatory cell infiltrates, necessitating surgical intervention to address the inflammatory process and improve hip mobility. Diagnosis: Interstitial myositis with synovitis confirmed histologically. Postoperative care: Administered systemic corticosteroid therapy, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and joint rehabilitation.

9. Patient: Ms. KK, a 47-year-old female with severe muscle pain, joint stiffness, and marked inflammation in the knee joint. Operative Procedure: Arthroscopic synovectomy and joint irrigation performed under regional anesthesia. Intraoperative findings: Interstitial myositis with pronounced synovial inflammation, characterized by synovial hypertrophy, vascular congestion, and inflammatory cell infiltrates, necessitating surgical intervention to address the inflammatory response and improve knee function. Diagnosis: Interstitial myositis with synovitis confirmed intraoperatively. Postoperative care: Administered intra-articular corticosteroid injection, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and joint rehabilitation.

10. Patient: Mr. LL, a 48-year-old male presenting with progressive muscle weakness, joint pain, and marked inflammation in the ankle joint. Operative Procedure: Open joint debridement and synovial biopsy performed under general anesthesia. Intraoperative findings: Interstitial myositis with intense synovial inflammation, evidenced by synovial hyperplasia, increased vascularity, and inflammatory cell infiltrates, necessitating surgical intervention to address the inflammatory process and improve ankle function. Diagnosis: Interstitial myositis with synovitis confirmed histopathologically. Postoperative care: Administered systemic corticosteroid therapy, provided postoperative pain management, and scheduled regular follow-up visits for inflammation monitoring and joint rehabilitation.

1. Patient: Ms. MM, a 49-year-old female presenting with severe muscle pain, limited range of motion, and a confirmed diagnosis of advanced interstitial myositis. Follow-up plan: Scheduled weekly visits for the first month to monitor symptoms, disease progression, and response to treatment. Based on the evaluation, follow-up frequency will be adjusted accordingly.

2. Patient: Mr. NN, a 55-year-old male with chronic hip pain, muscle weakness, and a diagnosis of moderate interstitial myositis. Follow-up plan: Scheduled monthly visits for the first three months to assess treatment effectiveness, manage symptoms, and monitor disease activity. Subsequent follow-ups will be determined based on patient response and progression.

3. Patient: Mrs. OO, a 47-year-old female with progressive muscle weakness, joint pain, and a confirmed diagnosis of early-stage interstitial myositis. Follow-up plan: Scheduled bi-monthly visits for the first six months to closely monitor disease activity, adjust treatment protocols if necessary, and assess patient's response to therapy.

4. Patient: Mr. PP, a 52-year-old male complaining of severe elbow pain, muscle weakness, and a diagnosis of severe interstitial myositis. Follow-up plan: Weekly visits for the first two months to closely monitor disease progression, manage symptoms, and evaluate treatment efficacy. Subsequent follow-ups will be determined based on the patient's condition and treatment response.

5. Patient: Ms. QQ, a 44-year-old female with chronic ankle pain, limited mobility, and a confirmed diagnosis of moderate interstitial myositis. Follow-up plan: Scheduled bi-monthly visits for the first four months to assess treatment response, address any new symptoms or concerns, and adjust management strategies accordingly.

6. Patient: Mr. RR, a 51-year-old male presenting with severe muscle pain, joint stiffness, and a diagnosis of advanced interstitial myositis. Follow-up plan: Weekly visits for the initial three months to closely monitor disease activity, manage symptoms, and evaluate the effectiveness of treatment interventions. Follow-up frequency will be adjusted based on the patient's response and disease progression.

7. Patient: Mrs. SS, a 48-year-old female with progressive muscle weakness, joint pain, and a confirmed diagnosis of mild interstitial myositis. Follow-up plan: Scheduled quarterly visits for the first year to monitor disease stability, manage symptoms, and assess the need for treatment modifications. Subsequent follow-ups will be determined based on the patient's condition and disease activity.

8. Patient: Mr. TT, a 49-year-old male with chronic finger pain, limited range of motion, and a diagnosis of moderate interstitial myositis. Follow-up plan: Scheduled monthly visits for the first six months to evaluate treatment response, provide supportive care, and assess any disease progression. Further follow-up intervals will be determined based on the patient's condition and treatment outcomes.

9. Patient: Ms. UU, a 46-year-old female with severe muscle pain, joint stiffness, and a confirmed diagnosis of advanced interstitial myositis. Follow-up plan: Weekly visits for the first two months to closely monitor disease activity, manage symptoms, and adjust treatment interventions accordingly. Follow-up frequency will be reevaluated based on the patient's response and disease severity.

10. Patient: Mr. VV, a 47-year-old male presenting with progressive muscle weakness, joint pain, and a diagnosis of mild interstitial myositis. Follow-up plan: Scheduled semi-annual visits for the first two years to monitor disease stability, assess treatment efficacy, and evaluate the need for any modifications in management. Subsequent follow-ups will be determined based on the patient's condition and disease progression.

## M60.2 Foreign body granuloma of soft tissue, not elsewhere classified

1. Operative Note: Foreign Body Granuloma Excision - Right Hand The patient was prepped and draped in a sterile fashion. A longitudinal incision was made over the right hand to expose the foreign body granuloma. Careful dissection was performed to identify and remove the granuloma, which was found to be surrounding a retained glass fragment. Hemostasis was achieved, and the wound was irrigated thoroughly. The wound was closed using interrupted sutures. The patient tolerated the procedure well, and postoperative instructions were given. The excised specimen was sent for histopathological examination.

2. Operative Note: Foreign Body Granuloma Excision - Left Foot Following sterile preparation, an elliptical incision was made on the left foot to access the foreign body granuloma. The granuloma was meticulously dissected from the surrounding soft tissue, revealing a small wooden splinter as the causative foreign body. After complete removal, the wound was irrigated and examined for hemostasis. The wound edges were then approximated using sutures. The patient exhibited no complications during the procedure, and appropriate postoperative care instructions were provided. The excised tissue was sent for pathological analysis to confirm the diagnosis.

3. Operative Note: Foreign Body Granuloma Excision – Abdomen Under aseptic conditions, a transverse incision was made on the lower abdomen. The foreign body granuloma was identified and carefully dissected from the surrounding tissue layers. The granuloma encapsulated a metallic object, which was removed completely. Thorough irrigation was performed, and hemostasis was achieved. The wound was closed in layers using absorbable sutures. The patient tolerated the procedure without any adverse events, and postoperative care instructions were provided. The excised specimen was sent for pathological examination for confirmation and further analysis.

4. Operative Note: Foreign Body Granuloma Excision - Facial Region After sterile draping, a curvilinear incision was made on the facial region, exposing the foreign body granuloma. Dissection revealed a deep-seated non-absorbable suture material as the causative foreign body. The granuloma was excised with caution to preserve adjacent structures. Irrigation and hemostasis were carried out meticulously. The wound was closed with sutures, taking care to achieve an optimal cosmetic outcome. The patient tolerated the procedure well, and postoperative instructions were given. The excised tissue was submitted for histopathological evaluation to confirm the diagnosis.

5. Operative Note: Foreign Body Granuloma Excision - Upper Extremity Following sterile preparation, an incision was made along the upper extremity to expose the foreign body granuloma. Dissection revealed a retained piece of broken needle as the inciting object. The granuloma was meticulously excised, ensuring complete removal. The wound was irrigated thoroughly, and hemostasis was achieved. Closure was performed using interrupted sutures. The patient experienced no complications during the procedure, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and rule out any underlying pathology.

6. Operative Note: Foreign Body Granuloma Excision - Lower Leg Under sterile conditions, a linear incision was made on the lower leg to access the foreign body granuloma. Dissection revealed a small metallic fragment embedded within the granulomatous tissue. The granuloma was carefully excised, ensuring complete removal of the foreign body. The wound was thoroughly irrigated, and hemostasis was achieved. Closure was performed using deep sutures and skin adhesive. The patient tolerated the procedure well, and postoperative instructions were provided. The excised specimen was sent for pathological examination to confirm the diagnosis and identify any associated complications.

7. Operative Note: Foreign Body Granuloma Excision - Neck Region After sterile preparation, a transverse incision was made on the neck region. The foreign body granuloma was identified and dissected from the surrounding soft tissues. A small piece of embedded glass was found to be the causative foreign body. Complete removal of the granuloma was achieved, and meticulous irrigation was performed. Hemostasis was confirmed, and the wound was closed using layered sutures. The patient exhibited no intraoperative complications, and appropriate postoperative care instructions were provided. The excised tissue was sent for histopathological analysis to confirm the diagnosis and guide further management.

8. Operative Note: Foreign Body Granuloma Excision - Thoracic Region Under aseptic conditions, a thoracotomy incision was made to access the foreign body granuloma in the thoracic region. Dissection revealed a retained metallic object within the granulomatous tissue. The granuloma was excised meticulously, ensuring complete removal of the foreign body. Thorough irrigation and hemostasis were achieved. The thoracic wall layers were closed using absorbable sutures, and the skin was closed using staples. The patient tolerated the procedure well, and postoperative care instructions were provided. The excised tissue was sent for pathological examination to confirm the diagnosis and rule out any associated complications.

9. Operative Note: Foreign Body Granuloma Excision - Pelvic Region Following sterile draping, a midline incision was made in the pelvic region to access the foreign body granuloma. Dissection revealed an encapsulated foreign body consisting of retained surgical gauze. The granuloma and foreign body were excised meticulously, with care taken to avoid damage to nearby structures. The wound was irrigated thoroughly, and hemostasis was achieved. Closure was performed in layers using absorbable sutures. The patient tolerated the procedure without complications, and postoperative instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any underlying pathology.

10. Operative Note: Foreign Body Granuloma Excision - Cranial Region Under sterile conditions, a curvilinear incision was made on the cranial region to access the foreign body granuloma. Dissection revealed an embedded metallic fragment as the causative foreign body. The granuloma was excised meticulously, preserving surrounding neurovascular structures. Thorough irrigation and hemostasis were ensured. The wound was closed in layers using absorbable sutures, and the skin was closed with staples. The patient exhibited no intraoperative complications, and appropriate postoperative care instructions were given. The excised tissue was sent for pathological examination to confirm the diagnosis and rule out any associated complications.

1. Operative Note: Foreign Body Granuloma Excision – Scalp Following aseptic preparation, a linear incision was made on the scalp to access the foreign body granuloma. Dissection revealed a buried glass shard as the inciting foreign body. The granuloma was meticulously excised, ensuring complete removal. The wound was thoroughly irrigated, and hemostasis was achieved. Closure was performed using deep sutures and skin adhesive. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and rule out any underlying infections.

2. Operative Note: Foreign Body Granuloma Excision – Back Under sterile conditions, a midline incision was made on the patient's back to access the foreign body granuloma. Dissection revealed an encapsulated foreign object, identified as a retained piece of a broken acupuncture needle. The granuloma was meticulously excised, preserving surrounding structures. Thorough irrigation and hemostasis were achieved. The wound was closed using interrupted sutures. The patient tolerated the procedure without complications, and postoperative care instructions were given. The excised tissue was sent for histopathological examination to confirm the diagnosis and evaluate for any underlying malignancy.

3. Operative Note: Foreign Body Granuloma Excision – Perineum Following aseptic preparation, a curvilinear incision was made in the perineal region to access the foreign body granuloma. Dissection revealed a retained non-absorbable suture material as the causative foreign body. The granuloma was carefully excised, ensuring complete removal. The wound was thoroughly irrigated, and hemostasis was achieved. Closure was performed using layered sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated infections.

4. Operative Note: Foreign Body Granuloma Excision – Breast Under sterile conditions, an elliptical incision was made on the breast to access the foreign body granuloma. Dissection revealed a silicone implant rupture as the causative foreign body. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using absorbable sutures. The patient tolerated the procedure without complications, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated complications.

5. Operative Note: Foreign Body Granuloma Excision – Groin Following sterile draping, a vertical incision was made in the groin to access the foreign body granuloma. Dissection revealed an encapsulated foreign body consisting of a retained mesh fragment. The granuloma and foreign body were excised meticulously, with care taken to avoid injury to nearby structures. The wound was thoroughly irrigated, and hemostasis was achieved. Closure was performed using absorbable sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated infections.

6. Operative Note: Foreign Body Granuloma Excision – Shoulder After aseptic preparation, a transverse incision was made on the shoulder to access the foreign body granuloma. Dissection revealed a retained metal fragment as the causative foreign body. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using layered sutures. The patient tolerated the procedure without complications, and postoperative care instructions were given. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated inflammatory reactions.

7. Operative Note: Foreign Body Granuloma Excision – Knee Under sterile conditions, a longitudinal incision was made on the knee to access the foreign body granuloma. Dissection revealed a retained piece of a broken hypodermic needle as the causative foreign body. The granuloma was carefully excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using interrupted sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated infectious processes.

8. Operative Note: Foreign Body Granuloma Excision – Wrist Following aseptic preparation, a curvilinear incision was made on the wrist to access the foreign body granuloma. Dissection revealed an embedded piece of glass as the inciting foreign body. The granuloma was meticulously excised, ensuring complete removal. The wound was thoroughly irrigated, and hemostasis was achieved. Closure was performed using sutures and a sterile adhesive dressing. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated complications.

9. Operative Note: Foreign Body Granuloma Excision – Ankle Under sterile conditions, a curved incision was made on the ankle to access the foreign body granuloma. Dissection revealed an encapsulated foreign object consisting of a retained broken piece of jewelry. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using absorbable sutures. The patient tolerated the procedure well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated foreign body reactions.

10. Operative Note: Foreign Body Granuloma Excision – Elbow Following sterile draping, a longitudinal incision was made on the elbow to access the foreign body granuloma. Dissection revealed an embedded metal fragment as the inciting foreign body. The granuloma was meticulously excised, ensuring complete removal. The wound was thoroughly irrigated, and hemostasis was achieved. Closure was performed using sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination to confirm the diagnosis and assess for any associated complications or foreign body-related infections.

1. Operative Note: Foreign Body Granuloma Excision - Right Hand The patient was prepped and draped in a sterile fashion. After induction of general anesthesia with intravenous propofol (100 mg), endotracheal intubation was performed. A longitudinal incision was made over the right hand to expose the foreign body granuloma. Careful dissection was performed to identify and remove the granuloma. Anesthesia was maintained with sevoflurane (1-1.5%) and a continuous infusion of remifentanil (0.05-0.2 mcg/kg/min). Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient tolerated the procedure well, and postoperative instructions were given. The excised specimen was sent for histopathological examination.

2. Operative Note: Foreign Body Granuloma Excision - Left Foot Following sterile preparation, a regional anesthesia technique using a popliteal nerve block was performed on the patient's left foot. The patient received sedation with intravenous midazolam (1-2 mg) and fentanyl (25-50 mcg). A longitudinal incision was made to expose the foreign body granuloma. Dissection was carried out, and the granuloma was removed. Local infiltration of lidocaine with epinephrine (1% lidocaine with 1:100,000 epinephrine) was administered for additional anesthesia. Hemostasis was achieved, and the wound was closed using sutures. The patient tolerated the procedure well, and postoperative care instructions were provided. The excised tissue was sent for histopathological analysis.

3. Operative Note: Foreign Body Granuloma Excision – Abdomen Under general anesthesia, the patient received a balanced anesthetic technique with induction using intravenous propofol (1-2 mg/kg) and fentanyl (1-2 mcg/kg). Endotracheal intubation was performed, and anesthesia was maintained with a combination of sevoflurane (1-1.5%) and a continuous infusion of remifentanil (0.05-0.2 mcg/kg/min). A transverse incision was made on the lower abdomen to access the foreign body granuloma. Dissection and removal of the granuloma were performed. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure without complications, and postoperative instructions were provided. The excised tissue was sent for pathological examination.

4. Operative Note: Foreign Body Granuloma Excision - Facial Region The patient was placed under monitored anesthesia care (MAC) with conscious sedation. Intravenous midazolam (1-4 mg) and fentanyl (25-100 mcg) were administered for sedation and analgesia. A curvilinear incision was made on the facial region to access the foreign body granuloma. Dissection was performed, and the granuloma was excised. Local infiltration of lidocaine with epinephrine (1% lidocaine with 1:100,000 epinephrine) was used for local anesthesia. Hemostasis was achieved, and the wound was closed using sutures. The patient remained stable throughout the procedure, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

5. Operative Note: Foreign Body Granuloma Excision - Upper Extremity Under general anesthesia, the patient received induction with intravenous propofol (1-2 mg/kg) and rocuronium (0.6-1 mg/kg) for muscle relaxation. Endotracheal intubation was performed, and anesthesia was maintained with sevoflurane (1-1.5%) and a continuous infusion of remifentanil (0.05-0.2 mcg/kg/min). A transverse incision was made on the upper extremity to access the foreign body granuloma. Dissection and meticulous removal of the granuloma were performed. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination.

6. Operative Note: Foreign Body Granuloma Excision - Lower Extremity Following sterile preparation, the patient received a spinal anesthesia with 0.5% hyperbaric bupivacaine (10-15 mg). The patient was positioned supine, and the level of sensory block was confirmed. A longitudinal incision was made on the lower extremity to access the foreign body granuloma. Dissection and removal of the granuloma were performed. Additional local infiltration of lidocaine with epinephrine (1% lidocaine with 1:100,000 epinephrine) was used for surgical anesthesia. Hemostasis was achieved, and the wound was closed using sutures. The patient remained stable throughout the procedure, and postoperative care instructions were provided. The excised tissue was sent for histopathological analysis.

7. Operative Note: Foreign Body Granuloma Excision - Thoracic Region Under general anesthesia, the patient received induction with intravenous propofol (1-2 mg/kg) and rocuronium (0.6-1 mg/kg) for muscle relaxation. Endotracheal intubation was performed, and anesthesia was maintained with sevoflurane (1-1.5%) and a continuous infusion of remifentanil (0.05-0.2 mcg/kg/min). A thoracotomy incision was made to access the foreign body granuloma in the thoracic region. Dissection and excision of the granuloma were performed. Hemostasis was achieved, and the thoracic wall layers were closed using absorbable sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for pathological examination.

8. Operative Note: Foreign Body Granuloma Excision - Pelvic Region Following aseptic preparation, the patient received a combined spinal-epidural anesthesia with intrathecal administration of 0.5% hyperbaric bupivacaine (10-15 mg) and epidural catheter placement for postoperative pain management. A midline incision was made in the pelvic region to access the foreign body granuloma. Dissection and excision of the granuloma were performed meticulously. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure without complications, and postoperative instructions were given. The excised tissue was sent for histopathological examination.

9. Operative Note: Foreign Body Granuloma Excision - Cranial Region Under general anesthesia, the patient received induction with intravenous propofol (1-2 mg/kg) and rocuronium (0.6-1 mg/kg) for muscle relaxation. Endotracheal intubation was performed, and anesthesia was maintained with sevoflurane (1-1.5%) and a continuous infusion of remifentanil (0.05-0.2 mcg/kg/min). A craniotomy incision was made to access the foreign body granuloma in the cranial region. Dissection and meticulous removal of the granuloma were performed. Hemostasis was achieved, and the skull was closed using absorbable sutures and bone flap fixation. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue was sent for histopathological examination.

10. Operative Note: Foreign Body Granuloma Excision – Neck Following aseptic preparation, the patient received general anesthesia with intravenous induction using propofol (1-2 mg/kg) and rocuronium (0.6-1 mg/kg) for muscle relaxation. Endotracheal intubation was performed, and anesthesia was maintained with sevoflurane (1-1.5%) and a continuous infusion of remifentanil (0.05-0.2 mcg/kg/min). A transverse incision was made on the neck to access the foreign body granuloma. Dissection and excision of the granuloma were performed carefully, avoiding injury to vital structures. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure well, and postoperative care instructions were given. The excised tissue was sent for histopathological analysis.

1. Operative Note: Foreign Body Granuloma Excision with Bone Erosion - Right Forearm Under general anesthesia, a longitudinal incision was made on the right forearm to access the foreign body granuloma with associated bone erosion. Dissection revealed a retained metal fragment as the causative foreign body. The granuloma was meticulously excised, and careful debridement of the eroded bone was performed. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue and bone fragments were sent for histopathological and microbiological examination.

2. Operative Note: Foreign Body Granuloma Excision with Bone Erosion - Left Leg Following aseptic preparation, a curvilinear incision was made on the left leg to access the foreign body granuloma associated with bone erosion. Dissection revealed an encapsulated foreign object, identified as a retained broken piece of orthopedic hardware. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using sutures and a sterile adhesive dressing. The patient tolerated the procedure well, and postoperative care instructions were given. The excised tissue and bone fragments were sent for histopathological and microbiological examination.

3. Operative Note: Foreign Body Granuloma Excision with Bone Erosion – Spine Under general anesthesia, a posterior midline incision was made on the spine to access the foreign body granuloma associated with bone erosion. Dissection revealed an embedded metal fragment as the inciting foreign body. The granuloma was meticulously excised, and thorough debridement of the eroded bone was performed. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure without complications, and postoperative instructions were provided. The excised tissue and bone specimens were sent for histopathological examination and culture analysis.

4. Operative Note: Foreign Body Granuloma Excision with Bone Erosion – Pelvis Following sterile draping, a transverse incision was made on the pelvis to access the foreign body granuloma associated with bone erosion. Dissection revealed an encapsulated foreign object consisting of a retained metal fragment. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using absorbable sutures. The patient tolerated the procedure well, and postoperative care instructions were given. The excised tissue and bone fragments were sent for histopathological examination and culture analysis to assess for underlying infections.

5. Operative Note: Foreign Body Granuloma Excision with Bone Erosion – Hand Under general anesthesia, the patient's hand was prepped and draped in a sterile fashion. A longitudinal incision was made over the hand to expose the foreign body granuloma with associated bone erosion. Dissection was carried out, revealing a retained glass shard as the causative foreign body. The granuloma was meticulously excised, and debridement of the eroded bone was performed. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient tolerated the procedure well, and postoperative instructions were given. The excised tissue and bone specimens were sent for histopathological examination and culture analysis.

6. Operative Note: Foreign Body Granuloma Excision with Bone Erosion - Facial Region Following aseptic preparation, a curvilinear incision was made on the facial region to access the foreign body granuloma associated with bone erosion. Dissection revealed an embedded foreign object, identified as a retained broken piece of dental material. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using sutures and a sterile adhesive dressing. The patient tolerated the procedure well, and postoperative care instructions were given. The excised tissue and bone fragments were sent for histopathological examination and culture analysis.

7. Operative Note: Foreign Body Granuloma Excision with Bone Erosion - Lower Extremity Under general anesthesia, a longitudinal incision was made on the lower extremity to access the foreign body granuloma with associated bone erosion. Dissection revealed a retained metal fragment as the inciting foreign body. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using layered sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue and bone specimens were sent for histopathological examination and culture analysis to assess for underlying infections.

8. Operative Note: Foreign Body Granuloma Excision with Bone Erosion - Thoracic Region Following sterile draping, a thoracotomy incision was made to access the foreign body granuloma with associated bone erosion in the thoracic region. Dissection revealed an embedded foreign object, identified as a retained metal fragment. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the thoracic wall layers were closed using absorbable sutures. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue and bone fragments were sent for histopathological examination and culture analysis.

9. Operative Note: Foreign Body Granuloma Excision with Bone Erosion - Cranial Region Under general anesthesia, a craniotomy incision was made to access the foreign body granuloma with associated bone erosion in the cranial region. Dissection revealed an embedded metal fragment as the inciting foreign body. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the skull was closed using absorbable sutures and bone flap fixation. The patient tolerated the procedure well, and postoperative instructions were provided. The excised tissue and bone specimens were sent for histopathological examination and culture analysis.

10. Operative Note: Foreign Body Granuloma Excision with Bone Erosion – Shoulder Following sterile draping, a transverse incision was made on the shoulder to access the foreign body granuloma with associated bone erosion. Dissection revealed an encapsulated foreign object consisting of a retained metal fragment. The granuloma and eroded bone were meticulously excised, ensuring complete removal.

1. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain - Upper Arm Under general anesthesia, a longitudinal incision was made on the upper arm to access the foreign body granuloma associated with severe bone pain. Dissection revealed an embedded foreign object, identified as a retained metal fragment. The granuloma and surrounding inflamed tissues were meticulously excised, relieving the underlying pressure on the affected bone. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure well, and postoperative pain management instructions were provided. The excised tissue was sent for histopathological examination.

2. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain - Lower Leg Following sterile preparation, a curvilinear incision was made on the lower leg to access the foreign body granuloma with severe bone pain. Dissection revealed an encapsulated foreign object, identified as a retained glass shard. The granuloma and surrounding inflamed tissues were meticulously excised, relieving the pressure and addressing the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures. The patient tolerated the procedure well, and postoperative pain management instructions were provided. The excised tissue was sent for histopathological examination.

3. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain - Spinal Region Under general anesthesia, a posterior midline incision was made on the spine to access the foreign body granuloma associated with severe bone pain. Dissection revealed an embedded metal fragment as the inciting foreign body. The granuloma and surrounding inflamed tissues were meticulously excised, alleviating the severe bone pain. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure without complications, and postoperative pain management instructions were provided. The excised tissue was sent for histopathological examination.

4. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain – Pelvis Following aseptic preparation, a transverse incision was made on the pelvis to access the foreign body granuloma with severe bone pain. Dissection revealed an encapsulated foreign object consisting of a retained metal fragment. The granuloma and surrounding inflamed tissues were meticulously excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient tolerated the procedure well, and postoperative pain management instructions were given. The excised tissue was sent for histopathological examination.

5. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain – Hand Under general anesthesia, the patient's hand was prepped and draped in a sterile fashion. A longitudinal incision was made over the hand to expose the foreign body granuloma with associated severe bone pain. Dissection was carried out, revealing a retained glass shard as the causative foreign body. The granuloma and surrounding inflamed tissues were meticulously excised, alleviating the severe bone pain. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient tolerated the procedure well, and postoperative pain management instructions were given. The excised tissue was sent for histopathological examination.

6. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain - Facial Region Following aseptic preparation, a curvilinear incision was made on the facial region to access the foreign body granuloma with severe bone pain. Dissection revealed an embedded foreign object, identified as a retained broken piece of dental material. The granuloma and surrounding inflamed tissues were meticulously excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures and a sterile adhesive dressing. The patient tolerated the procedure well, and postoperative pain management instructions were given. The excised tissue was sent for histopathological examination.

7. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain – Foot Under general anesthesia, a longitudinal incision was made on the foot to access the foreign body granuloma associated with severe bone pain. Dissection revealed an encapsulated foreign object, identified as a retained metal fragment. The granuloma and surrounding inflamed tissues were meticulously excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the procedure well, and postoperative pain management instructions were provided. The excised tissue was sent for histopathological examination.

8. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain - Thoracic Region Following sterile draping, a thoracotomy incision was made to access the foreign body granuloma with severe bone pain in the thoracic region. Dissection revealed an embedded foreign object, identified as a retained metal fragment. The granuloma and surrounding inflamed tissues were meticulously excised, providing relief from the severe bone pain. Hemostasis was achieved, and the thoracic wall layers were closed using absorbable sutures. The patient tolerated the procedure well, and postoperative pain management instructions were provided. The excised tissue was sent for histopathological examination.

9. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain - Cranial Region Under general anesthesia, a craniotomy incision was made to access the foreign body granuloma with severe bone pain in the cranial region. Dissection revealed an embedded metal fragment as the inciting foreign body. The granuloma and surrounding inflamed tissues were meticulously excised, providing relief from the severe bone pain. Hemostasis was achieved, and the skull was closed using absorbable sutures and bone flap fixation. The patient tolerated the procedure well, and postoperative pain management instructions were provided. The excised tissue was sent for histopathological examination.

10. Operative Note: Foreign Body Granuloma Excision with Severe Bone Pain – Shoulder Following sterile draping, a transverse incision was made on the shoulder to access the foreign body granuloma with severe bone pain. Dissection revealed an encapsulated foreign object consisting of a retained metal fragment. The granuloma and surrounding inflamed tissues were meticulously excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures and a sterile adhesive dressing. The patient tolerated the procedure well, and postoperative pain management instructions were provided. The excised tissue was sent for histopathological examination.

1. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Upper Arm Under general anesthesia, a longitudinal incision was made on the upper arm to access the foreign body granuloma. The granuloma was carefully dissected and excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

2. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Lower Leg Following aseptic preparation, a curvilinear incision was made on the lower leg to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

3. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Spinal Region Under general anesthesia, a posterior midline incision was made on the spine to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the surgical intervention without complications, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

4. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Pelvis Following sterile draping, a transverse incision was made on the pelvis to access the foreign body granuloma. The granuloma was carefully dissected and excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

5. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision – Hand Under general anesthesia, the patient's hand was prepped and draped in a sterile fashion. A longitudinal incision was made over the hand to expose the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

6. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Facial Region Following aseptic preparation, a curvilinear incision was made on the facial region to access the foreign body granuloma. The granuloma was carefully dissected and excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

7. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision – Foot Under general anesthesia, a longitudinal incision was made on the foot to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

8.Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Thoracic Region Following sterile draping, a thoracotomy incision was made to access the foreign body granuloma in the thoracic region. The granuloma was meticulously excised, ensuring complete removal. Hemostasis was achieved, and the thoracic wall layers were closed using absorbable sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

9. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Cranial Region Under general anesthesia, a craniotomy incision was made to access the foreign body granuloma in the cranial region. The granuloma was meticulously excised, ensuring complete removal. Hemostasis was achieved, and the skull was closed using absorbable sutures and bone flap fixation. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

10. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision – Shoulder Following sterile draping, a transverse incision was made on the shoulder to access the foreign body granuloma. The granuloma was carefully dissected and excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

1. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion – Arm Under general anesthesia, a longitudinal incision was made on the arm to access the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Thorough irrigation and hemostasis were achieved. Closure was performed using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue and bone fragments were sent for histopathological examination.

2. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion – Leg Following aseptic preparation, a curvilinear incision was made on the leg to access the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were carefully excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue and bone specimens were sent for histopathological examination.

3. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion – Spine Under general anesthesia, a posterior midline incision was made on the spine to access the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the surgical intervention without complications, and postoperative care instructions were provided. The excised tissue and bone fragments were sent for histopathological examination.

4. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion – Pelvis Following sterile draping, a transverse incision was made on the pelvis to access the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue and bone fragments were sent for histopathological examination.

5. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion – Hand Under general anesthesia, the patient's hand was prepped and draped in a sterile fashion. A longitudinal incision was made over the hand to expose the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were carefully excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue and bone specimens were sent for histopathological examination.

6. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion - Facial Region Following aseptic preparation, a curvilinear incision was made on the facial region to access the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue and bone fragments were sent for histopathological examination.

7. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion – Foot Under general anesthesia, a longitudinal incision was made on the foot to access the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using layered sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue and bone specimens were sent for histopathological examination.

8. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion - Thoracic Region Following sterile draping, a thoracotomy incision was made to access the foreign body granuloma with associated bone erosion in the thoracic region. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the thoracic wall layers were closed using absorbable sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue and bone fragments were sent for histopathological examination.

9. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion - Cranial Region Under general anesthesia, a craniotomy incision was made to access the foreign body granuloma with associated bone erosion in the cranial region. The granuloma and eroded bone were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the skull was closed using absorbable sutures and bone flap fixation. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue and bone specimens were sent for histopathological examination.

10. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision with Bone Erosion – Shoulder Following sterile draping, a transverse incision was made on the shoulder to access the foreign body granuloma with associated bone erosion. The granuloma and eroded bone were carefully dissected and excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue and bone fragments were sent for histopathological examination.

1. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Knee Joint Under general anesthesia, a longitudinal incision was made on the knee joint to access the infected foreign body granuloma. The granuloma, along with surrounding infected tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using layered sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

2. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Shoulder Joint Following aseptic preparation, an arthroscopic approach was employed to access the infected foreign body granuloma in the shoulder joint. The granuloma and infected tissues were meticulously excised using arthroscopic instruments. Thorough irrigation with antibiotic solution was performed. The joint was stabilized, and the portals were closed. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

3. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Hip Joint Under general anesthesia, a surgical approach was made to access the infected foreign body granuloma in the hip joint. The granuloma, along with infected synovial tissues, was carefully excised, ensuring complete removal. Thorough irrigation with antibiotic solution was performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

4. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Elbow Joint Following sterile draping, an incision was made over the elbow joint to access the infected foreign body granuloma. The granuloma and infected tissues were meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using layered sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

5. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Ankle Joint Under general anesthesia, an incision was made on the ankle joint to access the infected foreign body granuloma. The granuloma, along with infected tissues, was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

6. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Wrist Joint Following aseptic preparation, an incision was made over the wrist joint to access the infected foreign body granuloma. The granuloma and surrounding infected tissues were meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

7. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - TMJ (Temporomandibular Joint) Under general anesthesia, an incision was made near the TMJ to access the infected foreign body granuloma. The granuloma, along with infected tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

8. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Finger Joint Following sterile draping, an incision was made over the finger joint to access the infected foreign body granuloma. The granuloma and surrounding infected tissues were carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

9. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - TMJ (Temporomandibular Joint) Under general anesthesia, an incision was made near the TMJ to access the infected foreign body granuloma. The granuloma, along with infected tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

10. Operative Note: Surgical Intervention for Infected Foreign Body Granuloma Excision - Toe Joint Following aseptic preparation, an incision was made over the toe joint to access the infected foreign body granuloma. The granuloma, along with infected tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. Intravenous antibiotics were initiated. The excised tissue was sent for histopathological examination.

1. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision - ShoulderUnder general anesthesia, a transverse incision was made on the shoulder to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissue, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

2. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Hand Following sterile draping, a longitudinal incision was made on the hand to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

3. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Knee Under general anesthesia, a medial parapatellar incision was made on the knee to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using layered sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

4. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Leg Following aseptic preparation, a curvilinear incision was made on the leg to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

5. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Hip Under general anesthesia, an anterior approach was used to access the inflamed foreign body granuloma in the hip region. The granuloma, along with the surrounding inflamed tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

6. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision - Wrist

Following sterile draping, an incision was made over the wrist to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

7. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Foot Under general anesthesia, an incision was made on the foot to access the infl amed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

8. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Elbow Following aseptic preparation, an incision was made over the elbow to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures and a sterile adhesive dressing. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

9. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Neck Under general anesthesia, a longitudinal incision was made on the neck to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were given. The excised tissue was sent for histopathological examination.

10. Operative Note: Surgical Intervention for Inflamed Foreign Body Granuloma Excision – Abdomen Following sterile draping, a midline incision was made on the abdomen to access the inflamed foreign body granuloma. The granuloma, along with the surrounding inflamed tissues, was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The patient tolerated the surgical intervention well, and postoperative care instructions were provided. The excised tissue was sent for histopathological examination.

1. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up as per Severity Under general anesthesia, an incision was made to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The severity of the diagnosis will determine the follow-up plan, which may include regular wound checks, antibiotic therapy, and imaging studies. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination to guide further management.

2. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up and Imaging as per Severity Following sterile draping, an incision was made to access the foreign body granuloma. The granuloma was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The severity of the diagnosis will determine the follow-up plan, including wound checks, antibiotic therapy, and imaging studies such as X-rays or CT scans. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further evaluation.

3. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Close Follow-up for Severe Cases Under general anesthesia, an incision was made to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. Given the severity of the diagnosis, close follow-up is essential. The patient will be monitored closely with regular wound checks, laboratory investigations, and consultation with other specialties if required. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further assessment.

4. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up Based on Severity and Healing Progress Following aseptic preparation, an incision was made to access the foreign body granuloma. The granuloma was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The follow-up plan will be tailored based on the severity of the diagnosis and the patient's healing progress. It may include regular wound checks, dressing changes, and close monitoring of inflammatory markers. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further evaluation.

5. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up with Specialized Consultation for Severe Cases Under general anesthesia, an incision was made to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. Given the severity of the diagnosis, a close follow-up plan was established. This may involve regular wound checks, specialized consultation with other disciplines such as infectious disease or orthopedics, and possible imaging studies. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further assessment.

6. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up and Antibiotic Therapy as per Severity Following sterile draping, an incision was made to access the foreign body granuloma. The granuloma was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The severity of the diagnosis will determine the follow-up plan, which may include regular wound checks, antibiotic therapy based on culture and sensitivity results, and close monitoring of clinical symptoms. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further evaluation.

7. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up and Physical Therapy for Rehabilitation Under general anesthesia, an incision was made to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The follow-up plan will depend on the severity of the diagnosis and may include regular wound checks, physical therapy for rehabilitation, and progressive functional exercises. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further assessment.

8. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Close Follow-up and Imaging for Monitoring Following aseptic preparation, an incision was made to access the foreign body granuloma. The granuloma was carefully excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. Close follow-up is recommended to monitor the patient's progress. This may involve regular wound checks, imaging studies such as MRI or ultrasound, and consultation with other specialties as needed. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further evaluation.

9. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up and Biopsy for Further Evaluation Under general anesthesia, an incision was made to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. The follow-up plan includes regular wound checks, close monitoring of symptoms, and a scheduled biopsy to further evaluate the nature of the granuloma. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination, and further management will be determined based on the results.

10. Operative Note: Surgical Intervention for Foreign Body Granuloma Excision - Follow-up with Infectious Disease Consultation Following sterile draping, an incision was made to access the foreign body granuloma. The granuloma was meticulously excised, ensuring complete removal. Thorough irrigation and debridement were performed. Closure was achieved using sutures. Given the severity of the diagnosis, a follow-up plan was established, including regular wound checks and consultation with an infectious disease specialist. Postoperative care instructions were provided accordingly. The excised tissue was sent for histopathological examination for further assessment, and the patient's management will be guided by the consultant's recommendations.

## M60.8 Other myositis

1. Patient presented with symptoms of Other Myositis, including muscle weakness, fatigue, and pain. Physical examination revealed proximal muscle weakness and elevated creatine kinase levels. MRI showed increased signal intensity in affected muscles. Patient was diagnosed with Other Myositis and started on high-dose corticosteroids.

2. Operative procedure performed for Other Myositis involved a muscle biopsy of the affected site. The specimen was sent to the pathology department for analysis. The procedure was performed under local anesthesia, and the incision was closed using absorbable sutures. The patient tolerated the procedure well and was discharged with post-operative instructions.

3. Surgical intervention was required for a patient with severe Other Myositis. A muscle release surgery was performed to relieve muscle contractures and improve range of motion. The procedure involved the release of tight muscle fibers and fascia through small incisions. Post-operatively, the patient received physical therapy to optimize recovery and functional outcomes.

4. Patient with Other Myositis underwent an electromyography (EMG) procedure to evaluate muscle function and detect any abnormal electrical activity. The test involved the insertion of fine needles into specific muscles and recording the electrical signals. EMG findings were consistent with myopathic changes, supporting the diagnosis of Other Myositis.

5. A muscle ultrasound was performed on a patient with suspected Other Myositis to assess muscle structure and detect any abnormalities. The ultrasound revealed increased muscle echogenicity and inflammation in the affected areas, consistent with Other Myositis. The findings helped guide the treatment plan and monitor disease progression.

6. Intraoperative consultation was requested during a surgical procedure for a patient with Other Myositis. The surgeon needed guidance regarding the optimal surgical approach and the extent of muscle involvement. The consultation confirmed the presence of Other Myositis and provided recommendations for the surgical technique.

7. Patient with Other Myositis underwent a muscle strength assessment using a dynamometer. The test measured the force generated by specific muscle groups and helped quantify the degree of muscle weakness. The results provided valuable information for monitoring disease progression and evaluating treatment effectiveness.

8. Surgical debridement was performed on a patient with Other Myositis to remove necrotic muscle tissue and reduce inflammation. The procedure involved excising the affected muscle areas and irrigating the wound thoroughly. The patient received appropriate post-operative care to facilitate healing and prevent infection.

9. A muscle MRI was performed on a patient with Other Myositis to assess the extent of muscle involvement and guide treatment decisions. The MRI revealed diffuse muscle edema and inflammation, confirming the diagnosis of Other Myositis. The findings were used to tailor the treatment plan and monitor disease activity.

10. Patient with Other Myositis underwent a muscle biopsy with immunohistochemical analysis to further characterize the disease. The biopsy specimens were stained for specific antibodies to identify inflammatory infiltrates and determine the type of myositis. The results confirmed the diagnosis of Other Myositis and guided subsequent treatment strategies.

1. Patient underwent a muscle enzyme analysis for suspected Other Myositis. Blood samples were taken to measure the levels of creatine kinase (CK) and aldolase. The results showed significantly elevated CK and aldolase levels, consistent with the diagnosis of Other Myositis.

2. Surgical intervention was performed on a patient with Other Myositis to address muscle contractures and improve functional mobility. The procedure involved a tendon release surgery, which allowed for increased range of motion and reduced pain in the affected joints. The patient was referred for post-operative physical therapy.

3. A muscle biopsy was performed on a patient with refractory Other Myositis to assess for possible necrotizing autoimmune myopathy. The biopsy samples were analyzed for necrotic muscle fibers, immune cell infiltrates, and immunofluorescence patterns. The findings confirmed the presence of necrotizing autoimmune myopathy in addition to Other Myositis.

4. Patient with Other Myositis underwent a comprehensive autoimmune panel to evaluate for associated autoimmune conditions. The panel included tests for antinuclear antibodies (ANA), anti-Jo-1 antibodies, and anti-mitochondrial antibodies (AMA). The results were negative, indicating no concurrent autoimmune disorders.

5. Electroneuromyography (ENMG) was performed on a patient with suspected Other Myositis to assess nerve and muscle function. The test involved measuring nerve conduction velocities and recording muscle responses to electrical stimulation. ENMG findings showed no evidence of peripheral neuropathy, supporting the diagnosis of Other Myositis.

6. Patient with Other Myositis underwent a muscle strength rehabilitation program to improve muscle function and enhance quality of life. The program included a combination of resistance training, stretching exercises, and aerobic conditioning. Regular assessments were conducted to monitor progress and adjust the treatment plan accordingly.

7. Intraoperative consultation was requested during a muscle biopsy procedure for a patient with atypical presentation of Other Myositis. The consultation involved reviewing the biopsy findings in real-time and providing additional insights to guide the diagnosis and subsequent management.

8. Patient with Other Myositis received intravenous immunoglobulin (IVIG) therapy as a treatment modality. IVIG was administered over several days to modulate the immune response and reduce inflammation. The patient was monitored closely for any adverse reactions and showed improvement in muscle strength following the treatment.

9. Genetic testing was conducted on a patient with suspected familial Other Myositis to identify potential underlying genetic mutations. The analysis focused on genes associated with hereditary myopathies, including those linked to Other Myositis. The results revealed a pathogenic mutation, confirming the familial nature of the condition.

10. A multidisciplinary team, including rheumatologists, neurologists, and physical therapists, collaborated to develop an individualized treatment plan for a patient with Other Myositis. The plan included a combination of pharmacotherapy, physical therapy, and lifestyle modifications to manage symptoms, improve muscle function, and optimize the patient's overall well-being. Regular follow-up appointments were scheduled to assess treatment response and make necessary adjustments.

1. Patient with Other Myositis underwent a muscle biopsy procedure under local anesthesia with minimal sedation. The procedure was well-tolerated, and the patient remained awake and responsive throughout.

2. Surgical intervention was performed on a patient with severe Other Myositis under general anesthesia. A muscle release surgery was conducted to address muscle contractures and improve range of motion. The patient received a balanced anesthesia approach, including volatile agents and intravenous medications, to maintain optimal depth of anesthesia.

3. Patient underwent a muscle ultrasound-guided aspiration of an abscess associated with Other Myositis. The procedure was performed under regional anesthesia using a nerve block, providing effective pain control and facilitating the drainage process.

4. Intraoperative consultation was requested during a muscle biopsy procedure for a patient with Other Myositis. The procedure was performed under monitored anesthesia care (MAC) to ensure patient comfort and cooperation while allowing the consulting specialist to assess the biopsy site.

5. Patient with Other Myositis underwent a muscle strength assessment under conscious sedation. The procedure involved the use of a dynamometer to measure muscle force, and the patient received a carefully titrated dose of intravenous sedative medication to minimize anxiety and discomfort.

6. Surgical debridement was performed on a patient with Other Myositis under general anesthesia. The procedure involved the removal of necrotic muscle tissue, and the anesthesia team employed a balanced approach using inhalational agents and opioids to provide appropriate pain management during and after the surgery.

7. Patient with Other Myositis underwent electromyography (EMG) under local anesthesia with supplemental intravenous sedation. The patient remained comfortable and cooperative during the procedure, allowing for accurate assessment of muscle function and electrical activity.

8. Muscle biopsy was performed on a patient with Other Myositis under regional anesthesia using a peripheral nerve block. The patient experienced excellent pain control and minimal discomfort during the procedure.

9. Patient with Other Myositis underwent a muscle MRI under conscious sedation. The anesthesia team administered a carefully titrated dose of sedative medication to ensure patient comfort and cooperation during the lengthy imaging procedure.

10. Surgical intervention was performed on a pediatric patient with Other Myositis under general anesthesia. The anesthesia team utilized a weight-based approach to calculate the appropriate dosage of anesthetic agents, ensuring safe and effective anesthesia throughout the procedure. Close monitoring was maintained to account for the patient's age-specific considerations.

1. Patient with Other Myositis underwent a surgical procedure to address bone erosion secondary to the disease. The procedure involved bone grafting to restore structural integrity and promote healing. The affected bone was carefully debrided and prepared, and the graft was secured in place using fixation hardware.

2. Intraoperative consultation was requested during a surgical procedure for a patient with Other Myositis and extensive bone erosion. The consultation involved assessing the extent of bone involvement and providing recommendations for bone reconstruction techniques, including the use of bone grafts or synthetic substitutes.

3. Patient with Other Myositis and significant bone erosion underwent a joint arthroplasty to restore joint function and alleviate pain. The affected joint was carefully evaluated, and the eroded bone surfaces were removed and replaced with prosthetic components. The patient received post-operative physical therapy for optimal rehabilitation.

4. Surgical intervention was performed on a patient with Other Myositis and bone erosion to address a pathological fracture. The fractured bone segments were aligned and stabilized using internal fixation devices. The patient received appropriate post-operative care, including immobilization and rehabilitation exercises.

5. A bone scan was performed on a patient with suspected bone erosion secondary to Other Myositis. The scan revealed increased tracer uptake in the affected bone, indicating active inflammation and bone remodeling. The findings guided the surgical planning and subsequent treatment decisions.

6. Patient with Other Myositis and bone erosion underwent a minimally invasive percutaneous bone augmentation procedure. The procedure involved injecting bone cement into the eroded bone to enhance stability and prevent further damage. The patient experienced improved pain control and functional outcomes post-operatively.

7. Surgical debridement was performed on a patient with Other Myositis and associated bone erosion. The procedure involved removing necrotic tissue and infected bone fragments to promote healing and prevent the spread of infection. The patient received appropriate antibiotic therapy and wound care.

8. Patient with Other Myositis and bone erosion underwent a bone biopsy to assess for underlying infections or malignancies. The biopsy samples were sent for histopathological and microbiological analysis. The results confirmed the presence of bone erosion due to Other Myositis without evidence of additional pathology.

9. Surgical intervention was performed on a patient with Other Myositis and severe bone erosion to address joint instability. The procedure involved joint reconstruction using autografts or allografts to restore bone integrity and facilitate joint stability. The patient underwent post-operative rehabilitation for functional recovery.

10. Patient with Other Myositis and bone erosion underwent a bone remodeling procedure to correct skeletal deformities caused by chronic inflammation. The surgery involved realigning and reshaping the affected bones to improve joint function and restore normal anatomy. Post-operative rehabilitation was initiated to optimize outcomes.

1. Patient with Other Myositis and severe bone pain underwent a joint denervation procedure to alleviate pain. The procedure involved surgically interrupting the sensory nerves supplying the affected joint, providing long-term pain relief.

2. Intraoperative consultation was requested during a surgical procedure for a patient with Other Myositis and debilitating bone pain. The consultation involved assessing the source of the pain and providing recommendations for targeted interventions, such as nerve blocks or neurolysis techniques.

3. Patient with Other Myositis and severe bone pain underwent a bone biopsy to rule out secondary causes. The biopsy samples were sent for histopathological and microbiological analysis to identify potential underlying infections or malignancies contributing to the pain.

4. Surgical intervention was performed on a patient with Other Myositis and intractable bone pain to address joint instability. The procedure involved joint fusion or arthrodesis to eliminate painful motion and provide stability. The patient received appropriate pain management strategies post-operatively.

5. Patient with Other Myositis and severe bone pain underwent a neuromodulation procedure to manage pain. The procedure involved the implantation of a spinal cord stimulator or peripheral nerve stimulator to deliver electrical impulses that interfere with pain signals, reducing the perception of pain.

6. Surgical debridement was performed on a patient with Other Myositis and severe bone pain to remove necrotic tissue and infected bone fragments. The procedure aimed to alleviate pain, prevent the spread of infection, and promote healing. The patient received appropriate pain medications and antibiotics post-operatively.

7. Patient with Other Myositis and severe bone pain underwent a nerve block procedure to temporarily block pain signals. The procedure involved injecting an anesthetic agent around the affected nerves, providing immediate pain relief. The patient reported significant pain reduction following the procedure.

8. Surgical intervention was performed on a patient with Other Myositis and severe bone pain to address bone deformities and malalignment. The procedure involved corrective osteotomy, realigning the bones to relieve pressure and reduce pain. The patient received comprehensive pain management and rehabilitation post-operatively.

9. Patient with Other Myositis and severe bone pain underwent a vertebroplasty or kyphoplasty procedure to stabilize vertebral fractures and relieve pain. The procedure involved injecting bone cement into the fractured vertebrae to provide structural support and reduce pain. The patient reported improved pain control after the intervention.

10. A bone scan was performed on a patient with Other Myositis and severe bone pain to assess the extent of bone involvement. The scan revealed increased tracer uptake in the affected bones, confirming active inflammation and explaining the severity of pain. The findings guided the treatment plan, focusing on pain management strategies and disease-specific interventions.

1. Patient with Other Myositis underwent a surgical intervention to address severe muscle weakness and functional impairment. The procedure involved a tendon transfer surgery to optimize muscle function and restore mobility. The patient received post-operative physical therapy for optimal recovery.

2. Surgical debridement was performed on a patient with Other Myositis to remove necrotic muscle tissue and reduce inflammation. The procedure aimed to alleviate pain, promote healing, and prevent further complications. The patient received appropriate post-operative care, including wound management and antibiotics.

3. Patient with Other Myositis underwent a muscle release surgery to address muscle contractures and improve range of motion. The procedure involved the release of tight muscle fibers and fascia to alleviate pain and restore functional mobility. Post-operative physical therapy was initiated to optimize outcomes.

4. Surgical intervention was performed on a patient with Other Myositis to address joint deformity and pain. The procedure involved joint arthroplasty or joint replacement surgery to improve joint function and relieve pain. The patient received post-operative rehabilitation to regain strength and mobility.

5. Patient with Other Myositis underwent a muscle biopsy procedure to obtain tissue samples for further diagnostic evaluation. The procedure involved the removal of a small portion of affected muscle for histopathological and immunohistochemical analysis. The patient tolerated the procedure well and was discharged with appropriate instructions.

6. Surgical intervention was performed on a patient with Other Myositis to treat a muscle abscess. The procedure involved incision and drainage of the abscess, followed by thorough irrigation and appropriate wound closure. The patient received antibiotics and regular follow-up to monitor healing.

7. Patient with Other Myositis underwent a joint synovectomy to alleviate pain and inflammation. The surgical intervention involved the removal of the inflamed synovial tissue from the affected joint to improve joint function and reduce symptoms. The patient was provided with post-operative pain management and rehabilitation.

8. Surgical debridement and bone grafting were performed on a patient with Other Myositis and bone erosion. The procedure involved the removal of necrotic bone and the placement of a bone graft to promote healing and restore bone integrity. The patient received post-operative care and follow-up imaging to assess bone healing.

9. Patient with Other Myositis underwent a surgical release of muscle compartments to relieve pressure and alleviate pain associated with compartment syndrome. The procedure involved creating incisions and releasing the constricting fascia to restore normal blood flow and relieve symptoms. The patient received appropriate wound care and rehabilitation.

10. Surgical intervention was performed on a patient with Other Myositis to address severe joint stiffness and contractures. The procedure involved an arthroscopic or open joint release to improve joint mobility and functionality. The patient underwent post-operative physical therapy to maximize functional outcomes.

1. Patient with Other Myositis underwent a fasciotomy procedure to alleviate pressure and improve blood flow in the affected muscle compartments. The surgical intervention involved creating incisions and releasing the tight fascia to relieve symptoms and prevent further complications.

2. Surgical debridement and wound closure were performed on a patient with Other Myositis and an infected ulcer. The procedure involved the removal of necrotic tissue and thorough cleaning of the wound, followed by appropriate closure techniques. The patient received post-operative wound care and antibiotics.

3. Patient with Other Myositis underwent a tenotomy procedure to address tendon involvement and relieve pain. The surgical intervention involved the partial or complete division of the affected tendon to alleviate tension and improve function. Post-operative physical therapy was initiated to facilitate recovery.

4. Surgical intervention was performed on a patient with Other Myositis to address a muscle hematoma. The procedure involved evacuation of the hematoma and meticulous hemostasis to prevent further bleeding. The patient received appropriate post-operative monitoring and management.

5. Patient with Other Myositis underwent a muscle resection surgery to remove a localized mass or tumor. The procedure involved the excision of the abnormal tissue while preserving surrounding healthy muscle. The patient received post-operative follow-up to monitor for recurrence.

6. Surgical debridement and reconstruction were performed on a patient with Other Myositis and extensive soft tissue necrosis. The procedure involved the removal of necrotic tissue and subsequent reconstruction using skin grafts or flaps to restore the affected area. The patient received comprehensive wound care and post-operative rehabilitation.

7. Patient with Other Myositis underwent a joint fusion surgery to address severe pain and instability. The surgical intervention involved the fusion of adjacent bones to immobilize the joint and alleviate pain. The patient received post-operative care, including pain management and rehabilitation.

8. Surgical intervention was performed on a patient with Other Myositis to address a muscle rupture. The procedure involved repairing the torn muscle fibers and reinforcing the surrounding tissue to restore muscle integrity. The patient underwent post-operative physical therapy for functional recovery.

9. Patient with Other Myositis underwent a synovectomy procedure to remove inflamed synovial tissue in the affected joint. The surgical intervention aimed to reduce pain, improve joint function, and prevent further joint damage. The patient received post-operative monitoring and appropriate management.

10. Surgical debridement and abscess drainage were performed on a patient with Other Myositis and a deep soft tissue infection. The procedure involved the removal of infected tissue and thorough irrigation of the affected area. The patient received antibiotics and close follow-up to monitor healing progress.

1. Patient with Other Myositis presented with a severe infection involving the knee joint. Surgical intervention was performed, consisting of an arthrotomy, thorough debridement of infected tissues, and irrigation. The joint was then stabilized, and appropriate antibiotic therapy was initiated for post-operative management.

2. Surgical intervention was undertaken on a patient with Other Myositis who had developed a severe infection in the shoulder joint. An open arthroscopic procedure was performed to access and debride the infected tissues, followed by irrigation and placement of a drain for continuous post-operative wound drainage.

3. Patient with Other Myositis presented with a severe infection in the hip joint. A surgical approach was employed, involving a hip arthrotomy, meticulous debridement of infected tissues, irrigation, and the placement of antibiotic-impregnated beads to facilitate local delivery of antibiotics for eradication of the infection.

4. Surgical intervention was performed on a patient with Other Myositis and a severe infection in the elbow joint. An incision was made, providing access to the infected area, followed by extensive debridement, thorough irrigation, and the placement of a drain. Intravenous antibiotic therapy was initiated to manage the infection post-operatively.

5. Patient with Other Myositis developed a severe infection in the ankle joint. Surgical intervention involved an arthrotomy with extensive debridement of infected tissues, irrigation, and the placement of a temporary joint spanning external fixator to stabilize the joint and allow for ongoing wound management.

6. Surgical intervention was performed on a patient with Other Myositis who presented with a severe infection in the wrist joint. A dorsal approach was utilized, with meticulous debridement, thorough irrigation, and the placement of a sterile wound vacuum-assisted closure (VAC) system for ongoing wound management and healing.

7. Patient with Other Myositis presented with a severe infection involving the temporomandibular joint. Surgical intervention was performed, involving an intraoral approach, meticulous debridement of infected tissues, extensive irrigation, and the placement of a temporomandibular joint prosthesis to restore joint function and alleviate pain.

8. Surgical intervention was performed on a patient with Other Myositis and a severe infection in the metacarpophalangeal joint. The joint was approached through a dorsal incision, and thorough debridement, irrigation, and the placement of a silicone spacer were performed to promote healing and prevent joint contracture.

9. Patient with Other Myositis presented with a severe infection in the knee joint that was resistant to non-surgical management. An open arthrotomy was performed, followed by extensive debridement, irrigation, and the placement of an antibiotic-impregnated cement spacer. Intravenous antibiotic therapy was continued post-operatively.

10. Surgical intervention was undertaken on a patient with Other Myositis who developed a severe infection in the temporomandibular joint. A combined intraoral and extraoral approach was employed for optimal exposure, followed by meticulous debridement, thorough irrigation, and the placement of a temporomandibular joint prosthesis to restore joint function and control the infection.

1. Patient with Other Myositis and severe inflammatory myopathy underwent surgical intervention to address muscle inflammation. The procedure involved extensive muscle biopsy for diagnostic confirmation and subsequent targeted immunosuppressive therapy to control inflammation.

2. Surgical debridement and drainage were performed on a patient with Other Myositis and an abscess formation secondary to severe inflammation. The procedure aimed to remove the infected tissue, reduce inflammation, and promote healing. The patient received appropriate post-operative antibiotics and wound care.

3. Patient with Other Myositis and chronic inflammation underwent a synovectomy procedure to remove inflamed synovial tissue in the affected joint. The surgical intervention aimed to reduce inflammation, improve joint function, and alleviate symptoms. The patient received post-operative immunosuppressive therapy for disease management.

4. Surgical intervention was performed on a patient with Other Myositis and severe inflammatory arthritis. The procedure involved joint debridement, removal of inflamed synovium, and the application of local anti-inflammatory agents to alleviate pain and control inflammation. Post-operative physical therapy was initiated for functional recovery.

5. Patient with Other Myositis and refractory inflammation underwent a surgical intervention to implant a biologic agent delivery system. The procedure involved the placement of a device that releases targeted anti-inflammatory agents to control the disease process. The patient received post-operative monitoring and adjustments to the medication regimen.

6. Surgical debridement and fasciotomy were performed on a patient with Other Myositis and compartment syndrome secondary to severe inflammation. The procedure aimed to relieve pressure and reduce inflammation, restoring adequate blood flow and preventing tissue damage. The patient received post-operative immunosuppressive therapy and rehabilitation.

7. Patient with Other Myositis and severe inflammation underwent a joint lavage procedure. The surgical intervention involved irrigating the affected joint with sterile saline solution to remove inflammatory mediators and debris, reducing inflammation and promoting symptom relief. The patient received post-operative management tailored to their specific inflammatory condition.

8. Surgical intervention was performed on a patient with Other Myositis and inflammatory tenosynovitis. The procedure involved tenosynovectomy, removing the inflamed synovial lining of the tendon sheath to alleviate pain and reduce inflammation. The patient received post-operative immunosuppressive therapy and hand therapy for optimal recovery.

9. Patient with Other Myositis and severe inflammation underwent a muscle release surgery to address muscle contractures and relieve pain. The surgical intervention involved releasing tight muscle fibers and fascia to improve mobility and reduce inflammation. The patient received post-operative immunosuppressive therapy and physical therapy.

10. Surgical debridement and reconstruction were performed on a patient with Other Myositis and severe inflammation causing tissue necrosis. The procedure involved the removal of necrotic tissue and subsequent reconstruction using tissue flaps or grafts to promote healing and reduce inflammation. The patient received post-operative immunosuppressive therapy and wound care.

1. Patient with Other Myositis and a mild diagnosis underwent a minimally invasive surgical procedure for diagnostic confirmation. The patient was discharged with a follow-up appointment in two weeks to review the biopsy results and discuss appropriate management options.

2. Surgical intervention was performed on a patient with Other Myositis and a moderate diagnosis to address muscle weakness and functional impairment. The patient was scheduled for regular follow-up visits at three-month intervals to monitor treatment response, adjust medications if necessary, and assess disease progression.

3. Patient with Other Myositis and a severe diagnosis underwent an extensive surgical intervention to manage complications and optimize disease control. The patient was placed on a close follow-up schedule, with regular visits every two weeks for the first three months, followed by monthly visits to closely monitor treatment response, manage symptoms, and adjust the therapeutic regimen as needed.

4. Surgical debridement and reconstruction were performed on a patient with Other Myositis and a diagnosis of moderate severity. The patient was instructed to schedule a follow-up appointment in six weeks to evaluate wound healing, assess pain control, and determine the need for further interventions, such as physical therapy or medication adjustments.

5. Patient with Other Myositis and a mild diagnosis underwent a surgical procedure for symptomatic relief. The patient was advised to follow up in three months to assess treatment response, evaluate the need for ongoing therapy, and discuss strategies for long-term disease management.

6. Surgical intervention was performed on a patient with Other Myositis and a severe diagnosis to address joint deformity and instability. The patient's follow-up plan included regular visits every four weeks for the first six months to monitor post-operative recovery, assess pain control, and consider additional interventions based on disease progression.

7. Patient with Other Myositis and a moderate diagnosis underwent a muscle biopsy procedure to guide treatment decisions. The patient was scheduled for a follow-up appointment in one week to discuss the biopsy results, initiate appropriate therapy, and establish a long-term monitoring plan.

8. Surgical intervention was performed on a patient with Other Myositis and a severe diagnosis to manage complications, including severe inflammation and muscle contractures. The patient's follow-up plan included frequent visits every two weeks for the first three months to monitor wound healing, manage pain, and adjust immunosuppressive therapy based on disease activity.

9. Patient with Other Myositis and a mild diagnosis underwent a diagnostic arthroscopy procedure. The patient's follow-up plan consisted of a single visit in four weeks to review the arthroscopy findings, discuss treatment options, and determine the need for further interventions or ongoing monitoring.

10. Surgical intervention was performed on a patient with Other Myositis and a severe diagnosis to address a deep tissue infection and prevent systemic complications. The patient's follow-up plan involved close monitoring with weekly visits for the first month to assess infection control, evaluate wound healing, and optimize antibiotic therapy. Subsequent follow-up visits were scheduled based on the patient's response to treatment and disease progression.

## M60.9 Myositis, unspecified

1. Operative Note: Patient with myositis underwent surgical intervention for muscle biopsy. A skin incision was made over the affected muscle, followed by dissection through subcutaneous tissue. The muscle fascia was identified and incised. Multiple muscle samples were obtained and sent for pathological examination. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well without complications.

2. Operative Note: Surgical excision of myositis ossificans was performed in the patient's thigh. An incision was made over the affected area, extending through the skin and subcutaneous tissue. Dissection was carried out to expose the lesion, and careful removal was performed using a combination of sharp dissection and electrocautery. The wound was irrigated, hemostasis was ensured, and the incision was closed in layers. The patient had an uneventful postoperative course.

3. Operative Note: Patient with myositis underwent a fasciotomy to relieve compartment syndrome. A longitudinal incision was made over the affected compartment, and the skin and subcutaneous tissues were dissected. The fascia was incised, and decompression was achieved. Bleeding was controlled, and the wound was left open for delayed primary closure. The patient's symptoms improved postoperatively, with no evidence of complications.

4. Operative Note: Surgical release of myositis-induced contracture was performed in the patient's forearm. An incision was made over the contracture site, and dissection was carried out to expose the affected muscle. The contracted muscle fibers were divided, allowing for improved range of motion. Hemostasis was achieved, and the wound was closed. The patient showed immediate improvement in flexion and extension of the forearm without any intraoperative or postoperative complications.

5. Operative Note: Arthroscopic synovectomy was performed in a patient with myositis-related synovitis of the knee. Arthroscopy portals were established, and intra-articular visualization was achieved. The inflamed synovium was excised using arthroscopic instruments. Hemostasis was obtained, and the joint was irrigated. The portals were closed, and a compression dressing was applied. The patient had a smooth postoperative course with decreased knee pain and improved joint mobility.

6. Operative Note: Patient with myositis underwent open muscle debridement due to extensive necrosis. An incision was made over the affected muscle compartment, and necrotic tissue was sharply excised. Extensive irrigation was performed to remove debris. Hemostasis was achieved, and a negative-pressure wound therapy system was applied. The patient was started on appropriate antibiotics and closely monitored for signs of infection during the postoperative period.

7. Operative Note: Surgical repair of myositis-induced muscle rupture was performed in the patient's lower leg. An incision was made over the site of the muscle tear, and the edges were debrided. The torn ends were approximated using absorbable sutures, ensuring proper alignment and tension. The wound was closed in layers. The patient had an uneventful recovery with gradual restoration of muscle strength and function.

8. Operative Note: Patient with myositis underwent a tendon transfer procedure to restore function in the affected limb. A longitudinal incision was made over the tendon transfer site, and the tendon was identified. The transfer was performed, securing the tendon to the target insertion site using sutures and anchors. The wound was closed, and the patient was placed in a splint for immobilization. Postoperative follow-up showed improved limb function.

9. Operative Note: Patient with myositis underwent a muscle lengthening procedure to address severe contractures. An incision was made over the contracted muscle group, and the muscle fibers were carefully lengthened. The procedure involved Z-plasty technique and release of tight fascial bands. Hemostasis was ensured, and the wound was closed. Postoperatively, the patient demonstrated increased range of motion and relief of contracture-related symptoms.

10. Operative Note: Patient with myositis underwent minimally invasive needle biopsy for diagnostic purposes. Under ultrasound guidance, a small skin incision was made, and a biopsy needle was advanced into the affected muscle. Multiple tissue samples were obtained and sent for pathological analysis. The needle was withdrawn, and the incision was closed with sutures. The procedure was well-tolerated, and the patient experienced minimal discomfort postoperatively.

1. Operative Note: Patient with myositis underwent electromyography (EMG) to assess muscle function. Needle electrodes were inserted into the affected muscle groups, and electrical activity was recorded during rest and contraction. The findings revealed abnormal spontaneous activity consistent with myositis. The procedure was well-tolerated, and the patient experienced minimal discomfort.

2. Operative Note: Patient with myositis underwent therapeutic plasma exchange (TPE) to remove circulating autoantibodies. A central venous catheter was inserted, and plasma was separated from the patient's blood using apheresis equipment. The patient received replacement fluids during the procedure. TPE was performed over several sessions, resulting in a reduction of autoantibody levels and improvement in myositis symptoms.

3. Operative Note: Patient with myositis underwent intravenous immunoglobulin (IVIG) therapy to modulate the immune response. IVIG was administered over several hours, and the patient was closely monitored for any adverse reactions. The treatment resulted in a reduction of muscle inflammation and improved muscle strength. The patient tolerated the therapy well, and no complications were noted.

4. Operative Note: Patient with myositis underwent high-dose corticosteroid infusion to suppress immune-mediated inflammation. The medication was administered intravenously over a specified period, and the patient's vital signs were closely monitored throughout. The treatment led to a decrease in muscle inflammation and alleviation of myositis symptoms. The patient exhibited a favorable response to the therapy without any adverse effects.

5. Operative Note: Patient with myositis underwent joint aspiration to relieve symptoms of associated arthritis. Using sterile technique, a needle was inserted into the affected joint space, and synovial fluid was aspirated for analysis. The procedure provided symptomatic relief and aided in diagnosing concurrent joint involvement in myositis. The patient experienced minimal discomfort, and no complications were encountered during the procedure.

6. Operative Note: Patient with myositis underwent magnetic resonance imaging (MRI) for further evaluation of muscle inflammation. The affected muscle groups were imaged using a high-field MRI scanner, providing detailed visualization of muscle involvement. The findings confirmed the presence of myositis-related edema and inflammation. The procedure was well-tolerated, and no adverse reactions were observed.

7. Operative Note: Patient with myositis underwent physical therapy to improve muscle strength and mobility. The therapy sessions included exercises targeting the affected muscle groups, stretching, and range-of-motion activities. The patient actively participated in the sessions, demonstrating gradual improvement in muscle function and reduced muscle weakness. The therapy was well-tolerated, and the patient reported increased overall functional capacity.

8. Operative Note: Patient with myositis underwent a muscle biopsy with enzyme histochemistry analysis. An incision was made over the affected muscle, and multiple tissue samples were obtained. Enzyme histochemistry staining was performed on the specimens to assess for specific enzymatic abnormalities associated with myositis. The procedure was uneventful, and the patient had an uncomplicated recovery.

9. Operative Note: Patient with myositis underwent genetic testing to identify any underlying genetic abnormalities contributing to the disease. A blood sample was collected, and genetic analysis was performed to evaluate for specific gene mutations associated with myositis. The test results revealed a mutation in a known myositis-related gene, confirming a genetic component in the patient's condition.

10. Operative Note: Patient with myositis underwent a muscle ultrasound examination to assess for muscle inflammation and damage. Ultrasonography was performed using a high-frequency probe, allowing visualization of muscle architecture, echogenicity changes, and vascularity

1. Operative Note: Patient with myositis underwent a muscle biopsy under local anesthesia. The affected muscle was infiltrated with a solution containing lidocaine and epinephrine for regional anesthesia. The procedure was well-tolerated, and the patient reported minimal discomfort throughout.

2. Operative Note: Patient with myositis underwent arthroscopic synovectomy under spinal anesthesia. A lumbar puncture was performed, and a local anesthetic agent was injected into the subarachnoid space. The patient remained conscious but free from pain during the procedure, which was completed without any complications.

3. Operative Note: Patient with myositis underwent fasciotomy under moderate sedation and regional anesthesia. Intravenous medications were administered to achieve conscious sedation, and a nerve block was performed to provide regional anesthesia to the affected limb. The patient remained comfortable and cooperative throughout the procedure, and there were no anesthesia-related issues.

4. Operative Note: Patient with myositis underwent muscle debridement under general anesthesia. After induction, endotracheal intubation was performed, and the patient was maintained on inhalational anesthetics and intravenous medications. The procedure was completed successfully without any intraoperative complications, and the patient was safely extubated at the end of surgery.

5. Operative Note: Patient with myositis underwent tendon transfer under combined anesthesia. The patient received a combination of general anesthesia and a peripheral nerve block for optimal pain control. The procedure was completed without any anesthetic complications, and the patient had a smooth recovery with effective postoperative pain management.

6. Operative Note: Patient with myositis underwent muscle lengthening under monitored anesthesia care (MAC). The patient received intravenous sedation and analgesics, and a local anesthetic agent was administered at the surgical site. The procedure was well-tolerated, and the patient remained relaxed and pain-free throughout.

7. Operative Note: Patient with myositis underwent electromyography (EMG) under local anesthesia with conscious sedation. A combination of local anesthetics and intravenous sedatives was administered to achieve pain control and patient comfort during the procedure. The patient cooperated well, and the EMG recordings were obtained without any significant disruptions.

8. Operative Note: Patient with myositis underwent therapeutic plasma exchange (TPE) under general anesthesia. After induction, the patient was maintained on total intravenous anesthesia (TIVA). The TPE procedure was performed smoothly, and the patient's vital signs remained stable throughout. The patient recovered well from anesthesia without any notable complications.

9. Operative Note: Patient with myositis underwent joint aspiration under local anesthesia supplemented with intravenous analgesics. The affected joint was infiltrated with a local anesthetic agent, providing adequate pain relief during the procedure. The patient reported minimal discomfort, and the joint fluid was successfully aspirated for analysis.

10. Operative Note: Patient with myositis underwent muscle ultrasound examination under conscious sedation. The patient received a carefully titrated dose of intravenous sedatives and analgesics to ensure comfort and cooperation during the procedure. The muscle ultrasound was performed successfully, and the patient remained relaxed and pain-free throughout the examination.

1. Operative Note: Patient with myositis and bone erosion underwent surgical debridement and bone grafting. An incision was made over the affected area, and extensive debridement of necrotic bone and surrounding tissues was performed. Bone graft material was then carefully placed to restore bone integrity and promote healing. The wound was closed in layers, and the patient was monitored closely for postoperative recovery.

2. Operative Note: Patient with myositis and bone erosion underwent joint arthroplasty. A surgical approach was made to the affected joint, and the eroded bone surfaces were carefully excised. A prosthetic joint was then implanted, ensuring proper alignment and stability. The joint was tested for functionality, and satisfactory range of motion was achieved. The patient had an uneventful postoperative course with improved joint function.

3. Operative Note: Patient with myositis and bone erosion underwent arthroscopic synovectomy and bone debridement. Arthroscopic portals were established, allowing visualization of the affected joint. The inflamed synovium was excised, and the eroded bone surfaces were carefully debrided using arthroscopic instruments. The joint was thoroughly irrigated, and the portals were closed. The patient had a smooth recovery with decreased joint pain and improved joint mobility.

4. Operative Note: Patient with myositis and bone erosion underwent bone biopsy for pathological evaluation. An incision was made over the affected bone, and a bone sample was obtained. The sample was sent for histopathological analysis to determine the underlying cause of bone erosion in the context of myositis. The procedure was uneventful, and the patient tolerated it well without any complications.

5. Operative Note: Patient with myositis and bone erosion underwent bone stabilization surgery. An incision was made over the affected bone, and the eroded segments were carefully aligned and fixed with orthopedic hardware. Stability and proper alignment were confirmed intraoperatively. The wound was closed, and the patient was immobilized in a cast or brace for postoperative healing and rehabilitation.

6. Operative Note: Patient with myositis and bone erosion underwent bone grafting and joint fusion. An incision was made over the affected joint, and the eroded bone surfaces were prepared for fusion. Bone graft material was inserted to promote fusion between the adjacent bones. The joint was immobilized with plates, screws, or external fixation devices. The patient had an uneventful postoperative course with successful fusion and improved joint stability.

7. Operative Note: Patient with myositis and bone erosion underwent minimally invasive percutaneous bone cement augmentation. Using image guidance, a needle was inserted into the eroded bone, and bone cement was injected to stabilize the area and provide structural support. The procedure was completed successfully, and the patient experienced immediate relief of pain and improved bone stability.

8. Operative Note: Patient with myositis and bone erosion underwent bone resection and joint reconstruction. An incision was made over the affected joint, and the eroded bone segments were carefully excised. Reconstruction of the joint was performed using autografts, allografts, or synthetic materials. The joint was stabilized, and the patient had a gradual recovery with improved joint function and reduced pain.

9. Operative Note: Patient with myositis and bone erosion underwent arthroscopic bone debridement and microfracture. Arthroscopic portals were established, and the eroded bone surfaces were debrided to remove loose fragments and damaged tissue. Microfracture techniques were employed to stimulate the formation of new bone and cartilage. The patient had a smooth postoperative course with reduced pain and improved joint function.

10. Operative Note: Patient with myositis and bone erosion underwent joint arthrodesis. An incision was made over the affected joint, and the eroded joint surfaces were meticulously prepared for fusion. Bone grafts were placed to facilitate fusion, and internal fixation devices were utilized for stability. The joint was immobilized, and the patient had a successful fusion and improved joint stability postoperatively.

1. Operative Note: Patient with myositis and severe bone pain underwent nerve block for pain management. Under ultrasound guidance, a local anesthetic agent was injected near the affected nerves to block pain signals. The procedure provided immediate relief of bone pain, and the patient reported significant improvement in comfort and mobility.

2. Operative Note: Patient with myositis and severe bone pain underwent radiofrequency ablation (RFA) of the affected nerves. Using fluoroscopic guidance, radiofrequency energy was delivered to the targeted nerves to disrupt pain signals. The procedure resulted in prolonged pain relief, and the patient experienced a reduction in severe bone pain postoperatively.

3. Operative Note: Patient with myositis and severe bone pain underwent minimally invasive kyphoplasty. Under fluoroscopic guidance, a balloon was inserted into the collapsed vertebra, creating a cavity. The cavity was then filled with bone cement to restore vertebral height and alleviate severe bone pain. The patient had a successful procedure with significant pain reduction and improved mobility.

4. Operative Note: Patient with myositis and severe bone pain underwent spinal cord stimulation (SCS) implantation. Electrodes were placed near the spinal cord, and a stimulator device was implanted. The SCS system delivered mild electrical pulses to interfere with pain signals. The patient reported significant relief from severe bone pain and improved quality of life postoperatively.

5. Operative Note: Patient with myositis and severe bone pain underwent vertebroplasty. Under fluoroscopic guidance, bone cement was injected directly into the fractured vertebra to stabilize it and alleviate pain. The procedure successfully relieved severe bone pain, and the patient experienced improved functionality and decreased reliance on pain medications.

6. Operative Note: Patient with myositis and severe bone pain underwent bone biopsy for diagnostic purposes. An incision was made over the affected bone, and a sample was obtained for histopathological analysis. The procedure helped identify the underlying cause of severe bone pain, leading to appropriate treatment and management strategies.

7. Operative Note: Patient with myositis and severe bone pain underwent corticosteroid injection into the affected bone. Under image guidance, a corticosteroid solution was injected directly into the painful bone area to reduce inflammation and relieve severe pain. The procedure provided significant pain relief, and the patient reported improved comfort and mobility.

8. Operative Note: Patient with myositis and severe bone pain underwent bone resection to relieve pressure on nerves and alleviate pain. A surgical approach was made to the affected bone, and careful resection was performed to remove the source of severe bone pain. The patient experienced immediate relief of pain and reported improved functionality.

9. Operative Note: Patient with myositis and severe bone pain underwent neuromodulation therapy implantation. Electrodes were placed near the affected nerves, and a neuromodulation device was implanted. The device delivered targeted electrical impulses to modulate pain signals. The patient had a successful procedure with significant reduction in severe bone pain and improved overall well-being.

10. Operative Note: Patient with myositis and severe bone pain underwent palliative surgical intervention. A comprehensive approach was employed, including nerve blocks, bone stabilization procedures, and pain medication adjustments. The aim was to improve pain management and enhance the patient's quality of life by alleviating severe bone pain. The procedure resulted in notable pain reduction and improved functional capacity.

1. Operative Note: Patient with myositis underwent a muscle release surgery. An incision was made over the affected muscle group, and meticulous dissection was performed to release tight fascial bands. The procedure successfully alleviated muscle contractures and improved range of motion. The patient had an uneventful postoperative course with notable functional improvement.

2. Operative Note: Patient with myositis underwent a tendon repair surgery. An incision was made over the affected tendon, and the torn or damaged ends were carefully reapproximated and sutured together. The procedure resulted in restoration of tendon integrity and improved functional outcomes. The patient had a smooth recovery with progressive improvement in strength and mobility.

3. Operative Note: Patient with myositis underwent a muscle transfer surgery. A healthy muscle was mobilized and transferred to replace a weakened or nonfunctional muscle affected by myositis. The procedure involved meticulous dissection, rerouting of the muscle, and secure fixation. The patient demonstrated improved muscle strength and functionality postoperatively.

4. Operative Note: Patient with myositis underwent a joint debridement and synovectomy surgery. An incision was made over the affected joint, and the inflamed synovial tissue was carefully excised. Concurrent joint debridement was performed to remove loose fragments or damaged tissues. The procedure resulted in decreased joint inflammation and improved joint function.

5. Operative Note: Patient with myositis underwent a muscle resection surgery. An incision was made over the affected muscle, and a portion of the muscle showing severe inflammation or damage was surgically excised. The procedure aimed to reduce inflammation, alleviate pain, and preserve the function of the remaining muscle fibers.

6. Operative Note: Patient with myositis underwent a tendon release and lengthening surgery. An incision was made over the affected tendon, and careful dissection was performed to release any adhesions and lengthen the contracted tendon. The procedure successfully improved tendon flexibility and range of motion, leading to enhanced functional outcomes.

7. Operative Note: Patient with myositis underwent a joint reconstruction surgery. An incision was made over the affected joint, and damaged or eroded joint surfaces were carefully removed. The joint was reconstructed using grafts, prosthetics, or other appropriate techniques to restore stability and improve joint function. The patient experienced improved joint mobility and reduced pain postoperatively.

8. Operative Note: Patient with myositis underwent a fasciectomy surgery. An incision was made over the affected fascia, and meticulous dissection was performed to remove the fibrotic or thickened fascial bands. The procedure aimed to release constricted muscles and improve overall muscle function. The patient had an uneventful recovery with improved range of motion and decreased pain.

9. Operative Note: Patient with myositis underwent a bursal excision surgery. An incision was made over the affected bursa, and the inflamed or enlarged bursa was carefully excised. The procedure aimed to alleviate pain, reduce inflammation, and improve joint function. The patient reported significant relief from bursal-related symptoms postoperatively.

10. Operative Note: Patient with myositis underwent a muscle biopsy with subsequent myectomy surgery. An initial biopsy was performed to confirm the diagnosis of myositis. Based on the biopsy findings, a subsequent myectomy surgery was undertaken to remove the affected muscle tissue, which showed severe inflammation and damage. The procedure aimed to reduce symptoms and improve functional outcomes.

1. Operative Note: Patient with myositis underwent a muscle fasciotomy. An incision was made over the affected muscle compartment, and the fascia was carefully released to relieve pressure and improve blood flow. The procedure resulted in decreased muscle swelling and improved tissue perfusion. The patient had an uneventful postoperative course with enhanced muscle function.

2. Operative Note: Patient with myositis underwent an arthroscopic debridement and microfracture of the joint. Arthroscopic portals were established, and the damaged cartilage and loose bodies were meticulously removed. Microfracture techniques were employed to stimulate the growth of new cartilage. The procedure aimed to improve joint function and alleviate pain.

3. Operative Note: Patient with myositis underwent a muscle strengthening surgery. An incision was made over the affected muscle, and a portion of the healthy tendon was reattached to the weakened muscle to provide additional support. The procedure resulted in improved muscle strength and enhanced functional outcomes.

4. Operative Note: Patient with myositis underwent a synovial biopsy for diagnostic purposes. An arthroscopic approach was utilized, and a small sample of the synovial tissue was obtained for histopathological analysis. The procedure helped determine the underlying cause of myositis and guided subsequent treatment decisions.

5. Operative Note: Patient with myositis underwent a muscle perfusion study. A radioactive tracer was injected into the bloodstream, and imaging techniques were employed to assess the blood flow within the affected muscle. The study provided valuable information about muscle perfusion and assisted in evaluating the extent of myositis.

6. Operative Note: Patient with myositis underwent a joint irrigation and drainage procedure. An incision was made over the affected joint, and the joint cavity was thoroughly irrigated to remove inflammatory debris and infected fluid. A drain was inserted to facilitate postoperative drainage. The procedure aimed to reduce inflammation and prevent the spread of infection.

7. Operative Note: Patient with myositis underwent a muscle revascularization procedure. A surgical approach was made to the affected muscle, and vascular bypass grafts were utilized to restore blood supply to the ischemic muscle tissue. The procedure aimed to improve muscle function and alleviate associated symptoms.

8. Operative Note: Patient with myositis underwent a myoplasty surgery. An incision was made over the affected muscle, and a portion of the adjacent healthy muscle tissue was repositioned or transferred to replace the weakened or damaged muscle fibers. The procedure aimed to enhance muscle strength and improve functional outcomes.

9. Operative Note: Patient with myositis underwent a joint arthroscopy with synovial biopsy. Arthroscopic portals were established, and the inflamed synovium was visualized. Multiple synovial samples were obtained and sent for analysis to help determine the underlying cause of myositis and guide treatment decisions.

10. Operative Note: Patient with myositis underwent a muscle reconstruction surgery. An incision was made over the affected muscle, and a combination of autograft or allograft tissue was used to reconstruct or reinforce the damaged muscle fibers. The procedure aimed to restore muscle integrity and improve functional outcomes.

1. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent an urgent joint irrigation and debridement. An extensive incision was made over the affected joint, and copious irrigation with antimicrobial solution was performed to remove infectious material. Necrotic tissue, pus, and debris were meticulously debrided. The joint was thoroughly flushed, and a drain was placed. The patient was initiated on appropriate antibiotic therapy postoperatively.

2. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent a joint fusion surgery. Due to the extensive infection compromising joint function, a decision was made to perform joint fusion. The infected joint surfaces were meticulously debrided, and bone graft material was utilized to facilitate fusion. Internal fixation devices were used to provide stability. The patient was started on broad-spectrum antibiotics.

3. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent an emergent joint arthroplasty. In light of the extensive infection and joint destruction, the decision was made to remove the infected joint and implant a prosthetic joint. The infected joint was excised, and a prosthetic joint was carefully inserted. The patient received intravenous antibiotics perioperatively.

4. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent a sequestrectomy procedure. An incision was made over the infected joint, and the sequestrum, a necrotic bone fragment, was meticulously removed. The surrounding infected tissues were debrided, and the joint was thoroughly irrigated. Postoperatively, the patient received intravenous antibiotics and wound care.

5. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent an urgent joint aspiration and washout. Using a sterile technique, the joint was aspirated to obtain fluid for culture and sensitivity testing. The joint cavity was then lavaged with sterile saline to remove infectious material. The patient was started on broad-spectrum antibiotics based on the culture results.

6. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent a joint resection arthroplasty. Due to the extensive infection and joint destruction, the infected joint surfaces were excised, and a prosthetic joint was not implanted. The wound was closed primarily, and the patient received intravenous antibiotics postoperatively.

7. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent an urgent joint arthroscopy with debridement. Arthroscopic portals were established, and the infected joint surfaces, synovium, and debris were meticulously debrided using arthroscopic instruments. The joint was thoroughly irrigated, and the patient received intravenous antibiotics.

8. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent a two-stage revision arthroplasty. The infected joint prosthesis was removed, and an antibiotic spacer was implanted. The patient received intravenous antibiotics for a specific duration. In the second stage, the spacer was removed, and a new joint prosthesis was implanted.

9. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwent a joint salvage procedure. An incision was made over the infected joint, and extensive debridement was performed to remove infected tissue. Local muscle flaps or soft tissue coverage techniques were utilized to provide vascularized tissue and promote healing. The patient received intravenous antibiotics postoperatively.

10. Operative Note: Patient with myositis and severe infection on the extreme moving joint underwentan amputation as a life-saving measure. Despite aggressive medical management, the infection was uncontrollable, and a decision was made to perform an amputation at an appropriate level. The patient received intravenous antibiotics perioperatively and was closely monitored for postoperative recovery.

1. Operative Note: Patient with myositis and severe inflammation underwent a synovectomy. An incision was made over the affected joint, and the inflamed synovial tissue was meticulously excised. The procedure aimed to reduce inflammation and improve joint function. The patient had an uneventful postoperative course with decreased joint pain and improved mobility.

2. Operative Note: Patient with myositis and chronic inflammation underwent a muscle biopsy. An incision was made over the affected muscle, and a small sample was obtained for histopathological analysis. The procedure helped evaluate the extent of inflammation and guide treatment decisions for the management of myositis.

3. Operative Note: Patient with myositis and persistent inflammation underwent a corticosteroid injection. Under ultrasound guidance, a corticosteroid solution was injected directly into the inflamed muscle or joint to reduce inflammation and alleviate symptoms. The patient reported significant relief from inflammation and improved functional outcomes post-procedure.

4. Operative Note: Patient with myositis and recurrent inflammation underwent a joint irrigation and corticosteroid infusion. An incision was made over the affected joint, and the joint cavity was thoroughly irrigated to remove inflammatory debris. Subsequently, a corticosteroid solution was infused into the joint to mitigate inflammation and promote healing. The patient experienced reduced inflammation and improved joint mobility.

5. Operative Note: Patient with myositis and acute inflammatory exacerbation underwent a plasma exchange procedure. A central venous catheter was placed, and plasma was removed and replaced with a substitute solution. The procedure aimed to reduce circulating inflammatory factors and modulate the immune response. The patient had a successful plasma exchange with improved control of inflammation.

6. Operative Note: Patient with myositis and localized inflammation underwent a percutaneous needle aspiration. Under image guidance, a needle was inserted into the inflamed area to aspirate fluid and inflammatory material. The procedure helped alleviate localized inflammation and provided symptomatic relief to the patient.

7. Operative Note: Patient with myositis and severe inflammatory myopathy underwent a muscle fasciotomy. An incision was made over the affected muscle compartment, and the fascia was released to relieve pressure and reduce inflammation. The procedure aimed to improve blood flow and prevent further muscle damage. The patient had an uneventful recovery with decreased muscle inflammation.

8. Operative Note: Patient with myositis and systemic inflammation underwent an immunosuppressive therapy procedure. Medications such as corticosteroids or immunosuppressants were administered to suppress the immune response and control systemic inflammation. The procedure aimed to reduce inflammation throughout the body and manage the underlying myositis condition.

9. Operative Note: Patient with myositis and moderate inflammation underwent a minimally invasive radiofrequency ablation (RFA) procedure. Using image guidance, radiofrequency energy was delivered to targeted areas to disrupt pain and inflammation signals. The procedure provided relief from inflammation and improved the patient's overall comfort.

10. Operative Note: Patient with myositis and diffuse inflammation underwent a lymph node biopsy. An incision was made over the affected lymph node, and a sample was obtained for histopathological analysis. The procedure helped assess the inflammatory nature of the myositis and guide treatment strategies for inflammation control.

1. Operative Note: Patient with severe myositis underwent a muscle biopsy. The procedure confirmed the diagnosis and revealed extensive muscle inflammation and damage. The patient was referred to a rheumatologist for further evaluation and initiation of aggressive immunosuppressive therapy.

2. Operative Note: Patient with moderate myositis underwent a muscle biopsy. The procedure confirmed the diagnosis and indicated moderate muscle inflammation. The patient was scheduled for regular follow-up appointments with a rheumatologist to monitor the disease progression and adjust treatment accordingly.

3. Operative Note: Patient with mild myositis underwent a muscle biopsy. The procedure confirmed the diagnosis and showed mild inflammation in the muscle tissue. The patient was prescribed a short course of oral corticosteroids and advised to follow up with the primary care physician for symptom monitoring.

4. Operative Note: Patient with severe myositis underwent a comprehensive immunological workup. The results revealed an underlying autoimmune condition contributing to the myositis. The patient was referred to a multidisciplinary team, including a rheumatologist and a neurologist, for ongoing management and treatment optimization.

5. Operative Note: Patient with moderate myositis underwent a comprehensive laboratory evaluation. The results indicated significant muscle enzyme elevation and confirmed the diagnosis of myositis. The patient was scheduled for regular follow-up visits with a neurologist to monitor muscle strength and assess the response to immunosuppressive therapy.

6. Operative Note: Patient with mild myositis underwent a thorough physical examination and laboratory investigations. The findings were consistent with mild muscle inflammation. The patient was advised to follow up with the primary care physician for routine monitoring and to report any worsening symptoms.

7. Operative Note: Patient with severe myositis underwent an electromyography (EMG) test. The results demonstrated abnormal muscle electrical activity consistent with myositis. The patient was referred to a neurologist for further evaluation and initiation of appropriate treatment, which may include immunosuppressive therapy.

8. Operative Note: Patient with moderate myositis underwent an imaging study, revealing significant muscle inflammation and edema. The patient was referred to a rheumatologist for further evaluation and management, including the consideration of additional diagnostic tests and treatment options.

9. Operative Note: Patient with mild myositis underwent a comprehensive evaluation, including laboratory tests and a muscle biopsy. The findings confirmed the diagnosis of myositis with mild inflammation. The patient was educated about the condition and advised to follow up with the primary care physician for periodic assessments.

10. Operative Note: Patient with severe myositis underwent a multidisciplinary evaluation involving a rheumatologist, a neurologist, and a physical therapist. The team developed a customized treatment plan that included high-dose corticosteroids, immunosuppressive therapy, and physical rehabilitation. The patient was scheduled for regular follow-up visits to assess treatment response and adjust the management accordingly.

## M61.0 Myositis ossificans traumatica

1. Operative Note - Myositis Ossificans Traumatica Excision: Under general anesthesia, a longitudinal incision was made over the affected muscle. Dissection through the subcutaneous tissue revealed a mass consistent with myositis ossificans traumatica. The mass was carefully excised, preserving surrounding structures. Hemostasis was achieved, and the wound was closed in layers. The excised specimen was sent for histopathological examination. Postoperative instructions were provided.

2. Operative Note - Myositis Ossificans Traumatica Debridement: After induction of general anesthesia, a curvilinear incision was made to expose the affected muscle. The necrotic and calcified tissues were sharply debrided, taking care not to damage nearby neurovascular structures. Copious irrigation was performed to cleanse the area. Hemostasis was ensured, and the wound was closed meticulously. Appropriate postoperative care instructions were given.

3. Operative Note - Myositis Ossificans Traumatica Open Biopsy: Under general anesthesia, a longitudinal incision was made over the lesion. The affected muscle was identified and a representative tissue sample was obtained for histopathological evaluation. Hemostasis was achieved, and the wound was closed. Specimen handling instructions were provided, and the patient was informed about the next steps in management.

4. Operative Note - Myositis Ossificans Traumatica Arthroscopic Resection: After anesthesia induction, arthroscopy was performed to visualize the joint affected by myositis ossificans traumatica. The calcified mass was identified and meticulously resected using arthroscopic instruments. Adequate hemostasis was ensured, and the joint was thoroughly irrigated. The portal sites were closed, and the patient received postoperative care instructions.

5. Operative Note - Myositis Ossificans Traumatica Muscle Release: Under general anesthesia, an incision was made along the muscle fibers affected by myositis ossificans traumatica. The tight fascial bands were released, allowing for improved muscle mobility. Care was taken to preserve neurovascular structures. Hemostasis was achieved, and the incision was closed in layers. The patient was educated about postoperative precautions.

6. Operative Note - Myositis Ossificans Traumatica Excision and Flap Reconstruction: Following general anesthesia, an elliptical incision was made encompassing the affected muscle and the surrounding healthy tissue. The myositis ossificans traumatica was excised en bloc, and the defect was reconstructed using a local flap. The flap was mobilized and inset with meticulous closure. Postoperative wound care instructions were provided.

7. Operative Note - Myositis Ossificans Traumatica Endoscopic Resection: Under general anesthesia, an endoscope was inserted through a small incision to visualize the affected area. The myositis ossificans traumatica was identified and resected using endoscopic instruments. Hemostasis was ensured, and the incision site was closed. The patient was instructed on postoperative care and advised to follow up for further evaluation.

8. Operative Note - Myositis Ossificans Traumatica Fasciotomy: After administering general anesthesia, longitudinal incisions were made along the affected muscle compartments. The fascia was released to relieve pressure and allow for expansion. Care was taken to protect vital structures. Hemostasis was achieved, and the incisions were closed. The patient was educated about the need for limb elevation and instructed on postoperative care.

9. Operative Note - Myositis Ossificans Traumatica Minimally Invasive Excision: Under general anesthesia, small incisions were made to access the myositis ossificans traumatica site. The calcified mass was meticulously excised using minimally invasive techniques. Hemostasis was ensured, and the incisions were closed with absorbable sutures. The patient was advised on postoperative pain management and encouraged to follow up for rehabilitation.

10. Operative Note - Myositis Ossificans Traumatica Radiofrequency Ablation: After appropriate anesthesia, a radiofrequency probe was inserted percutaneously into the myositis ossificans traumatica site. The probe was guided using imaging techniques to accurately target the lesion. Radiofrequency ablation was performed to destroy the calcified tissue. The probe was removed, and the puncture site was covered with a sterile dressing. Postoperative instructions were provided.

1. Operative Note - Myositis Ossificans Traumatica Mini-Open Approach: Under general anesthesia, a small incision was made to access the affected muscle. The myositis ossificans traumatica was visualized and carefully excised. Any residual calcified tissue was meticulously removed. Hemostasis was achieved, and the wound was closed using sutures. The patient was informed about postoperative rehabilitation and instructed to follow up for further evaluation.

2. Operative Note - Myositis Ossificans Traumatica Retrograde Nailing: After anesthesia induction, a retrograde approach was used to insert a nail into the affected bone. The myositis ossificans traumatica was meticulously excised to ensure appropriate nail placement. The nail was advanced under fluoroscopic guidance, stabilizing the fracture and preventing further ossification. The incision was closed, and postoperative care instructions were provided.

3. Operative Note - Myositis Ossificans Traumatica Soft Tissue Mobilization: Under general anesthesia, careful dissection was performed to mobilize the surrounding soft tissues affected by myositis ossificans traumatica. Adhesions were released, and the tissues were freed from the ossified mass. Hemostasis was achieved, and the incision was closed. The patient was advised on postoperative range of motion exercises.

4. Operative Note - Myositis Ossificans Traumatica Bursectomy: Following anesthesia induction, a curvilinear incision was made to expose the affected bursa. The calcified tissues within the bursa were meticulously excised. Any remaining ossificans tissue was removed. Hemostasis was ensured, and the wound was closed in layers. Postoperative instructions were provided to the patient.

5. Operative Note - Myositis Ossificans Traumatica Ultrasound-Guided Aspiration: Under local anesthesia, an ultrasound-guided needle was inserted into the myositis ossificans traumatica site. Aspiration was performed to extract fluid and relieve pain. A corticosteroid solution was injected to reduce inflammation. The needle was removed, and the area was covered with a sterile dressing. The patient was educated about possible post-procedure symptoms and advised to seek medical attention if needed.

6. Operative Note - Myositis Ossificans Traumatica Vascularized Bone Graft: After induction of general anesthesia, an appropriate incision was made to expose the affected bone. A vascularized bone graft was harvested from the donor site and meticulously transferred to the defect. The graft was secured with fixation devices, and the wound was closed. The patient was informed about the postoperative rehabilitation process.

7. Operative Note - Myositis Ossificans Traumatica Capsulotomy: Following anesthesia induction, an incision was made to expose the affected joint capsule. A capsulotomy was performed to release the contractures caused by myositis ossificans traumatica. Care was taken to protect the nearby structures. Hemostasis was achieved, and the incision was closed. The patient received instructions for postoperative joint mobilization.

8. Operative Note - Myositis Ossificans Traumatica Platelet-Rich Plasma Injection: Under local anesthesia, platelet-rich plasma (PRP) was prepared from the patient's own blood. Using ultrasound guidance, PRP was injected into the myositis ossificans traumatica site to promote tissue healing and reduce inflammation. The injection site was covered with a sterile dressing. Post-procedure care instructions were provided.

9. Operative Note - Myositis Ossificans Traumatica Tenotomy: After appropriate anesthesia, a small incision was made to expose the affected tendon. Tenotomy was performed to release the tendon from the ossified mass. Care was taken to protect surrounding structures. Hemostasis was achieved, and the incision was closed. The patient was advised on postoperative immobilization and rehabilitation.

10. Operative Note - Myositis Ossificans Traumatica Percutaneous Radiofrequency Ablation: Under local anesthesia and image guidance, a radiofrequency probe was inserted percutaneously into the myositis ossificans traumatica site. Radiofrequency ablation was performed to destroy the calcified tissue and alleviate symptoms. The probe was removed, and the puncture site was covered with a sterile dressing. The patient received postoperative instructions and scheduled for follow-up evaluation.

1. Operative Note - Myositis Ossificans Traumatica Excision with General Anesthesia: Under general anesthesia, a longitudinal incision was made over the affected muscle. Dissection through the subcutaneous tissue revealed a mass consistent with myositis ossificans traumatica. The mass was carefully excised, preserving surrounding structures. Hemostasis was achieved, and the wound was closed in layers. The excised specimen was sent for histopathological examination. Postoperative instructions were provided.

2. Operative Note - Myositis Ossificans Traumatica Debridement with Local Anesthesia: After administering local anesthesia, a curvilinear incision was made to expose the affected muscle. The necrotic and calcified tissues were sharply debrided, taking care not to damage nearby neurovascular structures. Copious irrigation was performed to cleanse the area. Hemostasis was ensured, and the wound was closed meticulously. Appropriate postoperative care instructions were given.

3. Operative Note - Myositis Ossificans Traumatica Open Biopsy with Regional Anesthesia: Under regional anesthesia, a longitudinal incision was made over the lesion. The affected muscle was identified and a representative tissue sample was obtained for histopathological evaluation. Hemostasis was achieved, and the wound was closed. Specimen handling instructions were provided, and the patient was informed about the next steps in management.

4. Operative Note - Myositis Ossificans Traumatica Arthroscopic Resection with Moderate Sedation: After inducing moderate sedation, arthroscopy was performed to visualize the joint affected by myositis ossificans traumatica. The calcified mass was identified and meticulously resected using arthroscopic instruments. Adequate hemostasis was ensured, and the joint was thoroughly irrigated. The portal sites were closed, and the patient received postoperative care instructions.

5. Operative Note - Myositis Ossificans Traumatica Muscle Release with General Anesthesia: Under general anesthesia, an incision was made along the muscle fibers affected by myositis ossificans traumatica. The tight fascial bands were released, allowing for improved muscle mobility. Care was taken to preserve neurovascular structures. Hemostasis was achieved, and the incision was closed in layers. The patient was educated about postoperative precautions.

6. Operative Note - Myositis Ossificans Traumatica Excision and Flap Reconstruction with Spinal Anesthesia: Following spinal anesthesia, an elliptical incision was made encompassing the affected muscle and the surrounding healthy tissue. The myositis ossificans traumatica was excised en bloc, and the defect was reconstructed using a local flap. The flap was mobilized and inset with meticulous closure. Postoperative wound care instructions were provided.

7. Operative Note - Myositis Ossificans Traumatica Endoscopic Resection with Deep Sedation: Under deep sedation, an endoscope was inserted through a small incision to visualize the affected area. The myositis ossificans traumatica was identified and resected using endoscopic instruments. Hemostasis was ensured, and the incision site was closed. The patient was instructed on postoperative care and advised to follow up for further evaluation.

8. Operative Note - Myositis Ossificans Traumatica Fasciotomy with Local Anesthesia and Sedation: After administering local anesthesia and sedation, longitudinal incisions were made along the affected muscle compartments. The fascia was released to relieve pressure and allow for expansion. Care was taken to protect vital structures. Hemostasis was achieved, and the incisions were closed. The patient was educated about the need for limb elevation and instructed on postoperative care.

9. Operative Note - Myositis Ossificans Traumatica Minimally Invasive Excision with General Anesthesia: Under general anesthesia, small incisions were made to access the myositis ossificans traumatica site. The calcified mass was meticulously excised using minimally invasive techniques. Hemostasis was ensured, and the incisions were closed with absorbable sutures. The patient was advised on postoperative pain management and encouraged to follow up for rehabilitation.

10. Operative Note - Myositis Ossificans Traumatica Radiofrequency Ablation with Local Anesthesia: After administering local anesthesia, a radiofrequency probe was inserted percutaneously into the myositis ossificans traumatica site. Radiofrequency ablation was performed to destroy the calcified tissue and alleviate symptoms. The probe was removed, and the puncture site was covered with a sterile dressing. The patient received postoperative instructions and scheduled for follow-up evaluation.

1. Operative Note - Myositis Ossificans Traumatica Excision with Bone Erosion: Under general anesthesia, a longitudinal incision was made over the affected muscle with associated bone erosion. Dissection revealed a mass consistent with myositis ossificans traumatica extending into the eroded bone. Careful excision of the calcified mass and bone debridement was performed. Hemostasis was achieved, and the wound was closed in layers. Postoperative instructions were provided.

2. Operative Note - Myositis Ossificans Traumatica Bone Grafting with Erosion: Following induction of general anesthesia, an incision was made to access the eroded bone affected by myositis ossificans traumatica. The necrotic bone was meticulously debrided, and a bone graft was carefully inserted into the defect. Adequate fixation was achieved to promote healing and restore bone integrity. The incision was closed, and postoperative care instructions were given.

3. Operative Note - Myositis Ossificans Traumatica Soft Tissue Mobilization with Bone Erosion: Under general anesthesia, careful dissection was performed to mobilize the surrounding soft tissues affected by myositis ossificans traumatica with underlying bone erosion. Adhesions were released, and the tissues were freed from the ossified mass and eroded bone. Hemostasis was achieved, and the incision was closed. The patient was advised on postoperative range of motion exercises.

4. Operative Note - Myositis Ossificans Traumatica Bone Resection and Reconstruction: After anesthesia induction, an incision was made to expose the affected bone with extensive erosion due to myositis ossificans traumatica. Resection of the eroded bone was performed, followed by reconstruction using an appropriate bone graft or implant. Stable fixation was achieved, and the wound was closed. Postoperative instructions were given for rehabilitation and monitoring.

5. Operative Note - Myositis Ossificans Traumatica Arthroscopic Debridement with Bone Erosion: After administering general anesthesia, arthroscopy was performed to visualize the joint affected by myositis ossificans traumatica with associated bone erosion. The calcified mass was meticulously debrided, and attention was given to the eroded bone. Thorough irrigation was performed, and hemostasis was ensured. The portals were closed, and postoperative care instructions were provided.

6. Operative Note - Myositis Ossificans Traumatica Bone Augmentation with Erosion: Under general anesthesia, an incision was made to access the bone with erosion due to myositis ossificans traumatica. Bone augmentation was performed using appropriate graft material to fill the defect and promote bone regeneration. The augmented area was secured with fixation devices, and the incision was closed. The patient was educated on postoperative care and follow-up evaluations.

7. Operative Note - Myositis Ossificans Traumatica Bone Curettage and Grafting with Erosion: Following anesthesia induction, a bone curettage procedure was performed to remove the eroded bone affected by myositis ossificans traumatica. The cavity was meticulously cleaned, and a bone graft was inserted to promote healing and restore bone integrity. Hemostasis was achieved, and the wound was closed. The patient was instructed on postoperative care and rehabilitation.

8. Operative Note - Myositis Ossificans Traumatica Joint Fusion with Bone Erosion: After appropriate anesthesia, an incision was made to expose the joint affected by myositis ossificans traumatica with significant bone erosion. Joint fusion was performed to stabilize the eroded bone and alleviate pain. Adequate fixation was achieved, and the incision was closed. Postoperative care instructions were provided, emphasizing the need for immobilization and rehabilitation.

9. Operative Note - Myositis Ossificans Traumatica Bone Erosion Repair with Internal Fixation: Under general anesthesia, an incision was made to access the bone erosion caused by myositis ossificans traumatica. The eroded bone segments were meticulously realigned, and internal fixation devices were utilized to stabilize the bone. The incision was closed, and postoperative instructions were given for weight-bearing restrictions and follow-up visits.

10. Operative Note - Myositis Ossificans Traumatica Bone Erosion Debridement and Antibiotic Spacer Placement: After induction of general anesthesia, an incision was made to expose the eroded bone affected by myositis ossificans traumatica. Thorough debridement of the necrotic bone and soft tissues was performed. An antibiotic-loaded spacer was placed to address any underlying infection. The wound was closed, and the patient received instructions for postoperative care and subsequent treatment.

1. Operative Note - Myositis Ossificans Traumatica Bone Resection for Severe Bone Pain: Under general anesthesia, a surgical approach was chosen to address the severe bone pain caused by myositis ossificans traumatica. The affected bone was exposed, and a segmental resection was performed to alleviate pain. The resected bone was sent for histopathological evaluation. Hemostasis was achieved, and the wound was closed. Postoperative pain management strategies were discussed with the patient.

2. Operative Note - Myositis Ossificans Traumatica Minimally Invasive Neurolysis for Severe Bone Pain: Under appropriate anesthesia, a minimally invasive approach was undertaken to perform neurolysis on the affected nerve near the myositis ossificans traumatica site, targeting the severe bone pain. The nerve was meticulously freed from any adhesions or entrapments. Hemostasis was ensured, and the incisions were closed. The patient was educated on postoperative pain management and rehabilitation.

3. Operative Note - Myositis Ossificans Traumatica Percutaneous Nerve Block for Severe Bone Pain: Under local anesthesia, a percutaneous nerve block was performed to provide temporary relief from severe bone pain associated with myositis ossificans traumatica. The nerve responsible for transmitting pain signals was targeted, and a local anesthetic agent was injected. The patient experienced immediate pain relief. Postoperative instructions were provided, including the possibility of repeat nerve blocks if needed.

4. Operative Note - Myositis Ossificans Traumatica Epidural Steroid Injection for Severe Bone Pain: Under sterile conditions and appropriate anesthesia, an epidural steroid injection was administered to alleviate severe bone pain associated with myositis ossificans traumatica. The injection was guided by imaging techniques to ensure accurate placement. The patient tolerated the procedure well, and immediate post-procedure pain relief was observed. The patient was educated about potential temporary pain relief and the need for further management.

5. Operative Note - Myositis Ossificans Traumatica Opioid Infusion Pump Placement for Severe Bone Pain: Under general anesthesia, an opioid infusion pump was placed to manage severe bone pain caused by myositis ossificans traumatica. The pump was implanted subcutaneously, and a catheter was positioned to deliver analgesic medication directly to the affected area. The system was programmed and tested for proper functioning. The patient received instructions for pump management and pain medication adjustment.

6. Operative Note - Myositis Ossificans Traumatica Radiofrequency Ablation for Severe Bone Pain:Under appropriate anesthesia, a radiofrequency ablation procedure was performed to target the nerves responsible for severe bone pain associated with myositis ossificans traumatica. The affected nerves were identified using imaging guidance, and radiofrequency energy was used to create a heat lesion, interrupting pain signals. The patient experienced immediate pain relief. Postoperative instructions were given, and pain management strategies were discussed.

7. Operative Note - Myositis Ossificans Traumatica Spinal Cord Stimulation for Severe Bone Pain:Following anesthesia induction, a spinal cord stimulation system was implanted to manage severe bone pain due to myositis ossificans traumatica. The leads were placed in the epidural space, and the system was activated to deliver electrical pulses to the spinal cord, modulating pain signals. The patient tolerated the procedure well, and postoperative pain relief was observed. The patient received instructions on device management and follow-up evaluations.

8.Operative Note - Myositis Ossificans Traumatica Transcutaneous Electrical Nerve Stimulation for Severe Bone Pain:Under local anesthesia, transcutaneous electrical nerve stimulation (TENS) electrodes were applied to the affected area in order to alleviate severe bone pain caused by myositis ossificans traumatica. The TENS unit was programmed to deliver electrical impulses, providing pain relief. The patient experienced immediate pain reduction. Postoperative instructions were provided, including the use of TENS at home for pain management.

9. Operative Note - Myositis Ossificans Traumatica Lumbar Sympathetic Block for Severe Bone Pain:Under fluoroscopic guidance and local anesthesia, a lumbar sympathetic block was performed to address severe bone pain associated with myositis ossificans traumatica. The sympathetic nerve chain was targeted, and a local anesthetic agent was injected to block pain signals. The patient experienced significant pain relief. Postoperative instructions were given, and further management options were discussed.

10. Operative Note - Myositis Ossificans Traumatica Dorsal Root Ganglion Stimulation for Severe Bone Pain: Following anesthesia induction, a dorsal root ganglion stimulation system was implanted to manage severe bone pain caused by myositis ossificans traumatica. Electrodes were placed near the dorsal root ganglion, and the system was activated to deliver electrical pulses, modulating pain signals. The patient tolerated the procedure well, and postoperative pain relief was observed. The patient received instructions on device management and follow-up evaluations.

1. Operative Note - Myositis Ossificans Traumatica Fasciotomy for Compartment Syndrome: Under general anesthesia, a fasciotomy was performed to address compartment syndrome associated with myositis ossificans traumatica. Longitudinal incisions were made to relieve pressure within the affected compartments. Muscle compartments were inspected, and any necrotic or calcified tissue was debrided. The wounds were left open for delayed primary closure. Postoperative instructions were provided, emphasizing limb elevation and close monitoring.

2. Operative Note - Myositis Ossificans Traumatica Open Reduction and Internal Fixation for Fracture: Following anesthesia induction, an open reduction and internal fixation procedure was performed to stabilize a fracture associated with myositis ossificans traumatica. The fracture site was exposed, and fractured fragments were reduced and aligned. Appropriate fixation devices were utilized, and stability was achieved. The incision was closed, and postoperative instructions were given for immobilization and follow-up.

3. Operative Note - Myositis Ossificans Traumatica Tendon Release for Contracture:

Under general anesthesia, a surgical intervention was undertaken to address contracture caused by myositis ossificans traumatica. Tendon release procedures were performed to restore joint mobility and alleviate restriction. Care was taken to protect adjacent structures. Adequate hemostasis was achieved, and the incisions were closed. Postoperative instructions were given for range of motion exercises and rehabilitation.

4. Operative Note - Myositis Ossificans Traumatica Arthroscopic Debridement and Synovectomy for Joint Involvement: After anesthesia induction, arthroscopy was performed to address joint involvement in myositis ossificans traumatica. The joint was visualized, and meticulous debridement of the calcified mass and synovectomy were performed. Irrigation was carried out to cleanse the joint. The portals were closed, and postoperative care instructions were provided, emphasizing joint protection and rehabilitation.

5. Operative Note - Myositis Ossificans Traumatica Soft Tissue Release for Joint Contracture: Under general anesthesia, a surgical soft tissue release procedure was performed to address joint contracture associated with myositis ossificans traumatica. Tightly contracted soft tissues were carefully released, allowing for improved joint mobility. Hemostasis was ensured, and the incisions were closed. The patient was educated on postoperative care, including rehabilitation exercises.

6. Operative Note - Myositis Ossificans Traumatica Excision and Flap Reconstruction for Extensive Soft Tissue Involvement: Following anesthesia induction, an excision and flap reconstruction procedure was performed to manage extensive soft tissue involvement in myositis ossificans traumatica. The affected tissue was excised, and a local or regional flap was mobilized and inset to cover the defect. Meticulous closure was achieved, and postoperative wound care instructions were provided.

7. Operative Note - Myositis Ossificans Traumatica Joint Arthrodesis for Irreparable Damage: After appropriate anesthesia, a joint arthrodesis procedure was performed to address irreparable damage caused by myositis ossificans traumatica. The joint surfaces were prepared, and fixation was achieved using appropriate hardware to achieve bony fusion. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions and was scheduled for follow-up evaluations.

8. Operative Note - Myositis Ossificans Traumatica Exploratory Surgery for Diagnostic Evaluation: Under anesthesia, an exploratory surgery was performed to obtain a definitive diagnosis of myositis ossificans traumatica. Multiple muscle compartments were explored, and tissue samples were collected for histopathological analysis. Hemostasis was achieved, and the incisions were closed. Postoperative instructions were given, and the patient was informed about further treatment options.

9. Operative Note - Myositis Ossificans Traumatica Soft Tissue Reconstruction for Defect Closure: Following anesthesia induction, a soft tissue reconstruction procedure was performed to close a defect caused by myositis ossificans traumatica. Local or regional flaps were designed and mobilized to provide adequate coverage and promote wound healing. The flaps were inset, and meticulous closure was achieved. Postoperative wound care instructions were provided.

10. Operative Note - Myositis Ossificans Traumatica Resection and Reconstruction of Extensive Calcified Mass: Under general anesthesia, resection and reconstruction of an extensive calcified mass associated with myositis ossificans traumatica were performed. The mass was meticulously dissected and removed, ensuring clear margins. Reconstruction was performed using appropriate tissue grafts or flaps. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given for wound care and follow-up evaluations.

1. Operative Note - Myositis Ossificans Traumatica Endoscopic Assisted Resection for Minimally Invasive Approach: Under general anesthesia, an endoscopic-assisted resection was performed to address myositis ossificans traumatica. Small incisions were made to introduce the endoscope and surgical instruments. The calcified mass was visualized and carefully resected using minimally invasive techniques. Hemostasis was achieved, and the incisions were closed. Postoperative instructions were given for wound care and follow-up.

2. Operative Note - Myositis Ossificans Traumatica Intralesional Steroid Injection for Symptomatic Relief: Under local anesthesia, an intralesional steroid injection was performed to alleviate symptoms associated with myositis ossificans traumatica. The affected area was identified, and a corticosteroid solution was injected directly into the lesion. The procedure was well-tolerated by the patient. Postoperative instructions were given for pain management and monitoring of symptoms.

3. Operative Note - Myositis Ossificans Traumatica Percutaneous Biopsy for Diagnostic Confirmation: Under local anesthesia, a percutaneous biopsy procedure was performed to obtain a tissue sample for histopathological examination and confirmation of myositis ossificans traumatica. A biopsy needle was guided into the affected area, and a sample was obtained for analysis. Hemostasis was achieved, and postoperative instructions were given regarding wound care and follow-up.

4. Operative Note - Myositis Ossificans Traumatica Vascularized Bone Graft for Large Bone Defect: Following anesthesia induction, a vascularized bone graft procedure was performed to address a large bone defect caused by myositis ossificans traumatica. A suitable vascularized bone flap was harvested from a donor site and transferred to the defect site. The flap was carefully inset and secured, ensuring vascular supply. The incisions were closed, and postoperative care instructions were provided.

5. Operative Note - Myositis Ossificans Traumatica Soft Tissue Debridement and Negative Pressure Wound Therapy: Under general anesthesia, extensive soft tissue debridement was performed to remove necrotic or infected tissue associated with myositis ossificans traumatica. Negative pressure wound therapy was initiated to promote wound healing and reduce the risk of infection. The wound was dressed with an appropriate wound dressing. Postoperative instructions were given for wound care and therapy management.

6. Operative Note - Myositis Ossificans Traumatica Implant Removal for Infection Control: Following anesthesia induction, a surgical procedure was performed to remove implants associated with myositis ossificans traumatica that were causing infection. The affected area was exposed, and the implants were carefully removed. Thorough irrigation and debridement were performed, and the wound was closed. Postoperative instructions were given for antibiotic therapy and wound care.

7. Operative Note - Myositis Ossificans Traumatica External Fixation for Fracture Stabilization: Under general anesthesia, an external fixation device was applied to stabilize a fracture associated with myositis ossificans traumatica. The fracture site was aligned, and the fixator was positioned and secured with pins or wires. Adequate stability was achieved, and the incisions were closed. Postoperative instructions were provided for pin care, weight-bearing restrictions, and follow-up evaluations.

8. Operative Note - Myositis Ossificans Traumatica Myofascial Release for Muscular Adhesions: Under local anesthesia, a myofascial release procedure was performed to address muscular adhesions caused by myositis ossificans traumatica. Manual techniques were used to apply sustained pressure and stretching to release the adhesions and restore muscle function. The procedure was well-tolerated by the patient. Postoperative instructions were given for pain management and rehabilitation exercises.

9. Operative Note - Myositis Ossificans Traumatica Resection and Reconstruction of Extensive Soft Tissue Mass: Following anesthesia induction, resection and reconstruction of an extensive soft tissue mass associated with myositis ossificans traumatica were performed. The mass was excised with adequate margins, and the defect was reconstructed using local or regional tissue flaps. The flaps were inset and secured, and the wound was closed. Postoperative instructions were given for wound care and follow-up evaluations.

10. Operative Note - Myositis Ossificans Traumatica Platelet-Rich Plasma Injection for Enhanced Healing: Under local anesthesia, a platelet-rich plasma (PRP) injection was administered to promote enhanced healing in myositis ossificans traumatica. PRP was prepared from the patient's own blood and injected into the affected area, providing a concentrated source of growth factors. The procedure was well-tolerated, and postoperative instructions were given for pain management and activity modification.

1. Operative Note - Myositis Ossificans Traumatica Debridement and Irrigation for Severe Joint Infection:

Under general anesthesia, a surgical debridement and irrigation procedure were performed to address a severe joint infection associated with myositis ossificans traumatica. The joint was opened, and necrotic tissue and infected material were meticulously debrided. Copious irrigation with a sterile saline solution was carried out to cleanse the joint. The wound was closed, and postoperative instructions were provided for antibiotic therapy and wound care.

2. Operative Note - Myositis Ossificans Traumatica Arthroscopic Lavage and Drainage for Infected Joint:

Following anesthesia induction, arthroscopic lavage and drainage were performed to treat an infected joint affected by myositis ossificans traumatica. The joint was visualized using an arthroscope, and infected fluid and debris were thoroughly irrigated and removed. Drainage tubes were inserted to promote ongoing drainage. Postoperative instructions were given for antibiotic therapy, joint immobilization, and follow-up evaluations.

3. Operative Note - Myositis Ossificans Traumatica Joint Exploration and Synovectomy for Severe Infection:

Under general anesthesia, a joint exploration and synovectomy procedure were performed to address severe infection in the affected joint caused by myositis ossificans traumatica. The joint was opened, and the infected synovium was meticulously excised. Hemostasis was achieved, and the joint was thoroughly irrigated. The wound was closed, and postoperative instructions were given for antibiotic therapy and rehabilitation.

4. Operative Note - Myositis Ossificans Traumatica Joint Fusion for Chronic Infection Control:

Following anesthesia induction, a joint fusion procedure was performed to control chronic infection in the affected joint associated with myositis ossificans traumatica. The joint surfaces were prepared, and fixation was achieved using appropriate hardware to promote bony fusion and eliminate the infected joint. The incision was closed, and postoperative instructions were given for antibiotic therapy and postoperative care.

5. Operative Note - Myositis Ossificans Traumatica Joint Arthroplasty for Severe Infection and Joint Reconstruction:

Under general anesthesia, a joint arthroplasty procedure was performed to address severe infection and reconstruct the affected joint in myositis ossificans traumatica. The damaged joint surfaces were removed, and a prosthetic joint was implanted. The incision was closed, and postoperative instructions were given for antibiotic therapy, joint immobilization, and rehabilitation.

6. Operative Note - Myositis Ossificans Traumatica Soft Tissue Flap Reconstruction for Infected Joint Wound:

Following anesthesia induction, a soft tissue flap reconstruction was performed to address an infected joint wound associated with myositis ossificans traumatica. A local or regional flap was designed and harvested to provide coverage over the wound. The flap was carefully inset, and the wound was closed. Postoperative instructions were given for wound care, antibiotic therapy, and follow-up evaluations.

7. Operative Note - Myositis Ossificans Traumatica Joint Irrigation with Antibiotic Solution for Infection Control:

Under general anesthesia, a joint irrigation procedure was performed using an antibiotic solution to control the severe infection in the affected joint caused by myositis ossificans traumatica. The joint was opened, and the infected fluid was flushed out with the antibiotic solution. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given for antibiotic therapy and joint immobilization.

8.Operative Note - Myositis Ossificans Traumatica Joint Capsulectomy for Infected Joint Capsule:

Following anesthesia induction, a joint capsulectomy was performed to address an infected joint capsule in myositis ossificans traumatica. The joint capsule was opened and meticulously excised to remove the infected tissue. Thorough irrigation was carried out, and the wound was closed. Postoperative instructions were given for antibiotic therapy, joint immobilization, and wound care.

9. Operative Note - Myositis Ossificans Traumatica Limited Joint Resection for Severe Infection:

Under general anesthesia, a limited joint resection procedure was performed to address severe infection in the affected joint associated with myositis ossificans traumatica. The infected portion of the joint was carefully excised, and healthy tissue margins were established. The wound was closed, and postoperative instructions were given for antibiotic therapy, joint immobilization, and follow-up evaluations.

10. Operative Note - Myositis Ossificans Traumatica Amputation for Uncontrolled Joint Infection:

Following anesthesia induction, an amputation procedure was performed as a last resort to control the uncontrolled joint infection associated with myositis ossificans traumatica. The amputation level was determined based on the extent of infection and tissue viability. Hemostasis was achieved, and appropriate wound closure techniques were utilized. Postoperative instructions were given for antibiotic therapy, wound care, and rehabilitation.

1. Operative Note - Myositis Ossificans Traumatica Incision and Drainage for Acute Inflammatory Abscess:

Under local anesthesia, an incision and drainage procedure were performed to address an acute inflammatory abscess associated with myositis ossificans traumatica. The abscess was identified and incised, allowing for drainage of purulent material. The wound was irrigated, and a drain was placed to facilitate ongoing drainage. Postoperative instructions were given for wound care, antibiotic therapy, and follow-up evaluations.

2. Operative Note - Myositis Ossificans Traumatica Corticosteroid Injection for Inflammatory Flare:

Under local anesthesia, a corticosteroid injection was administered to manage an inflammatory flare-up in myositis ossificans traumatica. The affected area was identified, and a corticosteroid solution was injected to reduce inflammation and alleviate symptoms. The procedure was well-tolerated, and postoperative instructions were given for pain management and monitoring of symptoms.

3. Operative Note - Myositis Ossificans Traumatica Synovectomy for Chronic Inflammation Control:

Following anesthesia induction, a synovectomy procedure was performed to address chronic inflammation in myositis ossificans traumatica. The inflamed synovium was meticulously excised to alleviate symptoms and prevent further progression of the condition. Hemostasis was achieved, and the incision was closed. Postoperative instructions were given for wound care, pain management, and rehabilitation exercises.

4. Operative Note - Myositis Ossificans Traumatica Bursectomy for Inflamed Bursa:

Under local anesthesia, a bursectomy procedure was performed to address an inflamed bursa associated with myositis ossificans traumatica. The inflamed bursa was carefully excised, and any underlying adhesions were released. The wound was closed, and postoperative instructions were given for wound care, pain management, and gradual return to activity.

5. Operative Note - Myositis Ossificans Traumatica Fasciotomy for Compartment Syndrome and Inflammation:

Following anesthesia induction, a fasciotomy procedure was performed to relieve compartment syndrome and address inflammation in myositis ossificans traumatica. The affected compartments were decompressed, allowing for improved tissue perfusion and reduction of inflammatory response. The incisions were left open, and postoperative instructions were given for wound care, elevation, and close monitoring of compartment pressures.

6. Operative Note - Myositis Ossificans Traumatica Anti-inflammatory Medication Injection for Inflammation Reduction:

Under local anesthesia, an injection of anti-inflammatory medication was administered to reduce inflammation in myositis ossificans traumatica. The medication was injected directly into the affected area to provide localized relief. The procedure was well-tolerated, and postoperative instructions were given for pain management and monitoring of inflammatory markers.

7. Operative Note - Myositis Ossificans Traumatica Arthroscopic Debridement for Inflamed Joint:

Following anesthesia induction, arthroscopic debridement was performed to address inflammation in the affected joint associated with myositis ossificans traumatica. The joint was visualized using an arthroscope, and inflamed tissues, loose bodies, or adhesions were meticulously removed. Thorough irrigation was carried out, and the incisions were closed. Postoperative instructions were given for wound care, pain management, and rehabilitation exercises.

8. Operative Note - Myositis Ossificans Traumatica Biologic Therapy Injection for Inflammatory Control: Under local anesthesia, a biologic therapy injection was administered to control inflammation in myositis ossificans traumatica. The biologic agent was injected into the affected area to modulate the immune response and reduce inflammation. The procedure was well-tolerated, and postoperative instructions were given for pain management and monitoring of response to therapy.

9. Operative Note - Myositis Ossificans Traumatica Deep Tissue Massage for Inflammatory Muscle Tension: Under local anesthesia, a deep tissue massage was performed to alleviate inflammatory muscle tension in myositis ossificans traumatica. Manual techniques were used to apply deep pressure and release tension in the affected muscles. The procedure was well-tolerated, and postoperative instructions were given for pain management and stretching exercises.

10. Operative Note - Myositis Ossificans Traumatica Tenotomy for Inflamed Tendon Release: Following anesthesia induction, a tenotomy procedure was performed to release an inflamed tendon associated with myositis ossificans traumatica. The inflamed tendon was carefully incised to relieve tension and reduce inflammation. The wound was closed, and postoperative instructions were given for wound care, pain management, and gradual return to activity.

1. Operative Note - Myositis Ossificans Traumatica Excision and Curettage with Close Follow-up: Following anesthesia induction, excision and curettage of the affected area were performed to address myositis ossificans traumatica. The procedure was successful in removing the ossified tissue. Close follow-up appointments were scheduled to monitor for any recurrence or complications and to provide appropriate rehabilitation guidance.

2. Operative Note - Myositis Ossificans Traumatica Minimal Invasive Procedure with Regular Check-ups: Under local anesthesia, a minimal invasive procedure was performed to address myositis ossificans traumatica. The procedure was well-tolerated, and the patient was advised to attend regular check-ups for monitoring and assessment of the condition's progression and response to treatment.

3. Operative Note - Myositis Ossificans Traumatica Extensive Surgical Intervention with Intensive Follow-up: Following anesthesia induction, an extensive surgical intervention was performed to manage severe myositis ossificans traumatica. The patient was informed about the complexity of the procedure and the need for intensive follow-up appointments to monitor the healing process, manage pain, and provide ongoing rehabilitation.

4. Operative Note - Myositis Ossificans Traumatica Non-Surgical Management with Periodic Evaluations: Based on the patient's specific case, non-surgical management was chosen to address myositis ossificans traumatica. The patient was advised to undergo periodic evaluations to assess the response to conservative treatment methods, such as physical therapy, medication, and activity modification, and to make any necessary adjustments to the treatment plan.

5. Operative Note - Myositis Ossificans Traumatica Exploratory Procedure with Follow-up Decision: Under general anesthesia, an exploratory procedure was performed to assess the extent and severity of myositis ossificans traumatica. Based on the findings during the surgery, a decision regarding the appropriate follow-up plan, such as further surgical intervention, conservative management, or additional diagnostic tests, was made and communicated to the patient.

6. Operative Note - Myositis Ossificans Traumatica Palliative Procedure with Palliative Care Consultation: Following anesthesia induction, a palliative procedure was performed to provide relief from symptoms associated with myositis ossificans traumatica. The patient was referred for a palliative care consultation to ensure comprehensive management of pain and other distressing symptoms, with regular follow-ups to assess the patient's quality of life and adjust the treatment plan as needed.

7. Operative Note - Myositis Ossificans Traumatica Revision Surgery with Postoperative Rehabilitation Program: Based on the patient's history and previous surgical interventions for myositis ossificans traumatica, a revision surgery was performed to address recurrent or persistent symptoms. A postoperative rehabilitation program was recommended, including physical therapy and close follow-up appointments to optimize the patient's recovery and functional outcomes.

8. Operative Note - Myositis Ossificans Traumatica Observation with Prompt Reporting of Any Changes: In cases where myositis ossificans traumatica is in its early stages or shows minimal progression, an observation approach may be chosen. The patient was instructed to closely monitor the affected area and report any changes or worsening of symptoms promptly. Follow-up appointments were scheduled to reassess the condition and determine the need for further intervention.

9. Operative Note - Myositis Ossificans Traumatica Multidisciplinary Team Consultation with Individualized Follow-up Plan: Given the complexity and severity of the myositis ossificans traumatic a diagnosis, a multidisciplinary team consultation was conducted to develop an individualized follow-up plan. The patient's case was reviewed by specialists from relevant fields, including orthopedics, radiology, and rehabilitation medicine, to determine the most appropriate course of action and establish a comprehensive follow-up schedule.

10. Operative Note - Myositis Ossificans Traumatica Emergency Procedure with Immediate Postoperative Assessment: In cases where myositis ossificans traumatica presents as an emergency situation, an immediate procedure was performed to address the critical condition. Following surgery, the patient was closely monitored in the post-anesthesia care unit, and a comprehensive assessment was conducted to evaluate the immediate outcomes and determine the subsequent steps for ongoing management and follow-up care.

## M61.1 Myositis ossificans progressiva

1. Patient presented with Myositis ossificans progressiva (MOP) affecting bilateral quadriceps muscles. Surgical excision of ectopic ossification performed, followed by extensive soft tissue debridement. Intraoperative findings revealed dense bone formation with surrounding fibrotic tissue. Hemostasis achieved using electrocautery. Wound closed in layers, and postoperative immobilization prescribed. Patient advised on rehabilitation protocol and scheduled for follow-up.

2. Operative intervention for Myositis ossificans progressiva involved excision of ectopic bone formation in patient's right elbow joint. Preoperative imaging confirmed ossification extending into the joint space. Intraoperatively, careful dissection was performed to expose the affected area, followed by meticulous removal of the abnormal bone. Joint integrity preserved, and the wound closed with absorbable sutures. Patient counseled on postoperative rehabilitation and provided with appropriate pain management.

3. A case of Myositis ossificans progressiva necessitated surgical intervention for ectopic bone excision in the patient's left hip region. Intraoperative exploration revealed extensive bone deposition within the hip capsule and surrounding soft tissues. Ossifications carefully removed while preserving hip joint integrity. The wound closed in layers, and sterile dressings applied. Patient advised on weight-bearing limitations and prescribed postoperative physical therapy.

4. Surgical intervention was performed on a patient with Myositis ossificans progressiva, targeting the ectopic bone formation in the left shoulder. Intraoperative assessment revealed significant bony growth adherent to the glenohumeral joint. Careful dissection allowed for complete excision of the ossification, followed by thorough irrigation and closure of the wound. Patient instructed on shoulder immobilization and referred for postoperative rehabilitation.

5. A patient diagnosed with Myositis ossificans progressiva underwent surgical management for ectopic bone removal in the cervical region. Intraoperative exploration revealed extensive bony growth compressing the spinal cord. Delicate dissection enabled successful excision of the ossification, relieving spinal cord compression. Wound closure performed meticulously, and postoperative imaging confirmed decompression. Patient placed on postoperative spinal precautions and referred for rehabilitation therapy.

6. Myositis ossificans progressiva necessitated surgical intervention in the patient's right knee joint. Intraoperative assessment revealed substantial ossification within the joint space, causing restriction of movement. Joint debridement performed, removing the ectopic bone, followed by thorough irrigation. The wound closed using absorbable sutures, and postoperative immobilization prescribed. Patient advised on weight-bearing limitations and referred to physical therapy for postoperative rehabilitation.

7. Patient presented with Myositis ossificans progressiva affecting the muscles of the left forearm. Operative intervention involved excision of ectopic ossification to restore functional range of motion. Intraoperatively, dense calcifications were encountered, requiring careful dissection to preserve neurovascular structures. Ectopic bone removed, and the wound meticulously closed. Patient instructed on forearm immobilization and referred for postoperative occupational therapy.

8. Surgical intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the thoracic spine. Intraoperative exploration revealed extensive ossification impinging on the spinal cord. Careful laminectomy and meticulous excision of ossifications performed to relieve neural compression. Spinal stabilization achieved using instrumentation. The wound closed in layers, and postoperative imaging confirmed decompression. Patient referred for postoperative rehabilitation and neurologic assessment.

9. A case of Myositis ossificans progressiva necessitated surgical intervention for the excision of ectopic bone in the patient's right ankle. Intraoperative findings showed extensive calcification affecting the ankle joint. Careful dissection enabled complete removal of the ossification, followed by thorough irrigation and wound closure. Patient instructed on ankle immobilization and referred for postoperative physical therapy to regain functional mobility.

10. Operative intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the paraspinal muscles. Intraoperative exploration revealed dense ossification causing impingement on adjacent nerve roots. Thorough excision of the ossification performed, preserving neural structures. The wound closed in layers, and postoperative imaging confirmed decompression. Patient referred for postoperative physical therapy and regular follow-up for monitoring disease progression.

1. Myositis ossificans progressiva patient underwent surgical intervention for ectopic bone excision in the left hip region. Intraoperatively, extensive ossification was encountered within the hip capsule, causing joint stiffness. Careful dissection allowed for complete removal of the ectopic bone while preserving hip joint integrity. Wound closed meticulously, and postoperative rehabilitation prescribed. Patient educated on weight-bearing restrictions and referred for physical therapy.

2. Surgical management of Myositis ossificans progressiva involved excision of ectopic bone in the patient's right elbow. Intraoperative assessment revealed dense ossification encasing the joint, limiting range of motion. Careful dissection enabled successful removal of the abnormal bone, followed by joint irrigation and closure. Patient instructed on elbow immobilization and referred for postoperative rehabilitation to regain functional mobility.

3. A patient with Myositis ossificans progressiva underwent surgical intervention for ectopic bone removal in the cervical spine. Intraoperatively, extensive ossification was found compressing the spinal cord. Careful laminectomy and excision of the ossification performed to relieve neural compression. The wound closed meticulously, and postoperative imaging confirmed decompression. Patient placed on spinal precautions and referred for neurologic assessment and rehabilitation therapy.

4. Operative intervention was performed on a Myositis ossificans progressiva patient to remove ectopic bone in the right knee joint. Intraoperative exploration revealed significant ossification within the joint space, causing severe joint pain and limited mobility. Joint debridement performed, removing the abnormal bone, followed by thorough irrigation and closure. Patient instructed on knee immobilization and referred for postoperative physical therapy.

5. Myositis ossificans progressiva patient underwent surgical management for ectopic bone excision in the left shoulder. Intraoperative assessment revealed extensive bony growth adherent to the glenohumeral joint, causing functional impairment. Careful dissection allowed for complete removal of the ossification, followed by joint irrigation and closure. Patient educated on shoulder immobilization and referred for postoperative rehabilitation to regain strength and range of motion.

6. A case of Myositis ossificans progressiva necessitated surgical intervention for ectopic bone removal in the patient's right ankle. Intraoperative findings showed dense calcification affecting the ankle joint, resulting in severe pain and limited mobility. Excision of the ectopic bone performed, followed by thorough irrigation and wound closure. Patient instructed on ankle immobilization and referred for postoperative physical therapy for functional recovery.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the thoracic spine. Intraoperative exploration revealed extensive ossification impinging on the spinal cord, causing neurological deficits. Careful laminectomy and meticulous excision of ossifications performed to relieve neural compression. Spinal stabilization achieved using instrumentation. The wound closed in layers, and postoperative imaging confirmed decompression. Patient referred for neurologic assessment and rehabilitation therapy.

8. Patient presented with Myositis ossificans progressiva affecting the muscles of the right forearm. Operative intervention involved excision of ectopic ossification to restore functional range of motion. Intraoperatively, dense calcifications were encountered, requiring careful dissection to preserve neurovascular structures. Ectopic bone removed, and the wound meticulously closed. Patient instructed on forearm immobilization and referred for postoperative occupational therapy for hand and wrist function restoration.

9. A case of Myositis ossificans progressiva necessitated surgical intervention for the excision of ectopic bone in the patient's lumbar spine. Intraoperative findings revealed extensive ossification

compressing the nerve roots. Careful laminectomy and excision of ossifications performed to alleviate neural compression. Spinal stability achieved using instrumentation. The wound closed meticulously, and postoperative imaging confirmed decompression. Patient referred for neurologic assessment and postoperative rehabilitation.

10. Operative intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the right temporomandibular joint. Intraoperative exploration revealed dense ossification causing jaw stiffness and limited mouth opening. Careful dissection allowed for successful removal of the ectopic bone, followed by joint irrigation and closure. Patient educated on jaw immobilization and referred for postoperative rehabilitation and jaw exercises to restore normal jaw function.

1. Patient with Myositis ossificans progressiva underwent surgical intervention for ectopic bone excision in the left hip under general anesthesia with careful monitoring. Intraoperatively, extensive ossification within the hip capsule was encountered. Anesthetic dosage adjusted to maintain hemodynamic stability. Complete removal of ectopic bone performed, followed by wound closure. Postoperative pain management ensured with appropriate analgesia. Patient referred for postoperative rehabilitation and physiotherapy.

2. Surgical management of Myositis ossificans progressiva involved excision of ectopic bone in the right elbow under regional anesthesia. Intraoperative assessment revealed dense ossification encasing the joint. Anesthetic dosage carefully titrated to ensure patient comfort and cooperation. Successful removal of the abnormal bone performed, followed by joint irrigation and closure. Postoperative pain control achieved using a combination of regional anesthesia and systemic analgesia.

3. A patient with Myositis ossificans progressiva underwent surgical intervention for ectopic bone removal in the cervical spine under general anesthesia. Intraoperatively, extensive ossification was found compressing the spinal cord. Anesthetic dosage adjusted to maintain stable hemodynamics and prevent cord injury during surgery. Careful laminectomy and excision of ossifications performed, followed by wound closure. Postoperative pain management tailored to patient's needs, considering anesthesia effects.

4. Operative intervention was performed on a Myositis ossificans progressiva patient to remove ectopic bone in the right knee joint under spinal anesthesia. Intraoperative exploration revealed significant ossification within the joint space. Anesthetic dosage carefully administered to ensure adequate surgical conditions and patient comfort. Joint debridement performed, followed by thorough irrigation and closure. Postoperative pain control achieved through a combination of spinal anesthesia and systemic analgesics.

5. Myositis ossificans progressiva patient underwent surgical management for ectopic bone excision in the left shoulder under general anesthesia with nerve block. Intraoperative assessment revealed extensive bony growth adherent to the glenohumeral joint. Anesthetic dosage adjusted to ensure optimal surgical conditions and effective pain management. Complete removal of the ossification performed, followed by joint irrigation and closure. Postoperative pain control ensured with a combination of regional anesthesia and systemic analgesia.

6. A case of Myositis ossificans progressiva necessitated surgical intervention for ectopic bone removal in the patient's right ankle under local anesthesia with sedation. Intraoperative findings showed dense calcification affecting the ankle joint. Anesthetic dosage carefully titrated to maintain patient comfort and cooperation. Excision of the ectopic bone performed, followed by thorough irrigation and wound closure. Postoperative pain control achieved through local anesthesia infiltration and adjunctive systemic analgesia.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the thoracic spine under general anesthesia. Intraoperative exploration revealed extensive ossification impinging on the spinal cord. Anesthetic dosage adjusted to ensure stable hemodynamics and prevent cord injury. Careful laminectomy and meticulous excision of ossifications performed, followed by wound closure. Postoperative pain management tailored to patient's needs, considering anesthesia effects.

8. Patient presented with Myositis ossificans progressiva affecting the muscles of the right forearm. Operative intervention involved excision of ectopic ossification under local anesthesia with monitored sedation. Intraoperatively, dense calcifications were encountered, requiring careful dissection. Anesthetic dosage titrated to maintain patient comfort and cooperation. Ectopic bone removed, and the wound meticulously closed. Postoperative pain control ensured through a combination of local anesthesia and adjunctive systemic analgesia.

9. A case of Myositis ossificans progressiva necessitated surgical intervention for the excision of ectopic bone in the patient's lumbar spine under general anesthesia with epidural analgesia. Intraoperative findings revealed extensive ossification compressing the nerve roots. Anesthetic dosage carefully managed to maintain stable hemodynamics and provide effective pain relief. Careful laminectomy and excision of ossifications performed, followed by wound closure. Postoperative pain management tailored to patient's needs, considering anesthesia effects.

10. Operative intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the right temporomandibular joint under local anesthesia with intravenous sedation. Intraoperative exploration revealed dense ossification causing jaw stiffness. Anesthetic dosage adjusted to ensure patient comfort and cooperation. Successful removal of the ectopic bone performed, followed by joint irrigation and closure. Postoperative pain control achieved through a combination of local anesthesia infiltration and systemic analgesics.

1. Myositis ossificans progressiva patient underwent surgical intervention for ectopic bone excision in the left hip with associated bone erosion. Intraoperative exploration revealed extensive ossification within the hip capsule and erosion of the adjacent femoral head. Careful dissection allowed for complete removal of the ectopic bone and debridement of eroded bone. Wound closed meticulously, and postoperative rehabilitation prescribed. Patient educated on weight-bearing restrictions and referred for physical therapy.

2. Surgical management of Myositis ossificans progressiva involved excision of ectopic bone in the right elbow with bone erosion. Intraoperative assessment revealed dense ossification encasing the joint and erosion of the radial head. Successful removal of the abnormal bone performed, followed by joint irrigation, debridement of eroded bone, and closure. Postoperative pain management tailored to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery.

3. A patient with Myositis ossificans progressiva underwent surgical intervention for ectopic bone removal in the cervical spine with bone erosion. Intraoperative exploration revealed extensive ossification compressing the spinal cord and erosion of adjacent vertebral bodies. Careful laminectomy and excision of ossifications performed, followed by wound closure. Postoperative pain management adjusted to address bone erosion-related symptoms. Patient referred for neurologic assessment and rehabilitation therapy.

4. Operative intervention was performed on a Myositis ossificans progressiva patient to remove ectopic bone in the right knee joint with associated bone erosion. Intraoperative exploration revealed significant ossification within the joint space and erosion of the tibial plateau. Joint debridement performed, followed by thorough irrigation, debridement of eroded bone, and closure. Postoperative pain control tailored to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery.

5. Myositis ossificans progressiva patient underwent surgical management for ectopic bone excision in the left shoulder with bone erosion. Intraoperative assessment revealed extensive bony growth adherent to the glenohumeral joint and erosion of the humeral head. Complete removal of the ossification performed, followed by joint irrigation, debridement of eroded bone, and closure. Postoperative pain management adjusted to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery.

6. A case of Myositis ossificans progressiva necessitated surgical intervention for ectopic bone removal in the patient's right ankle with bone erosion. Intraoperative findings showed dense calcification affecting the ankle joint and erosion of the talar bone. Excision of the ectopic bone performed, followed by thorough irrigation, debridement of eroded bone, and wound closure. Postoperative pain control tailored to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the thoracic spine with associated bone erosion. Intraoperative exploration revealed extensive ossification impinging on the spinal cord and erosion of adjacent vertebral bodies. Careful laminectomy and meticulous excision of ossifications performed, followed by wound closure. Postoperative pain management adjusted to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery and spinal stabilization.

8. Patient presented with Myositis ossificans progressiva affecting the muscles of the right forearm with bone erosion. Operative intervention involved excision of ectopic ossification and debridement of eroded bone to restore functional range of motion. Intraoperatively, dense calcifications were encountered, requiring careful dissection. Ectopic bone removed, eroded bone debrided, and the wound meticulously closed. Postoperative pain control tailored to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery.

9. A case of Myositis ossificans progressiva necessitated surgical intervention for the excision of ectopic bone in the lumbar spine with bone erosion. Intraoperative findings revealed extensive ossification compressing the nerve roots and erosion of adjacent vertebral bodies. Careful laminectomy and excision of ossifications performed, followed by wound closure. Postoperative pain management adjusted to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery and spinal stabilization.

10. Operative intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the right temporomandibular joint with bone erosion. Intraoperative exploration revealed dense ossification causing jaw stiffness and erosion of the condylar process. Successful removal of the ectopic bone performed, followed by joint irrigation, debridement of eroded bone, and closure. Postoperative pain management adjusted to address bone erosion-related symptoms. Rehabilitation initiated for functional recovery.

1. Myositis ossificans progressiva patient underwent surgical intervention for excision of ectopic bone in the left hip with severe bone pain. Intraoperative exploration revealed extensive ossification within the hip capsule causing impingement on surrounding structures. Careful dissection allowed for complete removal of the ectopic bone, providing relief from severe bone pain. Wound closed meticulously, and postoperative pain management tailored to address ongoing pain symptoms. Rehabilitation initiated for functional recovery.

2. Surgical management of Myositis ossificans progressiva involved excision of ectopic bone in the right elbow with severe bone pain. Intraoperative assessment revealed dense ossification encasing the joint, contributing to intense pain. Successful removal of the abnormal bone performed, followed by joint irrigation and closure. Postoperative pain control optimized to alleviate severe bone pain. Rehabilitation initiated for functional recovery and pain management.

3. A patient with Myositis ossificans progressiva underwent surgical intervention for ectopic bone removal in the cervical spine with severe bone pain. Intraoperative exploration revealed extensive ossification compressing the spinal cord, causing excruciating pain. Careful laminectomy and excision of ossifications performed, providing relief from severe bone pain. The wound closed meticulously, and postoperative pain management adjusted to address ongoing pain symptoms. Rehabilitation initiated for functional recovery and pain relief.

4. Operative intervention was performed on a Myositis ossificans progressiva patient to remove ectopic bone in the right knee joint with severe bone pain. Intraoperative exploration revealed significant ossification within the joint space, contributing to severe pain. Joint debridement performed, followed by thorough irrigation and closure. Postoperative pain control optimized to alleviate severe bone pain. Rehabilitation initiated for functional recovery and pain management.

5. Myositis ossificans progressiva patient underwent surgical management for ectopic bone excision in the left shoulder with severe bone pain. Intraoperative assessment revealed extensive bony growth adherent to the glenohumeral joint, causing intense pain. Complete removal of the ossification performed, followed by joint irrigation and closure. Postoperative pain control optimized to alleviate severe bone pain. Rehabilitation initiated for functional recovery and pain relief.

6. A case of Myositis ossificans progressiva necessitated surgical intervention for ectopic bone removal in the patient's right ankle with severe bone pain. Intraoperative findings showed dense calcification affecting the ankle joint, resulting in excruciating pain. Excision of the ectopic bone performed, followed by thorough irrigation and wound closure. Postoperative pain control optimized to alleviate severe bone pain. Rehabilitation initiated for functional recovery and pain management.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the thoracic spine with severe bone pain. Intraoperative exploration revealed extensive ossification impinging on the spinal cord, causing severe pain. Careful laminectomy and meticulous excision of ossifications performed, providing relief from severe bone pain. The wound closed meticulously, and postoperative pain management adjusted to address ongoing pain symptoms. Rehabilitation initiated for functional recovery and pain relief.

8. Patient presented with Myositis ossificans progressiva affecting the muscles of the right forearm with severe bone pain. Operative intervention involved excision of ectopic ossification to restore functional range of motion and alleviate severe bone pain. Intraoperatively, dense calcifications were encountered, requiring careful dissection. Ectopic bone removed, and the wound meticulously closed. Postoperative pain control optimized to address severe bone pain. Rehabilitation initiated for functional recovery and pain management.

9. A case of Myositis ossificans progressiva necessitated surgical intervention for the excision of ectopic bone in the lumbar spine with severe bone pain. Intraoperative findings revealed extensive ossification compressing the nerve roots, causing intense pain. Careful laminectomy and excision of ossifications performed, providing relief from severe bone pain. The wound closed meticulously, and postoperative pain management adjusted to address ongoing pain symptoms. Rehabilitation initiated for functional recovery and pain relief.

10. Operative intervention was performed on a patient with Myositis ossificans progressiva, targeting ectopic bone formation in the right temporomandibular joint with severe bone pain. Intraoperative exploration revealed dense ossification causing jaw stiffness and severe pain. Successful removal of the ectopic bone performed, followed by joint irrigation and closure. Postoperative pain control optimized to alleviate severe bone pain. Rehabilitation initiated for functional recovery and pain relief.

1. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the left hip joint. Intraoperative exploration revealed extensive ossification causing limited range of motion. Careful dissection allowed for successful excision of the abnormal bone, followed by joint irrigation and closure. Postoperative pain management initiated to optimize recovery. Patient referred for postoperative rehabilitation and physical therapy to restore hip function.

2. A surgical intervention was conducted on a patient with Myositis ossificans progressiva to address ectopic bone formation in the right elbow joint. Intraoperatively, dense calcification was encountered, leading to joint stiffness and pain. The surgical team carefully removed the ectopic bone, performed joint debridement, and closed the wound. Postoperative pain control and rehabilitation were initiated to aid in functional recovery and alleviate discomfort.

3. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the cervical spine. Intraoperative exploration revealed extensive ossification compressing the spinal cord. The surgical team performed laminectomy and meticulous excision of ossifications to alleviate neural compression. The wound was closed meticulously, and postoperative imaging confirmed decompression. Patient referred for postoperative rehabilitation and neurologic assessment.

4. A surgical intervention was conducted on a Myositis ossificans progressiva patient to address ectopic bone formation in the right knee joint. Intraoperatively, extensive ossification was encountered, causing pain and limited mobility. The surgical team successfully removed the ectopic bone, performed joint debridement, and closed the wound. Postoperative pain management and physical therapy were initiated to promote functional recovery and alleviate discomfort.

5. Surgical intervention was performed on a patient with Myositis ossificans progressiva to excise ectopic bone in the left shoulder joint. Intraoperative exploration revealed dense ossification adherent to the glenohumeral joint, causing pain and restricted movement. The surgical team carefully removed the abnormal bone, irrigated the joint, and closed the wound. Postoperative pain control and rehabilitation were initiated to restore shoulder function and alleviate discomfort.

6. A surgical intervention was conducted on a patient with Myositis ossificans progressiva to address ectopic bone formation in the right ankle joint. Intraoperatively, extensive calcification was found, leading to joint stiffness and pain. The surgical team successfully excised the ectopic bone, irrigated the joint, and closed the wound. Postoperative pain management and physical therapy were initiated to facilitate functional recovery and alleviate discomfort.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the thoracic spine. Intraoperative exploration revealed significant ossification impinging on the spinal cord, causing pain and neurological symptoms. The surgical team conducted laminectomy and meticulous excision of the ossifications to relieve neural compression. The wound was closed meticulously, and postoperative pain control and rehabilitation were initiated to optimize recovery and relieve discomfort.

8. A surgical intervention was conducted on a Myositis ossificans progressiva patient to address ectopic bone formation in the right forearm muscles. Intraoperatively, dense calcifications were encountered, leading to pain and functional impairment. The surgical team successfully excised the ectopic bone, closed the wound, and initiated postoperative pain management. Rehabilitation and physical therapy were recommended to promote functional recovery and alleviate discomfort.

9. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the lumbar spine. Intraoperative exploration revealed extensive ossification compressing the nerve roots and causing pain. The surgical team conducted laminectomy and excision of the ossifications, relieving neural compression. The wound was meticulously closed, and postoperative pain management and rehabilitation were initiated to optimize recovery and alleviate discomfort.

10. A surgical intervention was conducted on a patient with Myositis ossificans progressiva to address ectopic bone formation in the right temporomandibular joint. Intraoperatively, dense ossification was encountered, causing jaw stiffness and pain. The surgical team successfully removed the ectopic bone, irrigated the joint, and closed the wound. Postoperative pain control and rehabilitation were initiated to restore jaw function and alleviate discomfort.

1. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the left hip joint. The surgical team carefully excised the abnormal bone, followed by joint debridement and wound closure. Postoperative pain management and rehabilitation were initiated to promote functional recovery and alleviate discomfort. The patient was advised on weight-bearing restrictions and referred for physical therapy for hip rehabilitation.

2. A surgical intervention was conducted on a Myositis ossificans progressiva patient to address ectopic bone formation in the right elbow joint. The surgical team successfully excised the abnormal bone, performed joint debridement, and closed the wound. Postoperative pain control and rehabilitation were initiated to aid in functional recovery and alleviate discomfort. The patient was referred for occupational therapy to improve elbow function.

3. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the cervical spine. The surgical team conducted careful laminectomy and meticulous excision of ossifications to relieve neural compression. The wound was closed, and postoperative pain management and rehabilitation were initiated. The patient was referred for physical therapy and neurological assessment to monitor recovery and optimize spinal function.

4. A surgical intervention was conducted on a Myositis ossificans progressiva patient to address ectopic bone formation in the right knee joint. The surgical team successfully excised the abnormal bone, performed joint debridement, and closed the wound. Postoperative pain control and rehabilitation were initiated to promote functional recovery and alleviate discomfort. The patient was recommended for range-of-motion exercises and weight-bearing progression under supervision.

5. Surgical intervention was performed on a patient with Myositis ossificans progressiva to excise ectopic bone in the left shoulder joint. The surgical team meticulously removed the abnormal bone, irrigated the joint, and closed the wound. Postoperative pain management and rehabilitation were initiated to restore shoulder function and alleviate discomfort. The patient was advised on shoulder exercises and referred for physical therapy to improve range of motion and strength.

6. A surgical intervention was conducted on a Myositis ossificans progressiva patient to address ectopic bone formation in the right ankle joint. The surgical team successfully excised the abnormal bone, irrigated the joint, and closed the wound. Postoperative pain control and rehabilitation were initiated to facilitate functional recovery and alleviate discomfort. The patient was referred for ankle rehabilitation and gait training for proper mobility restoration.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the thoracic spine. The surgical team conducted laminectomy and meticulous excision of the ossifications, relieving neural compression. The wound was closed, and postoperative pain management and rehabilitation were initiated. The patient was advised on postoperative restrictions and referred for physical therapy to enhance spinal stability and regain functional mobility.

8. A surgical intervention was conducted on a Myositis ossificans progressiva patient to address ectopic bone formation in the muscles of the right forearm. The surgical team successfully excised the abnormal bone, closed the wound, and initiated postoperative pain management. Rehabilitation and physical therapy were recommended to optimize functional recovery and alleviate discomfort. The patient was advised on gradual return to activities of daily living and ergonomic modifications.

9. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the lumbar spine. The surgical team conducted laminectomy and excision of the ossifications, relieving neural compression. The wound was closed, and postoperative pain management and rehabilitation were initiated. The patient was referred for physical therapy and posture correction to improve spinal alignment and mitigate future complications.

10. A surgical intervention was conducted on a Myositis ossificans progressiva patient to address ectopic bone formation in the right temporomandibular joint. The surgical team successfully removed the abnormal bone, irrigated the joint, and closed the wound. Postoperative pain control and rehabilitation were initiated to restore jaw function and alleviate discomfort. The patient was referred for speech therapy and dental evaluation to assess and manage functional sequelae.

1. Urgent surgical intervention was performed on a patient with Myositis ossificans progressiva and a severe infection in the left hip joint. The surgical team performed thorough debridement, excision of necrotic tissue, and irrigation. Postoperative antibiotics were initiated, and wound care was optimized. Rehabilitation was delayed until infection resolution. Close monitoring of inflammatory markers and joint function was recommended for early detection of recurrent infections.

2. A surgical intervention was conducted on a Myositis ossificans progressiva patient with a severe infection in the right elbow joint. The surgical team performed joint debridement, irrigation, and thorough cleansing of the infected tissues. Intravenous antibiotics were administered postoperatively, and wound care was provided. Rehabilitation was temporarily deferred to allow for infection control. Serial joint aspirations and follow-up appointments were scheduled to monitor for recurrent infections.

3. Surgical intervention was performed on a patient with Myositis ossificans progressiva and a severe infection in the cervical spine. The surgical team conducted laminectomy, excision of infected tissue, and thorough irrigation. Intravenous antibiotics were initiated, and postoperative wound care was optimized. Due to the severe infection, rehabilitation was delayed until infection resolution. Close monitoring of neurologic function and imaging was recommended to assess treatment efficacy.

4. Urgent surgical intervention was conducted on a Myositis ossificans progressiva patient with a severe infection in the right knee joint. The surgical team performed extensive debridement, removal of infected tissues, and joint irrigation. Intravenous antibiotics were administered postoperatively, and wound care was meticulously provided. Rehabilitation was postponed until infection control was achieved. Close monitoring for signs of recurrent infection and joint stability was advised during follow-up visits.

5. Surgical intervention was performed on a patient with Myositis ossificans progressiva and a severe infection in the left shoulder joint. The surgical team conducted joint debridement, removal of infected tissue, and thorough irrigation. Intravenous antibiotics were initiated, and postoperative wound care was optimized. Rehabilitation was temporarily deferred to facilitate infection control. Regular follow-up visits were scheduled to monitor joint integrity and assess the resolution of infection.

6. Urgent surgical intervention was conducted on a Myositis ossificans progressiva patient with a severe infection in the right ankle joint. The surgical team performed debridement of infected tissue, thorough irrigation, and removal of necrotic material. Intravenous antibiotics were administered, and wound care was meticulously provided. Rehabilitation was postponed until infection resolution. Close monitoring for recurrent infections and joint stability was recommended during the follow-up period.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva and a severe infection in the thoracic spine. The surgical team conducted laminectomy, removal of infected tissue, and extensive irrigation. Intravenous antibiotics were initiated, and postoperative wound care was optimized. Rehabilitation was delayed until infection control was achieved. Close monitoring of neurologic function and imaging was advised to evaluate treatment response and prevent further complications.

8. Urgent surgical intervention was conducted on a Myositis ossificans progressiva patient with a severe infection in the right forearm muscles. The surgical team performed debridement of infected tissue, removal of necrotic material, and irrigation. Intravenous antibiotics were administered postoperatively, and wound care was provided. Rehabilitation was postponed until infection resolution. Serial monitoring of inflammatory markers and follow-up appointments were scheduled to ensure adequate healing.

9. Surgical intervention was performed on a patient with Myositis ossificans progressiva and a severe infection in the lumbar spine. The surgical team conducted laminectomy, removal of infected tissue, and meticulous irrigation. Intravenous antibiotics were initiated, and wound care was optimized. Rehabilitation was postponed until infection control was achieved. Close monitoring of neurologic function, imaging, and inflammatory markers was recommended during the follow-up period.

10. Urgent surgical intervention was conducted on a Myositis ossificans progressiva patient with a severe infection in the right temporomandibular joint. The surgical team performed debridement, removal of infected tissue, and thorough irrigation. Intravenous antibiotics were administered, and wound care was meticulously provided. Rehabilitation was temporarily deferred to facilitate infection control. Regular follow-up visits were scheduled to monitor joint function and assess the resolution of infection.

1. Surgical intervention was performed on a patient with Myositis ossificans progressiva and severe inflammation in the left hip joint. The surgical team carefully excised the abnormal bone, addressed the inflamed tissues, and closed the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to promote functional recovery and reduce inflammation. The patient was advised on pain management strategies and referred for physical therapy to improve hip mobility and alleviate discomfort.

2. A surgical intervention was conducted on a Myositis ossificans progressiva patient with significant inflammation in the right elbow joint. The surgical team successfully removed the ectopic bone, addressed the inflamed tissues, and closed the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to aid in functional recovery and reduce inflammation. The patient was referred for occupational therapy to improve elbow function and manage inflammation.

3. Surgical intervention was performed on a patient with Myositis ossificans progressiva to address severe inflammation in the cervical spine. The surgical team conducted laminectomy, excision of inflamed tissues, and meticulous closure of the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to promote recovery and reduce inflammation. The patient was referred for physical therapy and regular follow-up appointments to monitor inflammation and optimize spinal function.

4. A surgical intervention was conducted on a Myositis ossificans progressiva patient with intense inflammation in the right knee joint. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to facilitate functional recovery and alleviate inflammation. The patient was advised on joint protection measures and referred for physical therapy to manage inflammation and restore knee function.

5. Surgical intervention was performed on a patient with Myositis ossificans progressiva and persistent inflammation in the left shoulder joint. The surgical team meticulously removed the abnormal bone, addressed the inflamed tissues, and closed the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to restore shoulder function and reduce inflammation. The patient was advised on shoulder exercises and referred for physical therapy to manage inflammation and improve range of motion.

6. A surgical intervention was conducted on a Myositis ossificans progressiva patient with severe inflammation in the right ankle joint. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to promote functional recovery and alleviate inflammation. The patient was referred for ankle rehabilitation and exercises to manage inflammation and improve joint mobility.

7. Surgical intervention was performed on a patient with Myositis ossificans progressiva to remove ectopic bone in the lumbar spine, accompanied by significant inflammation. The surgical team conducted laminectomy, excision of inflamed tissues, and meticulous wound closure. Postoperative anti-inflammatory medications and rehabilitation were initiated to reduce inflammation and promote recovery. The patient was referred for physical therapy and lifestyle modifications to manage inflammation and improve spinal function.

8. A surgical intervention was conducted on a Myositis ossificans progressiva patient with pronounced inflammation in the right forearm muscles. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to alleviate inflammation and aid in functional recovery. The patient was advised on rest and proper joint positioning to manage inflammation and facilitate healing.

9. Surgical intervention was performed on a patient with Myositis ossificans progressiva to address severe inflammation in the thoracic spine. The surgical team conducted laminectomy, excision of inflamed tissues, and meticulous wound closure. Postoperative anti-inflammatory medications and rehabilitation were initiated to reduce inflammation and promote spinal recovery. The patient was referred for physical therapy and postoperative imaging to assess inflammation and monitor treatment efficacy.

10. A surgical intervention was conducted on a Myositis ossificans progressiva patient with significant inflammation in the right temporomandibular joint. The surgical team successfully removed the ectopic bone, addressed the inflamed tissues, and closed the wound. Postoperative anti-inflammatory medications and rehabilitation were initiated to manage inflammation and promote functional recovery. The patient was referred for speech therapy and dental evaluation to assess inflammation-related functional sequelae.

1. Surgical intervention was performed on a patient with severe Myositis ossificans progressiva in the left hip joint. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Postoperative follow-ups were scheduled based on the severity of the diagnosis, including regular imaging, monitoring of inflammatory markers, and physical therapy sessions. The patient was advised on pain management strategies and instructed to report any concerning symptoms for prompt evaluation.

2. A surgical intervention was conducted on a Myositis ossificans progressiva patient with moderate involvement in the right elbow joint. The surgical team meticulously removed the abnormal bone, addressed the inflamed tissues, and closed the wound. Follow-up appointments were recommended based on the severity of the diagnosis, including range-of-motion assessments, imaging as needed, and a personalized rehabilitation plan to optimize elbow function and monitor disease progression.

3. Surgical intervention was performed on a patient with mild Myositis ossificans progressiva in the cervical spine. The surgical team conducted laminectomy, excision of inflamed tissues, and meticulous closure of the wound. Follow-up visits were scheduled depending on the severity of the diagnosis, including regular neurological examinations, imaging, and physical therapy sessions to monitor spinal stability, manage symptoms, and provide appropriate interventions as required.

4. A surgical intervention was conducted on a Myositis ossificans progressiva patient with severe involvement in the right knee joint. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Follow-up appointments were scheduled based on the severity of the diagnosis, including regular joint assessments, imaging studies, and customized rehabilitation protocols to manage symptoms, optimize knee function, and monitor disease progression.

5. Surgical intervention was performed on a patient with moderate Myositis ossificans progressiva in the left shoulder joint. The surgical team meticulously removed the abnormal bone, addressed the inflamed tissues, and closed the wound. Follow-up visits were recommended depending on the severity of the diagnosis, including regular shoulder evaluations, imaging as needed, and a personalized rehabilitation plan to manage symptoms, improve range of motion, and monitor disease progression.

6. A surgical intervention was conducted on a Myositis ossificans progressiva patient with mild involvement in the right ankle joint. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Follow-up appointments were scheduled based on the severity of the diagnosis, including regular joint assessments, physical therapy sessions, and imaging studies to monitor ankle stability, manage symptoms, and provide necessary interventions as warranted.

7. Surgical intervention was performed on a patient with severe Myositis ossificans progressiva in the lumbar spine. The surgical team conducted laminectomy, excision of inflamed tissues, and meticulous wound closure. Follow-up visits were scheduled depending on the severity of the diagnosis, including regular neurological assessments, imaging studies, and physical therapy sessions to manage symptoms, monitor spinal stability, and provide appropriate interventions based on disease progression.

8. A surgical intervention was conducted on a Myositis ossificans progressiva patient with moderate involvement in the right forearm muscles. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Follow-up appointments were recommended based on the severity of the diagnosis, including regular assessments of joint function, imaging studies, and a personalized rehabilitation plan to manage symptoms, optimize forearm function, and monitor disease progression.

9. Surgical intervention was performed on a patient with mild Myositis ossificans progressiva in the thoracic spine. The surgical team conducted laminectomy, excision of inflamed tissues, and meticulous wound closure. Follow-up visits were scheduled depending on the severity of the diagnosis, including regular neurological examinations, imaging studies, and physical therapy sessions to manage symptoms, monitor spinal stability, and provide appropriate interventions based on disease progression.

10. A surgical intervention was conducted on a Myositis ossificans progressiva patient with severe involvement in the right temporomandibular joint. The surgical team successfully excised the ectopic bone, addressed the inflamed tissues, and closed the wound. Follow-up appointments were scheduled based on the severity of the diagnosis, including regular joint assessments, imaging studies, and referrals to speech therapy and dental evaluation to manage symptoms, monitor joint function, and address specific sequelae related to the condition.

## M61.2 Paralytic calcification and ossification of muscle

1. Patient presented with severe paralytic calcification and ossification of the right quadriceps muscle. Surgical intervention was performed to excise the calcified tissue and restore range of motion. Procedure was successful, and post-operative imaging confirmed removal of the calcified deposits.

2. Operative note: Patient underwent exploratory surgery for paralytic calcification and ossification of the left deltoid muscle. Extensive calcified masses were identified and meticulously excised, followed by thorough irrigation and wound closure. Post-operative X-rays revealed complete removal of the calcifications, and the patient's mobility improved significantly.

3. A case of paralytic calcification and ossification of the right pectoralis major muscle was surgically addressed. The calcified deposits were carefully dissected and excised, allowing for restoration of muscle function. The patient's post-operative recovery was uneventful, with improved range of motion observed during follow-up assessments.

4. Operative intervention was undertaken for paralytic calcification and ossification of the left gastrocnemius muscle. The calcified masses were meticulously removed, and the muscle tissue was repaired to enhance functionality. Post-operative examinations demonstrated successful removal of calcifications and significant improvement in the patient's ambulation.

5. Surgical management was performed to address paralytic calcification and ossification of the right biceps brachii muscle. The calcified deposits were excised, and the affected muscle was reconstructed to optimize range of motion. Post-operative evaluations revealed successful removal of calcifications and noticeable improvement in the patient's upper limb function.

6. Patient underwent surgery for paralytic calcification and ossification of the left hamstring muscles. The calcified masses were dissected and carefully removed, allowing for restoration of muscle flexibility. Post-operative imaging confirmed complete resection of calcifications, and the patient exhibited improved lower limb mobility during rehabilitation sessions.

7. Operative intervention was undertaken for paralytic calcification and ossification of the right trapezius muscle. The calcified deposits were meticulously excised, followed by thorough closure of the wound. Post-operative assessments revealed successful removal of the calcifications, resulting in improved shoulder movement and reduced pain for the patient.

8. A case of paralytic calcification and ossification of the left gluteus maximus muscle was surgically addressed. The calcified masses were carefully dissected and excised, followed by appropriate muscle reconstruction. Post-operative evaluations demonstrated complete removal of calcifications and significant improvement in the patient's hip function.

9. Surgical management was performed for paralytic calcification and ossification of the right latissimus dorsi muscle. The calcified deposits were meticulously removed, and the muscle tissue was repaired to optimize range of motion. Post-operative examinations revealed successful removal of calcifications and noticeable improvement in the patient's upper limb function.

10. Patient underwent surgery to address paralytic calcification and ossification of the left quadriceps muscle. The calcified masses were meticulously excised, followed by careful closure of the surgical site. Post-operative assessments confirmed successful removal of calcifications, leading to improved mobility and function of the affected limb.

1. Operative intervention was performed for paralytic calcification and ossification of the right soleus muscle. The calcified deposits were meticulously excised, followed by thorough irrigation and closure. Post-operative imaging confirmed successful removal of calcifications, and the patient experienced enhanced ankle mobility.

2. Patient underwent surgery to address paralytic calcification and ossification of the left rhomboid muscles. The calcified masses were carefully dissected and excised, allowing for restoration of muscle flexibility and improved shoulder function. Post-operative evaluations revealed successful removal of calcifications, with the patient experiencing reduced pain and increased range of motion.

3. A case of paralytic calcification and ossification of the right tibialis anterior muscle was surgically managed. The calcified masses were meticulously removed, and the muscle tissue was repaired to optimize dorsiflexion. Post-operative assessments demonstrated complete removal of calcifications and significant improvement in the patient's gait and lower limb function.

4. Surgical intervention was performed for paralytic calcification and ossification of the left serratus anterior muscle. The calcified deposits were excised, followed by meticulous closure. Post-operative evaluations revealed successful removal of calcifications, resulting in improved scapular movement and reduced discomfort for the patient.

5. Operative intervention was undertaken for paralytic calcification and ossification of the right gastrocnemius muscle. The calcified masses were carefully excised, followed by appropriate muscle reconstruction. Post-operative assessments revealed successful removal of calcifications, leading to improved ankle flexibility and reduced muscle stiffness.

6. Patient underwent surgery to address paralytic calcification and ossification of the left adductor magnus muscle. The calcified masses were meticulously dissected and excised, allowing for restoration of muscle function and improved hip mobility. Post-operative examinations confirmed successful removal of calcifications, and the patient exhibited enhanced range of motion.

7. A case of paralytic calcification and ossification of the right supraspinatus muscle was surgically managed. The calcified deposits were carefully excised, followed by meticulous closure. Post-operative evaluations demonstrated successful removal of calcifications, resulting in improved shoulder abduction and reduced pain for the patient.

8. Surgical intervention was performed for paralytic calcification and ossification of the left vastus lateralis muscle. The calcified masses were excised, followed by appropriate muscle repair. Post-operative assessments revealed successful removal of calcifications, leading to improved knee extension and enhanced lower limb function.

9. Operative intervention was undertaken for paralytic calcification and ossification of the right flexor hallucis longus muscle. The calcified deposits were meticulously excised, allowing for restoration of muscle flexibility and improved toe movement. Post-operative examinations confirmed successful removal of calcifications, and the patient experienced enhanced foot function.

10. Patient underwent surgery to address paralytic calcification and ossification of the left infraspinatus muscle. The calcified masses were carefully dissected and excised, followed by thorough irrigation and wound closure. Post-operative evaluations demonstrated successful removal of calcifications, resulting in improved shoulder external rotation and reduced discomfort for the patient.

1. Patient presented with severe paralytic calcification and ossification of the right quadriceps muscle. Under general anesthesia, the surgical team successfully excised the calcified tissue, utilizing adjusted dosages to ensure optimal pain management and patient comfort. Post-operative imaging confirmed complete removal of the calcifications.

2. Operative note: Patient underwent exploratory surgery for paralytic calcification and ossification of the left deltoid muscle. Local anesthesia with monitored sedation was administered to facilitate the meticulous excision of calcified masses. The patient tolerated the procedure well, and post-operative imaging demonstrated successful removal of the calcifications.

3. A case of paralytic calcification and ossification of the right pectoralis major muscle was surgically addressed. The surgical team employed regional anesthesia to minimize systemic effects while ensuring adequate pain control. The patient remained stable throughout the procedure, and post-operative examinations revealed complete removal of calcifications.

4. Operative intervention was undertaken for paralytic calcification and ossification of the left gastrocnemius muscle. Balanced anesthesia with adjusted dosages was administered to maintain optimal anesthesia depth and pain relief. The procedure was uneventful, and post-operative evaluations confirmed successful removal of calcifications.

5. Surgical management was performed to address paralytic calcification and ossification of the right biceps brachii muscle. The anesthesia team carefully titrated the medication doses to achieve a balanced level of sedation and analgesia. Post-operative assessments revealed successful removal of calcifications, and the patient experienced improved upper limb function.

6. Patient underwent surgery for paralytic calcification and ossification of the left hamstring muscles. The anesthesia plan included a combination of general anesthesia and regional nerve blocks to ensure effective pain control. Post-operative imaging confirmed complete removal of calcifications, and the patient exhibited improved lower limb mobility.

7. Operative intervention was performed for paralytic calcification and ossification of the right trapezius muscle. The anesthesia dosage was adjusted based on the patient's individual needs, taking into account factors such as age and medical history. Post-operative assessments revealed successful removal of calcifications and improved shoulder movement.

8. A case of paralytic calcification and ossification of the left gluteus maximus muscle was surgically addressed. The anesthesia team employed a multimodal approach, combining general anesthesia, regional nerve blocks, and adjunctive analgesics. Post-operative evaluations demonstrated complete removal of calcifications and significant improvement in hip function.

9. Surgical management was performed for paralytic calcification and ossification of the right latissimus dorsi muscle. The anesthesia dosage was carefully tailored to the patient's requirements, ensuring optimal pain control and minimizing side effects. Post-operative examinations revealed successful removal of calcifications and noticeable improvement in upper limb function.

10. Patient underwent surgery to address paralytic calcification and ossification of the left quadriceps muscle. The anesthesia team employed a balanced anesthesia technique, adjusting the dosages of medications throughout the procedure to maintain an appropriate level of anesthesia and analgesia. Post-operative assessments confirmed successful removal of calcifications, leading to improved mobility and muscle function.

1. Patient presented with severe paralytic calcification, ossification of the right quadriceps muscle, and bone erosion of the femur. The surgical team performed a complex procedure involving excision of calcified tissue, reconstruction of the muscle, and bone grafting to address the bone erosion. Post-operative imaging confirmed successful removal of calcifications and stabilization of the affected bone.

2. Operative note: Patient underwent exploratory surgery for paralytic calcification and ossification of the left deltoid muscle with concurrent bone erosion of the humerus. The surgical team meticulously excised the calcified masses, performed debridement of the eroded bone, and applied bone grafts for stabilization. Post-operative imaging demonstrated resolution of calcifications and improved bone integrity.

3. A case of paralytic calcification, ossification of the right pectoralis major muscle, and bone erosion of the sternum was surgically addressed. The surgical team excised the calcified masses, reconstructed the muscle, and performed bone grafting to restore stability to the eroded sternum. Post-operative examinations revealed successful removal of calcifications and improved bone structure.

4. Operative intervention was undertaken for paralytic calcification, ossification of the left gastrocnemius muscle, and bone erosion of the tibia. The surgical team excised the calcifications, repaired the muscle, and performed bone grafting to address the bone erosion. Post-operative assessments confirmed resolution of calcifications and improved bone integrity.

5. Surgical management was performed to address paralytic calcification, ossification of the right biceps brachii muscle, and bone erosion of the humerus. The surgical team meticulously excised the calcified masses, performed debridement of the eroded bone, and applied bone grafts to promote bone healing. Post-operative evaluations revealed successful removal of calcifications and improved bone stability.

6. Patient underwent surgery for paralytic calcification, ossification of the left hamstring muscles, and bone erosion of the femur. The surgical team excised the calcified masses, reconstructed the muscle, and performed bone grafting to address the bone erosion. Post-operative imaging confirmed successful removal of calcifications and improved bone integrity.

7. Operative intervention was performed for paralytic calcification, ossification of the right trapezius muscle, and bone erosion of the scapula. The surgical team excised the calcified masses, reconstructed the muscle, and performed bone grafting to stabilize the eroded scapula. Post-operative assessments revealed successful removal of calcifications and improved bone structure.

8. A case of paralytic calcification, ossification of the left gluteus maximus muscle, and bone erosion of the pelvis was surgically managed. The surgical team excised the calcified masses, reconstructed the muscle, and performed bone grafting to address the bone erosion. Post-operative examinations demonstrated successful removal of calcifications and improved bone integrity.

9. Surgical management was performed to address paralytic calcification, ossification of the right latissimus dorsi muscle, and bone erosion of the humerus. The surgical team excised the calcified masses, reconstructed the muscle, and performed bone grafting to stabilize the eroded humerus. Post-operative evaluations revealed successful removal of calcifications and improved bone structure.

10. Patient underwent surgery to address paralytic calcification, ossification of the left quadriceps muscle, and bone erosion of the femur. The surgical team excised the calcified masses, reconstructed the muscle, and performed bone grafting to address the bone erosion. Post-operative assessments confirmed successful removal of calcifications, improved muscle function, and stabilization of the eroded bone.

1. Patient presented with severe paralytic calcification, ossification of the right quadriceps muscle, bone erosion of the femur, and debilitating bone pain. The surgical team performed a comprehensive procedure involving excision of calcified tissue, bone debridement, and bone grafting to address the pain and stabilize the eroded bone. Post-operative assessments revealed significant reduction in bone pain and improved bone integrity.

2. Operative note: Patient underwent exploratory surgery for paralytic calcification, ossification of the left deltoid muscle, bone erosion of the humerus, and intractable bone pain. The surgical team meticulously excised the calcified masses, performed debridement of the eroded bone, and applied bone grafts to alleviate the severe bone pain and restore bone stability. Post-operative evaluations demonstrated marked relief from bone pain.

3. A case of paralytic calcification, ossification of the right pectoralis major muscle, bone erosion of the sternum, and excruciating bone pain was surgically addressed. The surgical team excised the calcified masses, performed bone debridement, and applied bone grafts to alleviate the severe bone pain and stabilize the eroded sternum. Post-operative examinations revealed substantial reduction in bone pain and improved bone structure.

4. Operative intervention was undertaken for paralytic calcification, ossification of the left gastrocnemius muscle, bone erosion of the tibia, and severe bone pain. The surgical team excised the calcifications, repaired the muscle, debrided the eroded bone, and performed bone grafting to address the severe bone pain and improve bone integrity. Post-operative assessments confirmed significant alleviation of bone pain.

5. Surgical management was performed to address paralytic calcification, ossification of the right biceps brachii muscle, bone erosion of the humerus, and severe bone pain. The surgical team meticulously excised the calcified masses, performed debridement of the eroded bone, and applied bone grafts to alleviate the excruciating bone pain and promote bone healing. Post-operative evaluations revealed remarkable reduction in bone pain.

6. Patient underwent surgery for paralytic calcification, ossification of the left hamstring muscles, bone erosion of the femur, and severe bone pain. The surgical team excised the calcified masses, reconstructed the muscle, debrided the eroded bone, and performed bone grafting to address the severe bone pain and stabilize the eroded femur. Post-operative imaging confirmed significant reduction in bone pain and improved bone integrity.

7. Operative intervention was performed for paralytic calcification, ossification of the right trapezius muscle, bone erosion of the scapula, and excruciating bone pain. The surgical team excised the calcified masses, reconstructed the muscle, debrided the eroded bone, and performed bone grafting to alleviate the severe bone pain and stabilize the eroded scapula. Post-operative assessments revealed marked relief from bone pain.

8. A case of paralytic calcification, ossification of the left gluteus maximus muscle, bone erosion of the pelvis, and severe bone pain was surgically managed. The surgical team excised the calcified masses, reconstructed the muscle, debrided the eroded bone, and performed bone grafting to address the severe bone pain and stabilize the eroded pelvis. Post-operative examinations demonstrated significant alleviation of bone pain.

9. Surgical management was performed to address paralytic calcification, ossification of the right latissimus dorsi muscle, bone erosion of the humerus, and severe bone pain. The surgical team excised the calcified masses, reconstructed the muscle, debrided the eroded bone, and performed bone grafting to alleviate the severe bone pain and improve bone structure. Post-operative evaluations revealed remarkable reduction in bone pain.

10. Patient underwent surgery to address paralytic calcification, ossification of the left quadriceps muscle, bone erosion of the femur, and debilitating bone pain. The surgical team excised the calcified masses, reconstructed the muscle, debrided the eroded bone, and performed bone grafting to alleviate the severe bone pain and stabilize the eroded femur. Post-operative assessments confirmed significant alleviation of bone pain and improved bone integrity.

1. Surgical intervention was performed to address severe paralytic calcification, ossification of the right quadriceps muscle, extensive bone erosion of the femur, and associated complications. The surgical team meticulously excised the calcified masses, performed extensive bone debridement, and utilized bone grafts to restore bone integrity. The procedure resulted in improved pain management and enhanced functional outcomes for the patient.

2. Operative note: Patient underwent an extensive surgical intervention for paralytic calcification, ossification of the left deltoid muscle, significant bone erosion of the humerus, and recurrent severe pain. The surgical team skillfully excised the calcified masses, performed meticulous bone debridement, and employed bone grafting techniques to address bone erosion. The procedure led to significant pain reduction and improved shoulder function.

3. A complex surgical intervention was undertaken to address paralytic calcification, ossification of the right pectoralis major muscle, extensive bone erosion of the sternum, and debilitating bone pain. The surgical team meticulously excised the calcifications, performed thorough debridement of the eroded bone, and utilized bone grafts to stabilize the sternum. The procedure resulted in remarkable relief from bone pain and improved bone stability.

4. Surgical intervention was performed to address paralytic calcification, ossification of the left gastrocnemius muscle, extensive bone erosion of the tibia, and severe bone pain. The surgical team skillfully excised the calcified masses, performed meticulous bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved lower limb function.

5. A comprehensive surgical intervention was undertaken to address paralytic calcification, ossification of the right biceps brachii muscle, extensive bone erosion of the humerus, and debilitating bone pain. The surgical team meticulously excised the calcified masses, performed extensive bone debridement, and utilized bone grafts to stabilize the eroded humerus. The procedure resulted in remarkable relief from bone pain and improved upper limb function.

6. Surgical intervention was performed to address paralytic calcification, ossification of the left hamstring muscles, extensive bone erosion of the femur, and severe bone pain. The surgical team skillfully excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved lower limb function.

7. A complex surgical intervention was undertaken to address paralytic calcification, ossification of the right trapezius muscle, extensive bone erosion of the scapula, and debilitating bone pain. The surgical team meticulously excised the calcified masses, performed extensive bone debridement, and utilized bone grafts to stabilize the eroded scapula. The procedure resulted in remarkable relief from bone pain and improved shoulder function.

8. Surgical intervention was performed to address paralytic calcification, ossification of the left gluteus maximus muscle, extensive bone erosion of the pelvis, and severe bone pain. The surgical team skillfully excised the calcified masses, performed meticulous bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved pelvic stability.

9. A comprehensive surgical intervention was undertaken to address paralytic calcification, ossification of the right latissimus dorsi muscle, extensive bone erosion of the humerus, and debilitating bone pain. The surgical team meticulously excised the calcified masses, performed thorough bone debridement, and utilized bone grafts to stabilize the eroded humerus. The procedure resulted in remarkable relief from bone pain and improved upper limb function.

10. Surgical intervention was performed to address paralytic calcification, ossification of the left quadriceps muscle, extensive bone erosion of the femur, and severe bone pain. The surgical team skillfully excised the calcified masses, performed meticulous bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved lower limb function.

1. A surgical intervention was performed to address severe paralytic calcification, extensive ossification of the right triceps muscle, significant bone erosion of the humerus, and debilitating bone pain. The surgical team skillfully excised the calcified masses, performed thorough bone debridement, and utilized bone grafts to restore bone integrity. The procedure resulted in substantial pain relief and improved range of motion.

2. Operative note: Patient underwent a complex surgical intervention for paralytic calcification, ossification of the left quadratus lumborum muscle, extensive bone erosion of the lumbar spine, and recurrent severe pain. The surgical team meticulously excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion. The procedure led to significant pain reduction and improved spinal stability.

3. A comprehensive surgical intervention was undertaken to address paralytic calcification, ossification of the right adductor muscles, extensive bone erosion of the pelvis, and debilitating bone pain. The surgical team skillfully excised the calcifications, performed meticulous bone debridement, and utilized bone grafts to stabilize the eroded pelvic bones. The procedure resulted in remarkable relief from bone pain and improved pelvic stability.

4. Surgical intervention was performed to address paralytic calcification, ossification of the left rhomboid muscles, extensive bone erosion of the scapula, and severe bone pain. The surgical team skillfully excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved shoulder function.

5. A complex surgical intervention was undertaken to address paralytic calcification, ossification of the right gastrocnemius muscle, extensive bone erosion of the tibia, and debilitating bone pain. The surgical team meticulously excised the calcified masses, performed extensive bone debridement, and utilized bone grafts to stabilize the eroded tibia. The procedure resulted in remarkable relief from bone pain and improved lower limb function.

6. Surgical intervention was performed to address paralytic calcification, ossification of the left trapezius muscle, extensive bone erosion of the scapula, and severe bone pain. The surgical team skillfully excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved shoulder function.

7. A comprehensive surgical intervention was undertaken to address paralytic calcification, ossification of the right gluteus maximus muscle, extensive bone erosion of the sacrum, and debilitating bone pain. The surgical team skillfully excised the calcified masses, performed meticulous bone debridement, and utilized bone grafts to stabilize the eroded sacrum. The procedure resulted in remarkable relief from bone pain and improved pelvic stability.

8. Surgical intervention was performed to address paralytic calcification, ossification of the left latissimus dorsi muscle, extensive bone erosion of the humerus, and severe bone pain. The surgical team skillfully excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved upper limb function.

9. A complex surgical intervention was undertaken to address paralytic calcification, ossification of the right quadriceps muscle, extensive bone erosion of the femur, and debilitating bone pain. The surgical team meticulously excised the calcified masses, performed extensive bone debridement, and utilized bone grafts to stabilize the eroded femur. The procedure resulted in remarkable relief from bone pain and improved lower limb function.

10. Surgical intervention was performed to address paralytic calcification, ossification of the left hamstring muscles, extensive bone erosion of the femur, and severe bone pain. The surgical team skillfully excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion and alleviate pain. The procedure led to significant reduction in bone pain and improved lower limb function.

1. Surgical intervention was urgently performed due to severe infection on the extreme moving joint, in addition to paralytic calcification, ossification of the right hip adductor muscles, extensive bone erosion of the femur, and debilitating bone pain. The surgical team excised the infected tissues, debrided the eroded bone, and employed bone grafts to stabilize the affected joint. The procedure aimed to address both the infection and underlying musculoskeletal pathologies.

2. Operative note: Patient presented with a severe infection on the extreme moving joint, accompanied by paralytic calcification, ossification of the left rotator cuff muscles, bone erosion of the humerus, and recurrent severe pain. The surgical team promptly addressed the infection, excised the calcified masses, performed extensive bone debridement, and utilized bone grafts to restore bone integrity and eliminate the infection.

3. A complex surgical intervention was undertaken to address severe infection on the extreme moving joint, in addition to paralytic calcification, ossification of the right patellar muscles, extensive bone erosion of the patella, and debilitating bone pain. The surgical team meticulously excised the infected tissues, performed thorough bone debridement, and utilized bone grafts to stabilize the eroded patella. The procedure aimed to eradicate the infection and restore joint function.

4. Surgical intervention was performed to address a severe infection on the extreme moving joint, along with paralytic calcification, ossification of the left ankle flexor muscles, bone erosion of the tibia, and severe bone pain. The surgical team meticulously excised the infected tissues, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion and eradicate the infection, aiming to restore joint stability and alleviate pain.

5. A comprehensive surgical intervention was undertaken to address severe infection on the extreme moving joint, accompanied by paralytic calcification, ossification of the right elbow extensor muscles, bone erosion of the humerus, and debilitating bone pain. The surgical team excised the infected tissues, performed extensive bone debridement, and utilized bone grafts to stabilize the eroded humerus. The procedure aimed to eliminate the infection and improve joint functionality.

6. Surgical intervention was performed to address severe infection on the extreme moving joint, in addition to paralytic calcification, ossification of the left quadriceps muscles, bone erosion of the femur, and severe bone pain. The surgical team promptly addressed the infection, excised the calcified masses, performed thorough bone debridement, and employed bone grafts to stabilize the affected joint. The procedure aimed to eliminate the infection and improve bone integrity.

7. A complex surgical intervention was undertaken to address severe infection on the extreme moving joint, accompanied by paralytic calcification, ossification of the right shoulder muscles, bone erosion of the humerus, and recurrent severe pain. The surgical team meticulously excised the infected tissues, performed extensive bone debridement, and utilized bone grafts to restore bone integrity and eradicate the infection.

8. Surgical intervention was performed to address a severe infection on the extreme moving joint, along with paralytic calcification, ossification of the left knee flexor muscles, bone erosion of the tibia, and debilitating bone pain. The surgical team promptly addressed the infection, excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to address bone erosion and eradicate the infection, aiming to restore joint stability and alleviate pain.

9. A comprehensive surgical intervention was undertaken to address severe infection on the extreme moving joint, accompanied by paralytic calcification, ossification of the right wrist flexor muscles, bone erosion of the radius, and debilitating bone pain. The surgical team excised the infected tissues, performed extensive bone debridement, and utilized bone grafts to stabilize the eroded radius. The procedure aimed to eliminate the infection and improve joint functionality.

10. Surgical intervention was performed to address severe infection on the extreme moving joint, in addition to paralytic calcification, ossification of the left hip abductor muscles, bone erosion of the femur, and severe bone pain. The surgical team promptly addressed the infection, excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to stabilize the affected joint. The procedure aimed to eliminate the infection and improve bone integrity.

1. Surgical intervention was performed to address severe inflammation, paralytic calcification, ossification of the right quadriceps muscle, extensive bone erosion of the femur, and debilitating bone pain. The surgical team excised the calcified masses, performed thorough bone debridement, and utilized bone grafts to stabilize the eroded femur. The procedure aimed to alleviate inflammation, restore bone integrity, and improve functional outcomes.

2. Operative note: Patient presented with intense inflammation, paralytic calcification, ossification of the left shoulder muscles, bone erosion of the humerus, and recurrent severe pain. The surgical team promptly addressed the inflammation, excised the calcified masses, performed extensive bone debridement, and utilized bone grafting techniques to restore bone integrity and alleviate symptoms.

3. A comprehensive surgical intervention was undertaken to address moderate inflammation, paralytic calcification, ossification of the right gluteus maximus muscle, extensive bone erosion of the pelvis, and debilitating bone pain. The surgical team meticulously excised the calcified masses, performed thorough bone debridement, and employed bone grafts to stabilize the eroded pelvic bones. The procedure aimed to reduce inflammation, alleviate pain, and restore pelvic stability.

4. Surgical intervention was performed to address mild inflammation, paralytic calcification, ossification of the left hamstring muscles, extensive bone erosion of the femur, and severe bone pain. The surgical team excised the calcified masses, performed meticulous bone debridement, and utilized bone grafting techniques to stabilize the eroded femur. The procedure aimed to relieve inflammation, improve bone integrity, and alleviate pain.

5. A complex surgical intervention was undertaken to address severe inflammation, paralytic calcification, ossification of the right trapezius muscle, extensive bone erosion of the scapula, and debilitating bone pain. The surgical team skillfully excised the calcified masses, performed extensive bone debridement, and utilized bone grafts to stabilize the eroded scapula. The procedure aimed to reduce inflammation, alleviate pain, and improve shoulder function.

6. Surgical intervention was performed to address moderate inflammation, paralytic calcification, ossification of the left quadriceps muscle, extensive bone erosion of the femur, and severe bone pain. The surgical team excised the calcified masses, performed thorough bone debridement, and employed bone grafting techniques to stabilize the eroded femur. The procedure aimed to alleviate inflammation, improve bone integrity, and reduce pain.

7. A comprehensive surgical intervention was undertaken to address mild inflammation, paralytic calcification, ossification of the right hamstring muscles, extensive bone erosion of the tibia, and debilitating bone pain. The surgical team meticulously excised the calcified masses, performed meticulous bone debridement, and utilized bone grafts to stabilize the eroded tibia. The procedure aimed to reduce inflammation, alleviate pain, and improve lower limb function.

8. Surgical intervention was performed to address severe inflammation, paralytic calcification, ossification of the left latissimus dorsi muscle, extensive bone erosion of the humerus, and severe bone pain. The surgical team excised the calcified masses, performed thorough bone debridement, and utilized bone grafting techniques to stabilize the eroded humerus. The procedure aimed to relieve inflammation, improve bone integrity, and reduce pain.

9. A complex surgical intervention was undertaken to address moderate inflammation, paralytic calcification, ossification of the right quadriceps muscle, extensive bone erosion of the femur, and debilitating bone pain. The surgical team skillfully excised the calcified masses, performed extensive bone debridement, and employed bone grafts to stabilize the eroded femur. The procedure aimed to alleviate inflammation, improve bone integrity, and reduce pain.

10. Surgical intervention was performed to address mild inflammation, paralytic calcification, ossification of the left trapezius muscle, extensive bone erosion of the scapula, and severe bone pain. The surgical team excised the calcified masses, performed meticulous bone debridement, and utilized bone grafting techniques to stabilize the eroded scapula. The procedure aimed to relieve inflammation, improve bone integrity, and reduce pain.

1. The patient underwent surgical intervention for severe paralytic calcification, ossification of the right quadriceps muscle, extensive bone erosion of the femur, and debilitating bone pain. Postoperative follow-ups will include regular imaging to assess bone healing, pain management evaluation, and physical therapy sessions to optimize functional recovery.

2. Operative note: The surgical team addressed moderate paralytic calcification, ossification of the left rotator cuff muscles, bone erosion of the humerus, and recurrent severe pain. Follow-up appointments will involve monitoring for signs of infection, range of motion assessments, and collaboration with pain management specialists for ongoing pain control.

3. A comprehensive surgical intervention was performed to address mild paralytic calcification, ossification of the right hip adductor muscles, bone erosion of the femur, and moderate bone pain. Postoperative follow-ups will include regular physical examinations, imaging to assess healing progress, and gradual rehabilitation programs to restore muscle strength and joint mobility.

4. Surgical intervention was performed to address severe paralytic calcification, ossification of the left quadriceps muscle, extensive bone erosion of the patella, and severe bone pain. Follow-up visits will involve regular wound assessments, monitoring for signs of infection, pain management adjustments, and physical therapy sessions to enhance knee function.

5. A complex surgical intervention was undertaken for moderate paralytic calcification, ossification of the right hamstring muscles, bone erosion of the tibia, and debilitating bone pain. Follow-up care will include close monitoring of surgical site healing, evaluation of pain management strategies, and gradual progression of weight-bearing activities based on radiographic findings.

6. Surgical intervention was performed to address mild paralytic calcification, ossification of the left shoulder muscles, bone erosion of the humerus, and severe bone pain. Postoperative follow-ups will include regular assessments of shoulder range of motion, monitoring for signs of infection, and collaboration with physical therapists to optimize functional recovery.

7. A comprehensive surgical intervention was performed to address severe paralytic calcification, ossification of the right gluteus maximus muscle, extensive bone erosion of the sacrum, and debilitating bone pain. Follow-up appointments will involve monitoring for signs of neurological deficits, evaluation of pain management effectiveness, and progressive rehabilitation exercises to enhance pelvic stability.

8. Surgical intervention was performed to address moderate paralytic calcification, ossification of the left latissimus dorsi muscle, extensive bone erosion of the humerus, and moderate bone pain. Follow-up care will include radiographic assessments to evaluate bone healing, range of motion evaluations, and collaboration with pain specialists for optimal pain control.

9. A complex surgical intervention was undertaken to address mild paralytic calcification, ossification of the right quadriceps muscle, bone erosion of the femur, and severe bone pain. Postoperative follow-ups will include regular wound care, pain management assessments, and tailored physical therapy programs to enhance functional recovery and reduce pain.

10. Surgical intervention was performed to address severe paralytic calcification, ossification of the left hamstring muscles, extensive bone erosion of the tibia, and debilitating bone pain. Follow-up visits will involve regular imaging to monitor bone healing, assessment of pain levels, and adjustment of rehabilitation protocols based on functional improvements.

## M61.3 Calcification and ossification of muscles associated with burns

Operative Note 1: Patient presented with extensive muscle calcification and ossification following burn injuries. A longitudinal incision was made to expose the affected muscles. Calcified and ossified tissues were carefully excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. Postoperative care included immobilization and physical therapy.

Operative Note 2: Intraoperatively, multiple muscles showed calcification and ossification due to burn injuries. A medial approach was chosen to access the affected muscles. Calcified and ossified tissues were meticulously debrided. Hemostasis was achieved using electrocautery, and the wound was closed. The patient was advised on postoperative rehabilitation to optimize muscle functionality.

Operative Note 3: Surgical intervention was performed to address severe muscle calcification and ossification secondary to burns. A transverse incision was made to expose the affected muscle group. Extensive excision of calcified and ossified tissues was performed. Hemostasis was ensured, and layered closure was done. Postoperative management involved splinting and physical therapy.

Operative Note 4: During the operation, deep muscle calcification and ossification related to burn injuries were identified. An oblique incision was made, providing optimal access to the affected muscles. Thorough debridement of calcified and ossified tissues was carried out. Hemostasis was achieved, and the wound was closed in layers. Postoperatively, the patient was referred for rehabilitation.

Operative Note 5: Surgical intervention was undertaken to address burn-related muscle calcification and ossification. An anterolateral approach was used to expose the affected muscles. Careful excision of calcified and ossified tissues was performed. Hemostasis was achieved using bipolar cautery, and the wound was closed meticulously. Postoperative instructions included immobilization and progressive muscle rehabilitation.

Operative Note 6: Intraoperatively, extensive muscle calcification and ossification were observed in relation to burn injuries. A posterior approach was employed to access the affected muscles. Thorough debridement of calcified and ossified tissues was performed meticulously. Hemostasis was obtained, and layered closure was executed. Postoperatively, the patient was referred for physical therapy to restore muscle function.

Operative Note 7: The surgical procedure aimed to address burn-induced muscle calcification and ossification. A paramedian incision was made, allowing access to the affected muscles. Careful excision of calcified and ossified tissues was performed, ensuring complete removal. Hemostasis was achieved, and layered closure was conducted. Postoperatively, the patient was advised on immobilization and prescribed rehabilitative exercises.

Operative Note 8: During the operation, muscle calcification and ossification secondary to burns were identified. An infraumbilical transverse incision was made to expose the affected muscles. Thorough excision of calcified and ossified tissues was carried out. Hemostasis was obtained, and layered closure was performed. The patient was referred for postoperative physical therapy and functional restoration.

Operative Note 9: Surgical intervention was performed to address burn-related muscle calcification and ossification. A midline incision was made, allowing access to the affected muscles. Extensive debridement of calcified and ossified tissues was carried out meticulously. Hemostasis was achieved using electrocautery, and the wound was closed layer by layer. Postoperatively, immobilization and physical therapy were recommended.

Operative Note 10: Intraoperatively, severe muscle calcification and ossification due to burns were encountered. A paramedian approach was chosen to access the affected muscles. Careful excision of calcified and ossified tissues was performed, ensuring wide margins. Hemostasis was achieved, and layered closure was executed. Postoperative management included splinting and referral for rehabilitative therapy.

Operative Note 11: The surgical procedure was conducted to address extensive muscle calcification and ossification associated with burn injuries. A curvilinear incision was made, providing adequate exposure to the affected muscles. Thorough excision of calcified and ossified tissues was performed meticulously. Hemostasis was achieved, and layered closure was done. The patient was advised on postoperative immobilization and prescribed a comprehensive rehabilitation program.

Operative Note 12: Intraoperatively, significant muscle calcification and ossification were observed secondary to burn injuries. A lateral approach was employed to access the affected muscles. Excision of calcified and ossified tissues was meticulously performed, ensuring complete removal. Hemostasis was achieved using a combination of sutures and electrocautery, followed by layered closure. Postoperatively, the patient was scheduled for specialized physical therapy to restore muscle function.

Operative Note 13: Surgical intervention was carried out to address burn-related muscle calcification and ossification. An oblique incision was made, providing optimal exposure to the affected muscle group. Thorough debridement of calcified and ossified tissues was performed meticulously. Hemostasis was achieved using clips and bipolar cautery, followed by layered closure. The patient was instructed on postoperative immobilization and referred for tailored rehabilitation.

Operative Note 14: During the operation, extensive muscle calcification and ossification were identified in relation to burn injuries. A midline vertical incision was made, allowing access to the affected muscles. Careful excision of calcified and ossified tissues was carried out, ensuring complete clearance. Hemostasis was achieved using a combination of hemostatic agents and sutures. Postoperatively, the patient was recommended a customized physical therapy regimen.

Operative Note 15: Surgical intervention was performed to address burn-induced muscle calcification and ossification. A modified transverse incision was made, providing excellent exposure to the affected muscles. Thorough excision of calcified and ossified tissues was meticulously performed. Hemostasis was achieved using electrocautery and meticulous surgical technique. The wound was closed in layers, and the patient was referred for postoperative rehabilitation to optimize muscle functionality.

Operative Note 16: Intraoperatively, significant muscle calcification and ossification secondary to burns were encountered. An inverted "T" incision was made, allowing access to the affected muscles. Careful excision of calcified and ossified tissues was performed, ensuring wide margins. Hemostasis was achieved using a combination of electrocautery and hemostatic agents. Postoperatively, the patient was prescribed immobilization and a structured physical therapy program.

Operative Note 17: The surgical procedure aimed to address burn-related muscle calcification and ossification. An infraclavicular incision was made, providing access to the affected muscles. Thorough excision of calcified and ossified tissues was carried out meticulously. Hemostasis was achieved using bipolar cautery, and the wound was closed layer by layer. The patient was advised on postoperative immobilization and referred for a comprehensive rehabilitative program.

Operative Note 18: During the operation, extensive muscle calcification and ossification were observed secondary to burn injuries. A subcostal incision was made to expose the affected muscles. Excision of calcified and ossified tissues was performed meticulously, ensuring complete removal. Hemostasis was achieved using a combination of sutures and electrocautery. Postoperatively, the patient was scheduled for specialized physical therapy to optimize muscle recovery.

Operative Note 19: Surgical intervention was performed to address burn-related muscle calcification and ossification. A paravertebral approach was chosen to access the affected muscles. Careful excision of calcified and ossified tissues was performed, ensuring wide clearance. Hemostasis was achieved using clips and bipolar cautery, followed by layered closure. The patient was instructed on postoperative immobilization and referred for tailored rehabilitative therapy.

Operative Note 20: Intraoperatively, severe muscle calcification and ossification due to burns were encountered. A transabdominal incision was made, providing optimal exposure to the affected muscles. Thorough debridement of calcified and ossified tissues was carried out meticulously. Hemostasis was achieved using a combination of sutures and electrocautery, followed by layered closure. Postoperatively, the patient was scheduled for intensive physical therapy to restore muscle function.

Operative Note 21: The patient presented with extensive muscle calcification and ossification following burn injuries. Under general anesthesia, a longitudinal incision was made to expose the affected muscles. Calcified and ossified tissues were carefully excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well under appropriate anesthesia dosage.

Operative Note 22: Intraoperatively, multiple muscles showed calcification and ossification due to burn injuries. An appropriate dosage of regional anesthesia was administered. A medial approach was chosen to access the affected muscles. Calcified and ossified tissues were meticulously debrided. Hemostasis was achieved, and the wound was closed. The patient remained stable throughout the procedure.

Operative Note 23: Surgical intervention was performed to address severe muscle calcification and ossification secondary to burns. The patient received general anesthesia with adjusted dosages. A transverse incision was made to expose the affected muscle group. Extensive excision of calcified and ossified tissues was performed. Hemostasis was achieved, and layered closure was done. The patient recovered smoothly from anesthesia.

Operative Note 24: During the operation, deep muscle calcification and ossification related to burn injuries were identified. An appropriate dosage of combined regional and general anesthesia was administered. An oblique incision was made to access the affected muscles. Thorough debridement of calcified and ossified tissues was carried out. Hemostasis was achieved, and the wound was closed in layers. The patient's vital signs remained stable under monitored anesthesia care.

Operative Note 25: Surgical intervention was undertaken to address burn-related muscle calcification and ossification. The patient received general anesthesia with adjusted dosages. A posterior approach was employed to access the affected muscles. Thorough debridement of calcified and ossified tissues was performed meticulously. Hemostasis was obtained, and layered closure was executed. The patient recovered smoothly from anesthesia without complications.

Operative Note 26: Intraoperatively, extensive muscle calcification and ossification were observed in relation to burn injuries. The patient received appropriate dosages of regional anesthesia. An anterolateral approach was used to expose the affected muscles. Careful excision of calcified and ossified tissues was performed. Hemostasis was achieved, and the wound was closed meticulously. The patient remained hemodynamically stable throughout the procedure.

Operative Note 27: The surgical procedure aimed to address burn-induced muscle calcification and ossification. The patient received general anesthesia with adjusted dosages. A paramedian incision was made, allowing access to the affected muscles. Careful excision of calcified and ossified tissues was performed, ensuring complete removal. Hemostasis was achieved, and layered closure was conducted. The patient recovered well from anesthesia.

Operative Note 28: During the operation, muscle calcification and ossification secondary to burns were identified. The patient received a tailored dosage of regional anesthesia. An infraumbilical transverse incision was made to expose the affected muscles. Thorough excision of calcified and ossified tissues was carried out. Hemostasis was obtained, and layered closure was performed. The patient's vital signs were stable throughout the procedure.

Operative Note 29: Surgical intervention was performed to address burn-related muscle calcification and ossification. The patient received general anesthesia with adjusted dosages. A midline incision was made, allowing access to the affected muscles. Extensive debridement of calcified and ossified tissues was carried out meticulously. Hemostasis was achieved, and the wound was closed layer by layer. The patient recovered smoothly from anesthesia.

Operative Note 30: Intraoperatively, significant muscle calcification and ossification were encountered due to burn injuries. The patient received appropriate dosages of regional anesthesia. An inverted "T" incision was made to expose the affected muscles. Careful excision of calcified and ossified tissues was carried out, ensuring wide margins. Hemostasis was achieved, and layered closure was performed. The patient remained comfortable throughout the procedure.

Operative Note 31: The patient presented with muscle calcification, ossification, and bone erosion due to severe burn injuries. Under general anesthesia, a longitudinal incision was made to expose the affected area. Extensive excision of calcified, ossified, and eroded tissues was performed. Bone grafting was done to restore structural integrity. Hemostasis was achieved, and the wound was closed meticulously. The patient tolerated the procedure well under appropriate anesthesia dosage.

Operative Note 32: Intraoperatively, extensive muscle calcification, ossification, and bone erosion were observed in relation to burn injuries. An appropriate dosage of regional anesthesia was administered. A medial approach was chosen to access the affected area. Thorough debridement of calcified, ossified, and eroded tissues was performed. Bone grafts were utilized to reconstruct the eroded bone. The patient remained stable throughout the procedure.

Operative Note 33: Surgical intervention was performed to address severe muscle calcification, ossification, and bone erosion secondary to burns. The patient received general anesthesia with adjusted dosages. A transverse incision was made to expose the affected area. Extensive excision of calcified, ossified, and eroded tissues was performed meticulously. Bone grafting was done to reconstruct the eroded bone. The patient recovered smoothly from anesthesia.

Operative Note 34: During the operation, deep muscle calcification, ossification, and bone erosion related to burn injuries were identified. An appropriate dosage of combined regional and general anesthesia was administered. An oblique incision was made to access the affected area. Thorough debridement of calcified, ossified, and eroded tissues was carried out. Bone grafts were utilized to restore the eroded bone structure. The patient's vital signs remained stable under monitored anesthesia care.

Operative Note 35: Surgical intervention was undertaken to address burn-related muscle calcification, ossification, and bone erosion. The patient received general anesthesia with adjusted dosages. A posterior approach was employed to access the affected area. Thorough debridement of calcified, ossified, and eroded tissues was performed meticulously. Bone grafting was done to reconstruct the eroded bone. The patient recovered smoothly from anesthesia without complications.

Operative Note 36: Intraoperatively, extensive muscle calcification, ossification, and bone erosion were observed in relation to burn injuries. The patient received appropriate dosages of regional anesthesia. An anterolateral approach was used to expose the affected area. Careful excision of calcified, ossified, and eroded tissues was performed. Bone grafts were utilized to reconstruct the eroded bone. The patient remained hemodynamically stable throughout the procedure.

Operative Note 37: The surgical procedure aimed to address burn-induced muscle calcification, ossification, and bone erosion. The patient received general anesthesia with adjusted dosages. A paramedian incision was made, allowing access to the affected area. Careful excision of calcified, ossified, and eroded tissues was performed, ensuring complete removal. Bone grafting was done to reconstruct the eroded bone. The patient recovered well from anesthesia.

Operative Note 38: During the operation, muscle calcification, ossification, and bone erosion secondary to burns were identified. The patient received a tailored dosage of regional anesthesia. An infraumbilical transverse incision was made to expose the affected area. Thorough excision of calcified, ossified, and eroded tissues was carried out. Bone grafting was done to reconstruct the eroded bone. Hemostasis was obtained, and layered closure was performed. The patient's vital signs were stable throughout the procedure.

Operative Note 39: Surgical intervention was performed to address burn-related muscle calcification, ossification, and bone erosion. The patient received general anesthesia with adjusted dosages. A midline incision was made, allowing access to the affected area. Extensive debridement of calcified, ossified, and eroded tissues was carried out meticulously. Bone grafting was done to reconstruct the eroded bone. Hemostasis was achieved, and the wound was closed layer by layer. The patient recovered smoothly from anesthesia.

Operative Note 40: Intraoperatively, significant muscle calcification, ossification, and bone erosion were encountered due to burn injuries. The patient received appropriate dosages of regional anesthesia. An inverted "T" incision was made to expose the affected area. Careful excision of calcified, ossified, and eroded tissues was carried out, ensuring wide margins. Bone grafts were utilized to reconstruct the eroded bone. Hemostasis was achieved, and layered closure was performed. The patient remained comfortable throughout the procedure.

Operative Note 41: The patient presented with severe muscle calcification, ossification, bone erosion, and debilitating bone pain resulting from burn injuries. Under general anesthesia, a longitudinal incision was made to expose the affected area. Thorough excision of calcified, ossified, and eroded tissues was performed, alleviating the source of bone pain. Bone grafting and stabilization were conducted to restore structural integrity. The patient tolerated the procedure well under appropriate anesthesia dosage, and postoperative pain management was initiated.

Operative Note 42: Intraoperatively, extensive muscle calcification, ossification, bone erosion, and severe bone pain were observed in relation to burn injuries. An appropriate dosage of regional anesthesia was administered. A medial approach was chosen to access the affected area. Meticulous debridement of calcified, ossified, and eroded tissues was performed to alleviate bone pain. Bone grafting and fixation were employed to reconstruct the eroded bone. The patient remained stable throughout the procedure.

Operative Note 43: Surgical intervention was performed to address severe muscle calcification, ossification, bone erosion, and intractable bone pain secondary to burns. The patient received general anesthesia with adjusted dosages. A transverse incision was made to expose the affected area. Thorough excision of calcified, ossified, and eroded tissues was carried out meticulously, providing relief from bone pain. Bone grafting and stabilization were performed to restore bone integrity. The patient recovered smoothly from anesthesia.

Operative Note 44: During the operation, deep muscle calcification, ossification, bone erosion, and severe bone pain related to burn injuries were identified. An appropriate dosage of combined regional and general anesthesia was administered. An oblique incision was made to access the affected area. Meticulous debridement of calcified, ossified, and eroded tissues was performed to alleviate bone pain. Bone grafting and fixation were utilized to reconstruct the eroded bone. The patient's vital signs remained stable under monitored anesthesia care.

Operative Note 45: Surgical intervention was undertaken to address burn-related muscle calcification, ossification, bone erosion, and severe bone pain. The patient received general anesthesia with adjusted dosages. A posterior approach was employed to access the affected area. Thorough debridement of calcified, ossified, and eroded tissues was meticulously performed, relieving the patient from debilitating bone pain. Bone grafting and stabilization were implemented to reconstruct the eroded bone. The patient recovered smoothly from anesthesia without complications.

Operative Note 46: Intraoperatively, extensive muscle calcification, ossification, bone erosion, and severe bone pain were observed in relation to burn injuries. The patient received appropriate dosages of regional anesthesia. An anterolateral approach was used to expose the affected area. Careful excision of calcified, ossified, and eroded tissues was performed to alleviate bone pain. Bone grafting and fixation were employed to reconstruct the eroded bone. The patient remained hemodynamically stable throughout the procedure.

Operative Note 47: The surgical procedure aimed to address burn-induced muscle calcification, ossification, bone erosion, and severe bone pain. The patient received general anesthesia with adjusted dosages. A paramedian incision was made, allowing access to the affected area. Careful excision of calcified, ossified, and eroded tissues was performed to relieve bone pain. Bone grafting and stabilization were conducted to restore the eroded bone. The patient recovered well from anesthesia.

Operative Note 48: During the operation, muscle calcification, ossification, bone erosion, and severe bone pain secondary to burns were identified. The patient received a tailored dosage of regional anesthesia. An infraumbilical transverse incision was made to expose the affected area. Thorough excision of calcified, ossified, and eroded tissues was carried out to alleviate bone pain. Bone grafting and reconstruction were performed to restore the eroded bone. Hemostasis was obtained, and layered closure was performed. The patient's vital signs were stable throughout the procedure.

Operative Note 49: Surgical intervention was performed to address burn-related muscle calcification, ossification, bone erosion, and severe bone pain. The patient received general anesthesia with adjusted dosages. A midline incision was made, allowing access to the affected area. Extensive debridement of calcified, ossified, and eroded tissues was carried out meticulously, providing relief from bone pain. Bone grafting and stabilization were conducted to restore the eroded bone. The patient recovered smoothly from anesthesia.

Operative Note 50: Intraoperatively, significant muscle calcification, ossification, bone erosion, and severe bone pain were encountered due to burn injuries. The patient received appropriate dosages of regional anesthesia. An inverted "T" incision was made to expose the affected area. Careful excision of calcified, ossified, and eroded tissues was carried out, ensuring wide margins and relieving bone pain. Bone grafts and fixation were utilized to reconstruct the eroded bone. Hemostasis was achieved, and layered closure was performed. The patient remained comfortable throughout the procedure.

Operative Note 51: A surgical intervention was performed to address extensive muscle calcification, ossification, bone erosion, severe bone pain, and functional impairment resulting from burn injuries. The patient received general anesthesia with adjusted dosages. An appropriate incision was made, providing access to the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously performed. Bone grafting, stabilization, and soft tissue reconstruction were carried out. The patient's condition improved postoperatively, and physical therapy was initiated to restore functionality.

Operative Note 52: During the surgical intervention, the patient's muscle calcification, ossification, bone erosion, severe bone pain, and limited range of motion due to burns were addressed. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to expose the affected area. Careful debridement of calcified, ossified, and eroded tissues was performed. Bone grafting, stabilization, and tissue release were conducted. The patient's symptoms improved postoperatively, and rehabilitation measures were implemented.

Operative Note 53: Surgical intervention was carried out to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional disability related to burn injuries. The procedure was performed under general anesthesia with appropriate dosages. An incision was made to access the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously executed. Bone grafting, stabilization, and soft tissue reconstruction were performed to enhance functionality. The patient showed positive outcomes postoperatively.

Operative Note 54: The surgical intervention aimed to address the patient's extensive muscle calcification, ossification, bone erosion, severe bone pain, and impaired mobility caused by burn injuries. Under general anesthesia with adjusted dosages, an incision was made to expose the affected area. Meticulous debridement of calcified, ossified, and eroded tissues was carried out. Bone grafting, stabilization, and soft tissue reconstruction were performed to alleviate symptoms and improve functionality. The patient's condition improved postoperatively.

Operative Note 55: Surgical intervention was performed to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional limitations resulting from burns. The procedure was conducted under general anesthesia with tailored dosages. An appropriate incision was made, providing access to the affected area. Careful excision of calcified, ossified, and eroded tissues was performed. Bone grafting, stabilization, and soft tissue release were carried out to improve functionality. The patient's symptoms improved following the intervention.

Operative Note 56: During the surgical intervention, extensive muscle calcification, ossification, bone erosion, severe bone pain, and functional impairment were addressed. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to expose the affected area. Thorough debridement of calcified, ossified, and eroded tissues was meticulously carried out. Bone grafting, stabilization, and soft tissue reconstruction were performed to enhance functionality. The patient showed improvement postoperatively.

Operative Note 57: Surgical intervention was undertaken to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and limited mobility associated with burn injuries. Under general anesthesia with appropriate dosages, an incision was made to access the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously performed. Bone grafting, stabilization, and soft tissue reconstruction were conducted to improve functionality. The patient's symptoms and mobility significantly improved postoperatively.

Operative Note 58: The surgical intervention aimed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional disability due to burn injuries. Under general anesthesia with adjusted dosages, an incision was made to expose the affected area. Meticulous debridement of calcified, ossified, and eroded tissues was performed. Bone grafting, stabilization, and soft tissue reconstruction were executed to enhance functionality. The patient showed favorable outcomes following the intervention.

Operative Note 59: Surgical intervention was performed to manage the patient's extensive muscle calcification, ossification, bone erosion, severe bone pain, and impaired function resulting from burn injuries. The procedure was carried out under general anesthesia with tailored dosages. An appropriate incision was made to access the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously executed. Bone grafting, stabilization, and soft tissue reconstruction were performed to alleviate symptoms and restore functionality. The patient's condition improved postoperatively.

Operative Note 60: During the surgical intervention, the patient's muscle calcification, ossification, bone erosion, severe bone pain, and limited range of motion were addressed. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to expose the affected area. Careful debridement of calcified, ossified, and eroded tissues was carried out. Bone grafting, stabilization, and soft tissue release were conducted to improve functionality. The patient experienced significant improvement postoperatively.

Operative Note 61: A surgical intervention was performed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional impairment resulting from burn injuries. Under general anesthesia with adjusted dosages, an incision was made to access the affected area. Thorough debridement of calcified, ossified, and eroded tissues was meticulously performed. Bone grafting, stabilization, and soft tissue reconstruction were carried out to restore functionality. The patient's condition improved postoperatively, and appropriate pain management was initiated.

Operative Note 62: Surgical intervention was carried out to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional disability associated with burn injuries. The procedure was performed under general anesthesia with tailored dosages. An incision was made to expose the affected area. Careful excision of calcified, ossified, and eroded tissues was performed. Bone grafting, stabilization, and soft tissue reconstruction were executed to alleviate symptoms and improve functionality. The patient's condition improved postoperatively.

Operative Note 63: During the surgical intervention, extensive muscle calcification, ossification, bone erosion, severe bone pain, and functional impairment were addressed. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to expose the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously carried out. Bone grafting, stabilization, and soft tissue reconstruction were performed to restore functionality. The patient showed significant improvement postoperatively.

Operative Note 64: Surgical intervention was performed to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and limited mobility caused by burn injuries. The procedure was conducted under general anesthesia with adjusted dosages. An appropriate incision was made, providing access to the affected area. Careful debridement of calcified, ossified, and eroded tissues was performed. Bone grafting, stabilization, and soft tissue reconstruction were carried out to alleviate symptoms and improve functionality. The patient's condition improved postoperatively.

Operative Note 65: The surgical intervention aimed to address the patient's extensive muscle calcification, ossification, bone erosion, severe bone pain, and functional disability due to burn injuries. Under general anesthesia with appropriate dosages, an incision was made to access the affected area. Meticulous debridement of calcified, ossified, and eroded tissues was performed. Bone grafting, stabilization, and soft tissue release were conducted to restore functionality. The patient showed favorable outcomes postoperatively.

Operative Note 66: Surgical intervention was undertaken to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and limited mobility associated with burn injuries. Under general anesthesia with adjusted dosages, an incision was made to access the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously performed. Bone grafting, stabilization, and soft tissue reconstruction were conducted to improve functionality. The patient's symptoms and mobility significantly improved postoperatively.

Operative Note 67: The surgical intervention aimed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional impairment related to burn injuries. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to expose the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously performed. Bone grafting, stabilization, and soft tissue reconstruction were carried out to restore functionality. The patient's condition improved postoperatively.

Operative Note 68: During the surgical intervention, the patient's muscle calcification, ossification, bone erosion, severe bone pain, and limited range of motion were addressed. The procedure was performed under general anesthesia with tailored dosages. An incision was made to access the affected area. Careful debridement of calcified, ossified, and eroded tissues was carried out. Bone grafting, stabilization, and soft tissue release were conducted to improve functionality. The patient experienced significant improvement postoperatively.

Operative Note 69: Surgical intervention was performed to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional limitations resulting from burn injuries. Under general anesthesia with appropriate dosages, an incision was made to expose the affected area. Thorough excision of calcified, ossified, and eroded tissues was meticulously performed. Bone grafting, stabilization, and soft tissue reconstruction were conducted to restore functionality. The patient's symptoms and mobility significantly improved following the intervention.

Operative Note 70: The surgical intervention aimed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and functional impairment caused by burn injuries. Under general anesthesia with adjusted dosages, an incision was made to access the affected area. Meticulous debridement of calcified, ossified, and eroded tissues was performed. Bone grafting, stabilization, and soft tissue reconstruction were executed to alleviate symptoms and improve functionality. The patient's condition improved postoperatively.

Operative Note 71: A surgical intervention was performed to address the patient's severe infection on the extreme moving joint, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain resulting from burn injuries. Under general anesthesia with adjusted dosages, an incision was made to access the affected area. Thorough debridement of infected tissues, along with excision of calcified, ossified, and eroded tissues, was meticulously carried out. Antibiotic irrigation and soft tissue reconstruction were performed to control the infection and restore joint function.

Operative Note 72: Surgical intervention was undertaken to manage the patient's severe infection on the extreme moving joint, in addition to muscle calcification, ossification, bone erosion, and severe bone pain related to burn injuries. The procedure was performed under general anesthesia with tailored dosages. An incision was made to expose the affected area. Thorough debridement of infected tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was performed. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were carried out to address the infection and alleviate symptoms.

Operative Note 73: During the surgical intervention, the patient's severe infection on the extreme moving joint, along with muscle calcification, ossification, bone erosion, and severe bone pain, were addressed. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to access the affected area. Meticulous debridement of infected tissues, as well as thorough excision of calcified, ossified, and eroded tissues, was carried out. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were performed to control the infection and relieve symptoms.

Operative Note 74: Surgical intervention was carried out to manage the patient's severe infection on the extreme moving joint, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain due to burn injuries. Under general anesthesia with adjusted dosages, an appropriate incision was made, providing access to the affected area. Thorough debridement of infected tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was performed. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were executed to address the infection and alleviate symptoms.

Operative Note 75: The surgical intervention aimed to address the patient's severe infection on the extreme moving joint, along with muscle calcification, ossification, bone erosion, and severe bone pain resulting from burn injuries. Under general anesthesia with appropriate dosages, an incision was made to access the affected area. Thorough debridement of infected tissues, as well as careful excision of calcified, ossified, and eroded tissues, was performed. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were carried out to control the infection and alleviate symptoms.

Operative Note 76: Surgical intervention was performed to manage the patient's severe infection on the extreme moving joint, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain related to burn injuries. The procedure was conducted under general anesthesia with tailored dosages. An incision was made to expose the affected area. Meticulous debridement of infected tissues, along with thorough excision of calcified, ossified, and eroded tissues, was performed. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were executed to control the infection and alleviate symptoms.

Operative Note 77: During the surgical intervention, extensive debridement of infected tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was performed to address the patient's severe infection on the extreme moving joint. Additionally, muscle calcification, ossification, bone erosion, and severe bone pain related to burn injuries were managed. The procedure was performed under general anesthesia with adjusted dosages. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were carried out to control the infection and improve joint function.

Operative Note 78: Surgical intervention was undertaken to manage the patient's severe infection on the extreme moving joint, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain due to burn injuries. Under general anesthesia with adjusted dosages, an incision was made to access the affected area. Thorough debridement of infected tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was performed. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were executed to address the infection and alleviate symptoms.

Operative Note 79: The surgical intervention aimed to address the patient's severe infection on the extreme moving joint, along with muscle calcification, ossification, bone erosion, and severe bone pain resulting from burn injuries. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to access the affected area. Thorough debridement of infected tissues, as well as careful excision of calcified, ossified, and eroded tissues, was carried out. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were performed to control the infection and improve joint functionality.

Operative Note 80: During the surgical intervention, the patient's severe infection on the extreme moving joint, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain, was addressed. The procedure was performed under general anesthesia with tailored dosages. An incision was made to expose the affected area. Thorough debridement of infected tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was meticulously carried out. Antibiotic irrigation, bone grafting, and soft tissue reconstruction were executed to control the infection and relieve symptoms.

Operative Note 81: A surgical intervention was performed to address the patient's severe inflammation, muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint resulting from burn injuries. Under general anesthesia with adjusted dosages, an incision was made to access the affected area. Thorough debridement of inflamed tissues, along with excision of calcified, ossified, and eroded tissues, was meticulously carried out. Anti-inflammatory measures, including medication and local treatments, were implemented to control inflammation and improve joint function.

Operative Note 82: Surgical intervention was undertaken to manage the patient's severe inflammation, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint due to burn injuries. The procedure was performed under general anesthesia with tailored dosages. An incision was made to expose the affected area. Meticulous debridement of inflamed tissues, as well as thorough excision of calcified, ossified, and eroded tissues, was performed. Anti-inflammatory interventions, including medication and local therapies, were employed to reduce inflammation and alleviate symptoms.

Operative Note 83: During the surgical intervention, the patient's severe inflammation, muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint were addressed. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to access the affected area. Careful debridement of inflamed tissues, along with meticulous excision of calcified, ossified, and eroded tissues, was carried out. Anti-inflammatory measures, such as medication and localized treatments, were utilized to control inflammation and promote joint healing.

Operative Note 84: Surgical intervention was carried out to manage the patient's severe inflammation, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint related to burn injuries. Under general anesthesia with adjusted dosages, an appropriate incision was made, providing access to the affected area. Thorough debridement of inflamed tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was performed. Anti-inflammatory interventions, including medication and local therapies, were implemented to reduce inflammation and alleviate symptoms.

Operative Note 85: The surgical intervention aimed to address the patient's severe inflammation, muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint resulting from burn injuries. Under general anesthesia with appropriate dosages, an incision was made to access the affected area. Meticulous debridement of inflamed tissues, along with careful excision of calcified, ossified, and eroded tissues, was performed. Anti-inflammatory interventions, including medication and localized treatments, were employed to control inflammation and facilitate joint recovery.

Operative Note 86: Surgical intervention was performed to manage the patient's severe inflammation, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint due to burn injuries. The procedure was conducted under general anesthesia with tailored dosages. An incision was made to expose the affected area. Thorough debridement of inflamed tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was executed. Anti-inflammatory measures, including medication and local therapies, were implemented to reduce inflammation and alleviate symptoms.

Operative Note 87: During the surgical intervention, extensive debridement of inflamed tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was performed to address the patient's severe inflammation on the extreme moving joint. Additionally, muscle calcification, ossification, bone erosion, and severe bone pain related to burn injuries were managed. The procedure was performed under general anesthesia with adjusted dosages. Anti-inflammatory interventions, including medication and localized treatments, were employed to control inflammation and promote joint healing.

Operative Note 88: Surgical intervention was undertaken to manage the patient's severe inflammation, accompanied by muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint resulting from burn injuries. Under general anesthesia with tailored dosages, an incision was made to access the affected area. Thorough debridement of inflamed tissues, as well as meticulous excision of calcified, ossified, and eroded tissues, was performed. Anti-inflammatory measures, including medication and local therapies, were utilized to reduce inflammation and alleviate symptoms.

Operative Note 89: The surgical intervention aimed to address the patient's severe inflammation, muscle calcification, ossification, bone erosion, and severe bone pain on the extreme moving joint due to burn injuries. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to access the affected area. Thorough debridement of inflamed tissues, as well as careful excision of calcified, ossified, and eroded tissues, was carried out. Anti-inflammatory interventions, including medication and localized treatments, were implemented to control inflammation and facilitate joint recovery.

Operative Note 90: During the surgical intervention, the patient's severe inflammation, muscle calcification, ossification, bone erosion, and severe bone pain were addressed on the extreme moving joint. The procedure was performed under general anesthesia with tailored dosages. An incision was made to expose the affected area. Meticulous debridement of inflamed tissues, along with thorough excision of calcified, ossified, and eroded tissues, was carried out. Anti-inflammatory interventions, including medication and local therapies, were employed to control inflammation and promote joint healing.

Operative Note 91: A surgical intervention was performed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and associated complications resulting from burn injuries. The severity of the diagnosis will determine the course of follow-up care. The procedure was performed under general anesthesia with tailored dosages. Thorough debridement of affected tissues, bone grafting, and soft tissue reconstruction were carried out. Postoperative monitoring and rehabilitation will be tailored to the patient's specific needs.

Operative Note 92: Surgical intervention was undertaken to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and accompanying complications due to burn injuries. The severity of the diagnosis will guide the postoperative follow-up plan. Under general anesthesia with adjusted dosages, an incision was made to access the affected area. Meticulous debridement of affected tissues, bone grafting, stabilization, and soft tissue release were performed. Close monitoring and targeted rehabilitation will be implemented based on the severity of the condition.

Operative Note 93: During the surgical intervention, the patient's muscle calcification, ossification, bone erosion, severe bone pain, and associated complications were addressed. The severity of the diagnosis will dictate the postoperative follow-up strategy. The procedure was performed under general anesthesia with tailored dosages. An incision was made to access the affected area, followed by thorough debridement, bone grafting, stabilization, and soft tissue reconstruction. The patient's progress and treatment plan will be adjusted accordingly.

Operative Note 94: Surgical intervention was carried out to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and associated complications related to burn injuries. The postoperative follow-up approach will be determined by the severity of the diagnosis. Under general anesthesia with adjusted dosages, an appropriate incision was made to expose the affected area. Meticulous debridement, bone grafting, stabilization, and soft tissue reconstruction were performed. The patient's recovery plan and rehabilitation will be tailored based on the severity of the condition.

Operative Note 95: The surgical intervention aimed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and accompanying complications resulting from burn injuries. The severity of the diagnosis will guide the postoperative follow-up plan. Under general anesthesia with appropriate dosages, an incision was made to access the affected area. Thorough debridement, bone grafting, stabilization, and soft tissue reconstruction were carried out. Individualized monitoring and rehabilitation protocols will be implemented based on the severity of the patient's condition.

Operative Note 96: Surgical intervention was performed to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and associated complications due to burn injuries. The postoperative follow-up will be tailored based on the severity of the diagnosis. The procedure was conducted under general anesthesia with tailored dosages. An incision was made to expose the affected area, followed by thorough debridement, bone grafting, stabilization, and soft tissue reconstruction. The patient's progress and treatment plan will be adjusted according to the severity of the condition.

Operative Note 97: During the surgical intervention, extensive debridement of affected tissues, bone grafting, stabilization, and soft tissue reconstruction were performed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and accompanying complications. The severity of the diagnosis will determine the postoperative follow-up plan. The procedure was performed under general anesthesia with adjusted dosages. Monitoring, rehabilitation, and further interventions will be individualized based on the severity of the patient's condition.

Operative Note 98: Surgical intervention was undertaken to manage the patient's muscle calcification, ossification, bone erosion, severe bone pain, and associated complications resulting from burn injuries. The postoperative follow-up strategy will be tailored based on the severity of the diagnosis. Under general anesthesia with tailored dosages, an incision was made to access the affected area. Meticulous debridement of affected tissues, bone grafting, stabilization, and soft tissue reconstruction were performed. The patient's progress and treatment plan will be adjusted according to the severity of the condition.

Operative Note 99: The surgical intervention aimed to address the patient's muscle calcification, ossification, bone erosion, severe bone pain, and accompanying complications due to burn injuries. The postoperative follow-up plan will be determined based on the severity of the diagnosis. The procedure was performed under general anesthesia with tailored dosages. An incision was made to access the affected area, followed by thorough debridement, bone grafting, stabilization, and soft tissue reconstruction. Individualized monitoring, rehabilitation, and further interventions will be implemented according to the severity of the patient's condition.

Operative Note 100: During the surgical intervention, the patient's muscle calcification, ossification, bone erosion, severe bone pain, and associated complications were addressed. The severity of the diagnosis will dictate the postoperative follow-up approach. The procedure was performed under general anesthesia with adjusted dosages. An incision was made to access the affected area, followed by meticulous debridement, bone grafting, stabilization, and soft tissue reconstruction. The patient's progress and treatment plan will be tailored based on the severity of the condition.

## M61.4 Other calcification of muscle

Operative Note: Patient underwent excision of other calcification of muscle. An incision was made over the affected muscle, and dissection was performed to expose the calcified area. The calcifications were carefully removed using surgical instruments. Hemostasis was achieved, and the wound was closed in layers. The specimen was sent for pathological examination.

Operative Note: Surgical intervention was carried out for other calcification of muscle. A longitudinal incision was made over the affected muscle, and careful dissection was performed to expose the calcified region. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. Specimen retrieval was done for further evaluation.

Operative Note: The patient underwent excisional surgery for other muscle calcification. An incision was made along the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were excised using sharp dissection, ensuring thorough removal. Hemostasis was achieved, and the wound was closed with interrupted sutures. The excised specimen was sent for histopathological analysis.

Operative Note: Excision of other calcification of muscle was performed. A transverse incision was made over the affected muscle, and careful dissection was done to visualize the calcified region. The calcifications were excised using a combination of sharp and blunt dissection. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination.

Operative Note: Surgical excision was carried out for other muscle calcification. A curvilinear incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were carefully dissected and removed. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for histopathological evaluation.

Operative Note: Patient underwent excisional surgery for other calcification of muscle. An elliptical incision was made over the affected muscle, and careful dissection was performed to expose the calcified region. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for further analysis.

Operative Note: Excision of other calcification of muscle was performed. A midline incision was made over the affected muscle, and meticulous dissection was done to visualize the calcified area. The calcifications were excised using sharp dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination.

Operative Note: Surgical intervention was carried out for other muscle calcification. A transverse elliptical incision was made over the affected muscle, and careful dissection was performed to expose the calcified region. The calcifications were carefully dissected and removed. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for histopathological evaluation.

Operative Note: Patient underwent excisional surgery for other calcification of muscle. A curved incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for further analysis.

Operative Note: Excision of other calcification of muscle was performed. A longitudinal incision was made over the affected muscle, and careful dissection was done to visualize the calcified area. The calcifications were excised using sharp dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination.

Operative Note: The patient underwent surgical excision for other calcification of muscle. A transverse curvilinear incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were carefully dissected and removed using sharp and blunt dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised specimen was sent for histopathological evaluation.

Operative Note: Excisional surgery was performed for other muscle calcification. An inverted "L" incision was made over the affected muscle, and meticulous dissection was carried out to visualize the calcified region. The calcifications were excised using a combination of sharp and blunt dissection. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for further analysis.

Operative Note: The patient underwent excision of other calcification of muscle. A paramedian incision was made over the affected muscle, and careful dissection was performed to expose the calcified area. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for pathological examination.

Operative Note: Surgical intervention was carried out for other muscle calcification. A transverse curved incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified region. The calcifications were carefully dissected and removed. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for histopathological evaluation.

Operative Note: Excision of other calcification of muscle was performed. A midline vertical incision was made over the affected muscle, and meticulous dissection was done to visualize the calcified area. The calcifications were excised using sharp dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination.

Operative Note: Patient underwent excisional surgery for other calcification of muscle. A curvilinear incision with extensions was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for further analysis.

Operative Note: Excision of other calcification of muscle was performed. An oblique incision was made over the affected muscle, and careful dissection was performed to expose the calcified region. The calcifications were excised using a combination of sharp and blunt dissection. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination.

Operative Note: Surgical intervention was carried out for other muscle calcification. A transverse zigzag incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were carefully dissected and removed. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for histopathological evaluation.

Operative Note: Patient underwent excisional surgery for other calcification of muscle. A curved incision with lateral extensions was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for further analysis.

Operative Note: Excision of other calcification of muscle was performed. A midline longitudinal incision was made over the affected muscle, and careful dissection was done to visualize the calcified area. The calcifications were excised using sharp dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination.

Operative Note: The patient underwent excisional surgery for other calcification of muscle under general anesthesia. A transverse curvilinear incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were carefully dissected and removed using sharp and blunt dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised specimen was sent for histopathological evaluation. Anesthesia dosage: Induction: Propofol 100 mg, Fentanyl 100 mcg; Maintenance: Sevoflurane 1-1.5%, Remifentanil infusion.

Operative Note: Excisional surgery was performed for other muscle calcification under regional anesthesia. A paramedian incision was made over the affected muscle, and careful dissection was performed to expose the calcified area. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised tissue was sent for pathological examination. Anesthesia dosage: Regional anesthesia: Bupivacaine 0.5% with Epinephrine.

Operative Note: Surgical intervention was carried out for other calcification of muscle under monitored anesthesia care (MAC). A transverse curved incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified region. The calcifications were carefully dissected and removed. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for histopathological evaluation. Anesthesia dosage: MAC with intravenous Midazolam, Remifentanil infusion.

Operative Note: The patient underwent excision of other calcification of muscle under general anesthesia with enhanced recovery protocol. An oblique incision was made over the affected muscle, and careful dissection was performed to expose the calcified region. The calcifications were excised using a combination of sharp and blunt dissection. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination. Anesthesia dosage: General anesthesia with low-dose Propofol, Remifentanil infusion.

Operative Note: Excisional surgery was performed for other muscle calcification under spinal anesthesia. A curvilinear incision with extensions was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for further analysis. Anesthesia dosage: Spinal anesthesia with Bupivacaine 0.5% + Fentanyl 15 mcg.

Operative Note: Patient underwent excisional surgery for other calcification of muscle under general anesthesia with controlled hypotension. A midline longitudinal incision was made over the affected muscle, and careful dissection was done to visualize the calcified area. The calcifications were excised using sharp dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination. Anesthesia dosage: General anesthesia with controlled hypotension using Sodium Nitroprusside infusion.

Operative Note: Surgical intervention was carried out for other muscle calcification under local anesthesia with sedation. A transverse zigzag incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were carefully dissected and removed. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for histopathological evaluation. Anesthesia dosage: Local anesthesia with Lidocaine infiltration + Midazolam sedation.

Operative Note: Excision of other calcification of muscle was performed under general anesthesia with regional nerve block. A curved incision with lateral extensions was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for further analysis. Anesthesia dosage: General anesthesia with regional nerve block using Ropivacaine.

Operative Note: The patient underwent excisional surgery for other calcification of muscle under combined spinal-epidural anesthesia. An inverted "L" incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified region. The calcifications were excised using a combination of sharp and blunt dissection. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for pathological examination. Anesthesia dosage: Combined spinal-epidural anesthesia with Bupivacaine spinal + Epidural infusion.

Operative Note: Excision of other calcification of muscle was performed under general anesthesia with muscle relaxant. A transverse curvilinear incision was made over the affected muscle, and meticulous dissection was performed to expose the calcified area. The calcifications were carefully dissected and removed using sharp and blunt dissection techniques. Hemostasis was achieved, and the wound was closed in layers. The excised specimen was sent for histopathological evaluation. Anesthesia dosage: General anesthesia with Rocuronium muscle relaxant.

Operative Note: The patient underwent surgical excision for other calcification of muscle with bone erosion. A transverse curvilinear incision was made over the affected area, exposing the calcified muscle and underlying eroded bone. The calcifications were carefully dissected and removed, and the eroded bone was debrided and smoothed. Hemostasis was achieved, and the wound was closed in layers. The excised specimen and bone fragments were sent for histopathological evaluation.

Operative Note: Excisional surgery was performed for other muscle calcification with bone erosion. An oblique incision was made over the affected region, revealing the calcified muscle and eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were thoroughly debrided and shaped. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue and bone samples were sent for pathological examination.

Operative Note: Surgical intervention was carried out for other calcification of muscle with associated bone erosion. A transverse curved incision was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were carefully dissected and removed, and the eroded bone was meticulously debrided and contoured. Hemostasis was achieved, and the wound was closed in layers. The excised specimen and bone fragments were sent for histopathological evaluation.

Operative Note: The patient underwent excision of other calcification of muscle with bone erosion. A midline vertical incision was made over the affected region, revealing the calcified muscle and underlying eroded bone. The calcifications were excised using sharp dissection techniques, and the eroded bone surfaces were thoroughly debrided and smoothed. Hemostasis was achieved, and the wound was closed in layers. The excised tissue and bone samples were sent for pathological examination.

Operative Note: Excisional surgery was performed for other muscle calcification with bone erosion. A curvilinear incision with extensions was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were carefully debrided and reshaped. Hemostasis was achieved, and the wound was closed with sutures. The excised tissue and bone fragments were sent for further analysis.

Operative Note: Patient underwent excisional surgery for other calcification of muscle with bone erosion. An elliptical incision was made over the affected region, revealing the calcified muscle and underlying eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were debrided and contoured to promote healing. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen and bone samples were sent for histopathological evaluation.

Operative Note: Excision of other calcification of muscle with bone erosion was performed. A paramedian incision was made over the affected region, exposing the calcified muscle and eroded bone. The calcifications were carefully dissected and removed, and the eroded bone surfaces were meticulously debrided and shaped. Hemostasis was achieved, and the wound was closed in layers. The excised tissue and bone fragments were sent for pathological examination.

Operative Note: Surgical intervention was carried out for other muscle calcification with associated bone erosion. A transverse zigzag incision was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were debrided and smoothed. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue and bone samples were sent for further analysis.

Operative Note: The patient underwent excisional surgery for other calcification of muscle with bone erosion. An inverted "L" incision was made over the affected region, revealing the calcified muscle and underlying eroded bone. The calcifications were excised using sharp and blunt dissection techniques, and the eroded bone surfaces were thoroughly debrided and contoured. Hemostasis was achieved, and the wound was closed in layers. The excised specimen and bone fragments were sent for histopathological evaluation.

Operative Note: Excision of other calcification of muscle with bone erosion was performed. An oblique incision was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were carefully dissected and removed, and the eroded bone surfaces were meticulously debrided and shaped. Hemostasis was achieved, and the wound was closed with sutures. The excised tissue and bone samples were sent for pathological examination.

Operative Note: The patient underwent surgical excision for other calcification of muscle with severe bone pain. A transverse curvilinear incision was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were carefully dissected and removed, and the eroded bone surfaces were thoroughly debrided and contoured. Special attention was given to relieving the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The excised specimen and bone fragments were sent for histopathological evaluation.

Operative Note: Excisional surgery was performed for other muscle calcification with severe bone pain. An oblique incision was made over the affected region, revealing the calcified muscle and underlying eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were carefully debrided and reshaped, aiming to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue and bone samples were sent for pathological examination.

Operative Note: Surgical intervention was carried out for other calcification of muscle with severe bone pain. A transverse curved incision was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were carefully dissected and removed, and the eroded bone surfaces were meticulously debrided and shaped to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The excised specimen and bone fragments were sent for histopathological evaluation.

Operative Note: The patient underwent excision of other calcification of muscle with severe bone pain. A midline vertical incision was made over the affected region, revealing the calcified muscle and underlying eroded bone. The calcifications were excised using sharp dissection techniques, and the eroded bone surfaces were thoroughly debrided and smoothed, targeting the relief of severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The excised tissue and bone samples were sent for pathological examination.

Operative Note: Excisional surgery was performed for other muscle calcification with severe bone pain. A curvilinear incision with extensions was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were carefully debrided and contoured to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed with sutures. The excised tissue and bone fragments were sent for further analysis.

Operative Note: Patient underwent excisional surgery for other calcification of muscle with severe bone pain. An elliptical incision was made over the affected region, revealing the calcified muscle and underlying eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were debrided and contoured with the goal of relieving severe bone pain. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen and bone samples were sent for histopathological evaluation.

Operative Note: Excision of other calcification of muscle with severe bone pain was performed. A paramedian incision was made over the affected region, exposing the calcified muscle and eroded bone. The calcifications were carefully dissected and removed, and the eroded bone surfaces were meticulously debrided and shaped to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The excised tissue and bone fragments were sent for pathological examination.

Operative Note: Surgical intervention was carried out for other muscle calcification with associated severe bone pain. A transverse zigzag incision was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were meticulously excised, and the eroded bone surfaces were debrided and smoothed, aiming to relieve the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue and bone samples were sent for further analysis.

Operative Note: The patient underwent excisional surgery for other calcification of muscle with severe bone pain. An inverted "L" incision was made over the affected region, revealing the calcified muscle and underlying eroded bone. The calcifications were excised using sharp and blunt dissection techniques, and the eroded bone surfaces were thoroughly debrided and contoured to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The excised specimen and bone fragments were sent for histopathological evaluation.

Operative Note: Excision of other calcification of muscle with severe bone pain was performed. An oblique incision was made over the affected area, exposing the calcified muscle and eroded bone. The calcifications were carefully dissected and removed, and the eroded bone surfaces were meticulously debrided and shaped, with the primary objective of alleviating the severe bone pain. Hemostasis was achieved, and the wound was closed with sutures. The excised tissue and bone samples were sent for pathological examination.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. A transverse curvilinear incision was made over the affected area, exposing the calcified muscle. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers using sutures. The excised tissue was sent for histopathological evaluation to confirm the diagnosis.

Operative Note: Surgical intervention was performed for other calcification of muscle. An oblique incision was made over the affected region, exposing the calcified muscle. The calcifications were carefully excised, taking care to preserve the surrounding tissues. Hemostasis was achieved, and the wound was closed using sutures. The excised specimen was sent for pathological examination for further evaluation.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. A transverse curved incision was made over the affected area, revealing the calcified muscle. The calcifications were excised using meticulous dissection techniques, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for histopathological evaluation to confirm the nature of the calcifications.

Operative Note: Surgical intervention was carried out for other calcification of muscle. A midline vertical incision was made over the affected region, exposing the calcified muscle. The calcifications were carefully dissected and removed, ensuring complete excision. Hemostasis was achieved, and the wound was closed in layers using sutures. The excised tissue was sent for pathological examination to determine the underlying cause of calcification.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. An elliptical incision was made over the affected area, revealing the calcified muscle. The calcifications were meticulously excised, taking care not to damage the surrounding structures. Hemostasis was achieved, and the wound was closed using sutures. The excised specimen was sent for further analysis to ascertain the etiology of the calcifications.

Operative Note: Surgical intervention was performed for other calcification of muscle. A paramedian incision was made over the affected region, exposing the calcified muscle. The calcifications were carefully excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers using sutures. The excised tissue was sent for histopathological examination to determine the underlying pathology.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. A transverse zigzag incision was made over the affected area, exposing the calcified muscle. The calcifications were meticulously excised, taking care to preserve the integrity of surrounding tissues. Hemostasis was achieved, and the wound was closed using sutures. The excised specimen was sent for pathological evaluation to confirm the diagnosis.

Operative Note: Surgical intervention was carried out for other calcification of muscle. An inverted "L" incision was made over the affected region, revealing the calcified muscle. The calcifications were excised using sharp and blunt dissection techniques, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for histopathological examination for further evaluation.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. An oblique incision was made over the affected area, exposing the calcified muscle. The calcifications were carefully dissected and removed, ensuring complete excision. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for pathological examination to determine the underlying cause of calcification.

Operative Note: Surgical intervention was performed for other calcification of muscle. A longitudinal incision was made over the affected region, exposing the calcified muscle. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for histopathological evaluation to confirm the diagnosis and determine the nature of the calcifications.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. A transverse curvilinear incision was made over the affected area, exposing the calcified muscle. The calcifications were carefully dissected and removed, ensuring complete excision. Hemostasis was achieved, and the wound was closed in layers using sutures. The excised tissue was sent for histopathological examination to confirm the diagnosis and determine the underlying cause.

Operative Note: Surgical intervention was performed for other calcification of muscle. An oblique incision was made over the affected region, revealing the calcified muscle. The calcifications were meticulously excised, preserving the surrounding structures. Hemostasis was achieved, and the wound was closed using sutures. The excised specimen was sent for pathological evaluation to determine the nature of the calcifications.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. A transverse curved incision was made over the affected area, exposing the calcified muscle. The calcifications were excised using meticulous dissection techniques, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for histopathological examination to confirm the diagnosis and identify any associated pathology.

Operative Note: Surgical intervention was carried out for other calcification of muscle. A midline vertical incision was made over the affected region, exposing the calcified muscle. The calcifications were carefully dissected and removed, ensuring complete excision. Hemostasis was achieved, and the wound was closed in layers using sutures. The excised tissue was sent for pathological examination to determine the underlying cause of the calcifications.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. An elliptical incision was made over the affected area, revealing the calcified muscle. The calcifications were meticulously excised, taking care not to damage the surrounding structures. Hemostasis was achieved, and the wound was closed using sutures. The excised specimen was sent for further analysis to ascertain the etiology of the calcifications.

Operative Note: Surgical intervention was performed for other calcification of muscle. A paramedian incision was made over the affected region, exposing the calcified muscle. The calcifications were carefully excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers using sutures. The excised tissue was sent for histopathological examination to determine the underlying pathology and extent of calcification.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. A transverse zigzag incision was made over the affected area, exposing the calcified muscle. The calcifications were meticulously excised, preserving the integrity of surrounding tissues. Hemostasis was achieved, and the wound was closed using sutures. The excised specimen was sent for pathological evaluation to confirm the diagnosis and assess the extent of calcification.

Operative Note: Surgical intervention was carried out for other calcification of muscle. An inverted "L" incision was made over the affected region, revealing the calcified muscle. The calcifications were excised using sharp and blunt dissection techniques, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for histopathological examination for further evaluation and identification of any associated abnormalities.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. An oblique incision was made over the affected area, exposing the calcified muscle. The calcifications were carefully dissected and removed, ensuring complete excision. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen was sent for pathological examination to determine the nature of the calcifications and assess for any underlying pathology.

Operative Note: Surgical intervention was performed for other calcification of muscle. A longitudinal incision was made over the affected region, exposing the calcified muscle. The calcifications were meticulously excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The excised tissue was sent for histopathological evaluation to confirm the diagnosis and determine the etiology of the calcifications.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with severe infection on the extreme moving joint. An extensive incision was made over the affected area, revealing the calcified muscle and the infected joint. The calcifications were meticulously excised, and the infected joint was thoroughly irrigated and debrided. Antibiotic-loaded bone cement was used to fill the voids created by excision. The wound was closed in layers, and appropriate drainage was placed. The excised tissue and joint fluid were sent for culture analysis.

Operative Note: Surgical intervention was performed for other calcification of muscle with severe infection involving the extreme moving joint. A modified extensile incision was made, allowing optimal exposure of the calcified muscle and the infected joint. The calcifications were carefully excised, and the infected joint was extensively debrided. Copious irrigation with antibiotic solution was performed. The wound was closed using sutures, and a drain was placed for postoperative drainage. Specimens for culture and sensitivity testing were obtained.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with severe infection on the extreme moving joint. A curvilinear incision was made over the affected region, exposing the calcified muscle and the infected joint. The calcifications were meticulously excised, and the infected joint was thoroughly debrided and irrigated. Local antibiotic beads were implanted to provide continuous antibiotic release. The wound was closed in layers, and a drain was placed for adequate drainage. Samples for culture and sensitivity were collected.

Operative Note: Surgical intervention was carried out for other calcification of muscle with severe infection involving the extreme moving joint. A medial parapatellar incision was made, providing direct access to the calcified muscle and the infected joint. The calcifications were carefully excised, and the infected joint was extensively debrided and irrigated with antibiotic solution. Absorbable antibiotic beads were placed in the joint space. The wound was closed using sutures, and a closed suction drain was inserted for postoperative drainage. Specimens were sent for microbial analysis.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with severe infection on the extreme moving joint. An anterolateral approach was used to expose the calcified muscle and the infected joint. The calcifications were meticulously excised, and the infected joint was thoroughly debrided and irrigated with antibiotic solution. Local antibiotic-impregnated collagen sponge was placed to facilitate wound healing. The wound was closed in layers, and a drain was placed for adequate drainage. Samples were collected for culture and sensitivity testing.

Operative Note: Surgical intervention was performed for other calcification of muscle with severe infection involving the extreme moving joint. A posterior approach was used to expose the calcified muscle and the infected joint. The calcifications were carefully excised, and the infected joint was extensively debrided, irrigated, and lavaged with antibiotic solution. A synthetic bone graft substitute was used to fill the voids created by excision. The wound was closed in layers, and a closed suction drain was inserted for postoperative drainage. Specimens were sent for microbial analysis.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with severe infection on the extreme moving joint. A lateral approach was used to expose the calcified muscle and the infected joint. The calcifications were meticulously excised, and the infected joint was thoroughly debrided, irrigated, and lavaged with antibiotic solution. Antibiotic-impregnated calcium sulfate beads were placed to provide local antibiotic therapy. The wound was closed using sutures, and a drain was inserted for proper drainage. Samples were collected for culture and sensitivity testing.

Operative Note: Surgical intervention was carried out for other calcification of muscle with severe infection involving the extreme moving joint. An anterior approach was used to expose the calcified muscle and the infected joint. The calcifications were carefully excised, and the infected joint was extensively debrided and irrigated with antibiotic solution. Local antibiotic-impregnated bone graft was used to promote bone healing and infection control. The wound was closed in layers, and a drain was placed for adequate drainage. Specimens were sent for microbial analysis.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with severe infection on the extreme moving joint. A medial approach was used to expose the calcified muscle and the infected joint. The calcifications were meticulously excised, and the infected joint was thoroughly debrided and irrigated with antibiotic solution. Antibiotic-impregnated collagen membrane was applied to facilitate wound healing. The wound was closed using sutures, and a drain was placed for proper drainage. Samples were collected for culture and sensitivity testing.

Operative Note: Surgical intervention was performed for other calcification of muscle with severe infection involving the extreme moving joint. A posterior midline incision was made, providing direct access to the calcified muscle and the infected joint. The calcifications were carefully excised, and the infected joint was extensively debrided and irrigated with antibiotic solution. Local antibiotic beads were placed in the joint space. The wound was closed in layers, and a closed suction drain was inserted for postoperative drainage. Specimens were sent for microbial analysis.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with severe inflammation. An oblique incision was made over the affected area, exposing the calcified muscle and the inflamed tissues. The calcifications were meticulously excised, and the inflamed tissues were debrided. Copious irrigation with saline was performed. The wound was closed in layers using sutures, and a drain was placed for postoperative drainage. Histopathological examination of the excised tissue was conducted to assess the degree of inflammation.

Operative Note: Surgical intervention was performed for other calcification of muscle with moderate inflammation. A transverse curved incision was made over the affected region, revealing the calcified muscle and the inflamed tissues. The calcifications were carefully excised, and the inflamed tissues were thoroughly irrigated. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for pathological evaluation to determine the extent of inflammation and rule out any underlying pathology.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with mild inflammation. A longitudinal incision was made over the affected area, exposing the calcified muscle and the mildly inflamed tissues. The calcifications were meticulously excised, and the inflamed tissues were irrigated with antibiotic solution. Hemostasis was achieved, and the wound was closed in layers. The excised specimen was sent for histopathological examination to assess the inflammatory response.

Operative Note: Surgical intervention was carried out for other calcification of muscle with severe inflammatory changes. A paramedian incision was made over the affected region, exposing the calcified muscle and the extensively inflamed tissues. The calcifications were carefully excised, and the inflamed tissues were thoroughly debrided and irrigated. Local antibiotic beads were implanted to control infection and inflammation. The wound was closed in layers, and a drain was placed for proper drainage. Specimens were collected for histopathological analysis.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with moderate inflammation. An elliptical incision was made over the affected area, revealing the calcified muscle and the moderately inflamed tissues. The calcifications were meticulously excised, and the inflamed tissues were irrigated with antibiotic solution. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for pathological examination to evaluate the extent of inflammation.

Operative Note: Surgical intervention was performed for other calcification of muscle with mild inflammation. A transverse zigzag incision was made over the affected region, exposing the calcified muscle and the mildly inflamed tissues. The calcifications were carefully excised, and the inflamed tissues were irrigated with saline. Hemostasis was achieved, and the wound was closed using sutures. The excised specimen was sent for histopathological evaluation to assess the inflammatory response.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with severe inflammatory changes. A vertical incision was made over the affected area, exposing the calcified muscle and the highly inflamed tissues. The calcifications were meticulously excised, and the inflamed tissues were extensively debrided and irrigated. Antibiotic-impregnated dressings were applied to control inflammation and promote wound healing. The wound was closed in layers, and a drain was placed for adequate drainage. Specimens were collected for histopathological analysis.

Operative Note: Surgical intervention was carried out for other calcification of muscle with moderate inflammation. An inverted "T" incision was made over the affected region, revealing the calcified muscle and the moderately inflamed tissues. The calcifications were carefully excised, and the inflamed tissues were irrigated with antibiotic solution. Hemostasis was achieved, and the wound was closed using sutures. The excised tissue was sent for pathological examination to assess the degree of inflammation and rule out any associated pathology.

Operative Note: The patient underwent surgical intervention for other calcification of muscle with mild inflammation. An oblique incision was made over the affected area, exposing the calcified muscle and the mildly inflamed tissues. The calcifications were meticulously excised, and the inflamed tissues were irrigated with saline. Hemostasis was achieved, and the wound was closed in layers. The excised specimen was sent for histopathological evaluation to assess the inflammatory response.

Operative Note: Surgical intervention was performed for other calcification of muscle with severe inflammatory changes. A curvilinear incision was made over the affected region, exposing the calcified muscle and the extensively inflamed tissues. The calcifications were carefully excised, and the inflamed tissues were thoroughly debrided and irrigated. Local antibiotic-impregnated dressings were applied to control inflammation and prevent infection. The wound was closed in layers, and a drain was placed for proper drainage. Specimens were collected for histopathological analysis.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. The severity of the diagnosis necessitates close postoperative monitoring. A follow-up appointment will be scheduled in 2 weeks for wound assessment and suture removal. Further imaging studies will be performed to evaluate the resolution of calcifications. Physical therapy and rehabilitation will be initiated based on the patient's progress. The patient will also be educated on pain management techniques and advised to report any concerning symptoms promptly.

Operative Note: Surgical intervention was performed for other calcification of muscle. Due to the severe nature of the diagnosis, the patient will be closely monitored postoperatively. A follow-up visit is scheduled in 1 week for wound evaluation and assessment of postoperative pain. Range of motion exercises will be initiated based on the patient's comfort level. Further imaging studies will be considered to monitor the resolution of calcifications. The patient will receive instructions on postoperative care and potential complications to watch for.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. Given the moderate severity of the diagnosis, a follow-up appointment is scheduled in 3 weeks. During this visit, the wound will be assessed, and sutures will be removed. Further imaging studies will be considered to evaluate the resolution of calcifications. Physical therapy will be initiated to restore functional mobility. The patient will be educated on home care instructions and advised to report any worsening symptoms or signs of infection.

Operative Note: Surgical intervention was performed for other calcification of muscle. The diagnosis indicates a mild severity, and a follow-up visit is scheduled in 4 weeks. During this appointment, the wound will be examined, and the need for suture removal will be assessed. The patient will be advised on self-care measures and provided with instructions for pain management. Physical therapy may be recommended depending on the patient's progress. The patient will be instructed to report any unexpected symptoms or concerns.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. Due to the complexity of the diagnosis, a close follow-up is required. A postoperative appointment is scheduled in 1 week to assess wound healing and address any immediate concerns. Further imaging studies will be conducted to evaluate the resolution of calcifications. Physical therapy and rehabilitation will be initiated based on the patient's condition. The patient will be educated on potential complications and advised to seek medical attention if symptoms worsen.

Operative Note: Surgical intervention was performed for other calcification of muscle. Given the mild severity of the diagnosis, a follow-up visit is scheduled in 6 weeks for wound evaluation and suture removal. The patient will be instructed on postoperative care, including pain management techniques and activity modification. A referral to physical therapy may be considered if symptoms persist. The patient will be advised to report any unexpected changes or concerns during the recovery period.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. The severity of the diagnosis requires regular follow-up. A postoperative visit is scheduled in 2 weeks for wound assessment and suture removal. Imaging studies will be conducted to evaluate the resolution of calcifications. Physical therapy will be initiated to improve mobility and functionality. The patient will receive instructions on postoperative care, pain management, and potential complications. Any worsening symptoms should be promptly reported.

Operative Note: Surgical intervention was performed for other calcification of muscle. Due to the moderate severity of the diagnosis, a follow-up appointment is scheduled in 3 weeks. During this visit, the wound will be evaluated, and sutures will be removed if necessary. Further imaging studies will be considered to assess the resolution of calcifications. Physical therapy will be initiated to optimize muscle function and range of motion. The patient will be educated on home care instructions and advised to report any concerning symptoms.

Operative Note: The patient underwent surgical intervention for other calcification of muscle. Given the mild severity of the diagnosis, a follow-up visit is scheduled in 6 weeks. During this appointment, the wound will be examined, and the need for suture removal will be determined. The patient will receive guidance on self-care measures, pain management, and gradual return to activities. The patient will be advised to report any unexpected changes or concerns during the recovery period.

Operative Note: Surgical intervention was performed for other calcification of muscle. Due to the complexity of the diagnosis, a comprehensive follow-up plan is essential. A postoperative visit is scheduled in 1 week to assess wound healing and address any immediate concerns. Further imaging studies will be conducted to monitor the resolution of calcifications. Physical therapy and rehabilitation will be initiated based on the patient's condition and progress. The patient will be provided with detailed instructions on postoperative care and encouraged to communicate any changes in symptoms or concerns.