## M63.0 Myositis in bacterial diseases classified elsewhere

1. Operative Note: Patient presented with myositis secondary to bacterial infection. A 5 cm incision was made over the affected muscle. Necrotic tissue was debrided, and the area was irrigated with saline. Antibiotic therapy was initiated. Hemostasis was achieved, and the wound was closed in layers. Postoperative care includes wound care, pain management, and close monitoring for signs of systemic infection.

2. Operative Note: Surgical intervention for myositis in the setting of bacterial infection was performed. A 7 cm incision was made, allowing access to the affected muscle. Extensive debridement of necrotic tissue was carried out. Copious irrigation with antibiotic solution was done. Hemostasis was achieved, and the wound was closed using sutures. Postoperative care includes antibiotics, immobilization, and close monitoring for complications.

3. Operative Note: Myositis due to bacterial infection required surgical intervention. A 6 cm incision was made, exposing the affected muscle. Thorough debridement of necrotic tissue was performed. The wound was irrigated with antimicrobial solution. Hemostasis was achieved, and the incision was closed with sutures. The patient was started on intravenous antibiotics and will receive physiotherapy to regain muscle function.

4. Operative Note: Patient with myositis secondary to bacterial infection underwent surgical management. An 8 cm incision was made over the affected muscle. Extensive debridement was performed to remove necrotic tissue. The wound was irrigated with sterile saline solution. Hemostasis was ensured, and layered closure was achieved. Postoperatively, the patient will receive broad-spectrum antibiotics, pain management, and regular wound dressing.

5. Operative Note: Surgical intervention was carried out for myositis caused by bacterial infection. An incision measuring 9 cm was made to access the affected muscle. Thorough debridement of necrotic tissue was performed. The wound was meticulously irrigated with antimicrobial solution. Hemostasis was achieved, and the incision was closed with sutures. Postoperatively, the patient will receive intravenous antibiotics, physical therapy, and close monitoring for any signs of recurrence.

6. Operative Note: Patient presented with myositis secondary to bacterial infection. A 10 cm incision was made over the affected muscle. Extensive debridement was performed, removing necrotic tissue. The wound was lavaged with antiseptic solution. Hemostasis was attained, and layered closure was done. The patient was started on broad-spectrum antibiotics and will be closely monitored for any signs of systemic spread.

7. Operative Note: Surgical management was performed for myositis associated with bacterial infection. A 6 cm incision was made, providing access to the affected muscle. Debridement of necrotic tissue was carried out meticulously. The wound was irrigated with antibiotic solution. Hemostasis was achieved, and layered closure was performed. The patient was started on appropriate antibiotic therapy and will undergo physical therapy for rehabilitation.

8. Operative Note: Myositis secondary to bacterial infection necessitated surgical intervention. An 8 cm incision was made, exposing the affected muscle. Extensive debridement was performed to remove necrotic tissue. The wound was irrigated with sterile saline solution. Hemostasis was achieved, and layered closure was performed. The patient will receive postoperative antibiotics, pain control, and close monitoring for signs of wound infection.

9. Operative Note: Patient with myositis due to bacterial infection underwent surgical treatment. A 7 cm incision was made to access the affected muscle. Debridement of necrotic tissue was carried out thoroughly. The wound was irrigated with antimicrobial solution. Hemostasis was ensured, and layered closure was performed. Postoperatively, the patient will receive appropriate antibiotics, wound care, and physiotherapy for muscle rehabilitation.

10. Operative Note: Surgical management was performed for myositis associated with bacterial infection. A 9 cm incision was made, providing access to the affected muscle. Debridement of necrotic tissue was performed meticulously. The wound was irrigated with antiseptic solution. Hemostasis was achieved, and layered closure was performed. The patient was started on broad-spectrum antibiotics and will undergo regular follow-up for wound healing assessment.

1. Operative Note: Surgical intervention was carried out for myositis in bacterial diseases classified elsewhere. A 6 cm incision was made over the affected muscle, allowing adequate exposure. Necrotic tissue was debrided, and the area was irrigated with sterile saline. Hemostasis was achieved, and the wound was closed using sutures. Postoperative management includes antibiotic therapy, immobilization, and close monitoring for signs of infection.

2. Operative Note: Patient presented with myositis secondary to bacterial infection, necessitating surgical treatment. An 8 cm incision was made, providing access to the affected muscle. Thorough debridement of necrotic tissue was performed, followed by irrigation with antimicrobial solution. Hemostasis was ensured, and layered closure was achieved. The patient will receive postoperative antibiotics, pain management, and physiotherapy for optimal recovery.

3. Operative Note: Surgical intervention was performed for myositis associated with bacterial infection. A 7 cm incision was made over the affected muscle, allowing visualization and debridement of necrotic tissue. The wound was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the incision was closed using sutures. The patient will receive postoperative antibiotics, wound care, and close monitoring for any signs of recurrence.

4. Operative Note: Myositis due to bacterial infection required surgical management. An 8 cm incision was made to access the affected muscle. Extensive debridement was performed, removing necrotic tissue. The wound was irrigated with antiseptic solution. Hemostasis was achieved, and layered closure was accomplished. Postoperatively, the patient will receive antibiotics, pain control, and physical therapy to restore muscle function.

5. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, necessitating surgical intervention. A 10 cm incision was made, providing exposure to the affected muscle. Necrotic tissue was debrided meticulously. The wound was irrigated with antimicrobial solution. Hemostasis was achieved, and layered closure was performed. The patient will receive intravenous antibiotics, wound care, and regular follow-up for monitoring and rehabilitation.

6. Operative Note: Surgical management was performed for myositis associated with bacterial infection. An 8 cm incision was made, allowing access to the affected muscle. Extensive debridement of necrotic tissue was performed, followed by thorough irrigation with antiseptic solution. Hemostasis was achieved, and layered closure was performed using sutures. Postoperatively, the patient will receive appropriate antibiotics, wound care, and physical therapy for optimal recovery.

7. Operative Note: Myositis secondary to bacterial infection necessitated surgical intervention. A 7 cm incision was made, providing exposure to the affected muscle. Debridement of necrotic tissue was performed meticulously. The wound was irrigated with antimicrobial solution. Hemostasis was achieved, and layered closure was done. The patient will receive postoperative antibiotics, wound care, and regular follow-up for assessment of muscle healing.

8. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, requiring surgical treatment. An 8 cm incision was made to access the affected muscle. Thorough debridement of necrotic tissue was performed, followed by irrigation with antibiotic solution. Hemostasis was ensured, and layered closure was achieved. Postoperatively, the patient will receive antibiotics, pain management, and physiotherapy for muscle rehabilitation.

9. Operative Note: Surgical intervention was carried out for myositis associated with bacterial infection. A 9 cm incision was made, providing access to the affected muscle. Necrotic tissue was debrided meticulously, and the wound was irrigated with sterile saline. Hemostasis was achieved, and the incision was closed using sutures. The patient will receive postoperative antibiotics, wound care, and close monitoring for any signs of infection or recurrence.

10. Operative Note: Myositis secondary to bacterial infection necessitated surgical management. An 8 cm incision was made over the affected muscle, allowing visualization and thorough debridement of necrotic tissue. The wound was irrigated with antimicrobial solution. Hemostasis was achieved, and layered closure was performed. Postoperatively, the patient will receive appropriate antibiotics, wound care, and physiotherapy for optimal recovery and restoration of muscle function.

1. Operative Note: Surgical intervention was performed for myositis in bacterial diseases classified elsewhere. Under general anesthesia, a 6 cm incision was made over the affected muscle, providing adequate exposure. Necrotic tissue was debrided, and the area was irrigated with sterile saline. Hemostasis was achieved, and the wound was closed using sutures. Postoperative management includes antibiotic therapy, immobilization, and close monitoring for signs of infection.

2. Operative Note: Patient presented with myositis secondary to bacterial infection, necessitating surgical treatment. After administering regional anesthesia, an 8 cm incision was made, providing access to the affected muscle. Thorough debridement of necrotic tissue was performed, followed by irrigation with antimicrobial solution. Hemostasis was ensured, and layered closure was achieved. The patient will receive postoperative antibiotics, pain management, and physiotherapy for optimal recovery.

3. Operative Note: Surgical intervention was performed for myositis associated with bacterial infection. Under local anesthesia, a 7 cm incision was made over the affected muscle, allowing visualization and debridement of necrotic tissue. The wound was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the incision was closed using sutures. The patient will receive postoperative antibiotics, wound care, and close monitoring for any signs of recurrence.

4. Operative Note: Myositis due to bacterial infection required surgical management. After administering general anesthesia, an 8 cm incision was made to access the affected muscle. Extensive debridement was performed, removing necrotic tissue. The wound was irrigated with antiseptic solution. Hemostasis was achieved, and layered closure was accomplished. Postoperatively, the patient will receive antibiotics, pain control, and physical therapy to restore muscle function.

5. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, necessitating surgical intervention. Following regional anesthesia, a 10 cm incision was made, providing exposure to the affected muscle. Necrotic tissue was debrided meticulously. The wound was irrigated with antimicrobial solution. Hemostasis was achieved, and layered closure was performed. The patient will receive intravenous antibiotics, wound care, and regular follow-up for monitoring and rehabilitation.

6. Operative Note: Surgical management was performed for myositis associated with bacterial infection. After administering local anesthesia, an 8 cm incision was made, allowing access to the affected muscle. Extensive debridement of necrotic tissue was performed, followed by thorough irrigation with antiseptic solution. Hemostasis was achieved, and layered closure was performed using sutures. Postoperatively, the patient will receive appropriate antibiotics, wound care, and physical therapy for optimal recovery.

7. Operative Note: Myositis secondary to bacterial infection necessitated surgical intervention. Under general anesthesia, a 7 cm incision was made, providing exposure to the affected muscle. Debridement of necrotic tissue was performed meticulously. The wound was irrigated with antimicrobial solution. Hemostasis was achieved, and layered closure was done. The patient will receive postoperative antibiotics, wound care, and regular follow-up for assessment of muscle healing.

8. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, requiring surgical treatment. Following regional anesthesia, an 8 cm incision was made to access the affected muscle. Thorough debridement of necrotic tissue was performed, followed by irrigation with antibiotic solution. Hemostasis was ensured, and layered closure was achieved. Postoperatively, the patient will receive antibiotics, pain management, and physiotherapy for muscle rehabilitation.

9. Operative Note: Surgical intervention was carried out for myositis associated with bacterial infection. Under general anesthesia, a 9 cm incision was made, providing access to the affected muscle. Necrotic tissue was meticulously debrided, and the wound was irrigated with sterile saline. Hemostasis was achieved, and the incision was closed using sutures. The patient will receive postoperative antibiotics, wound care, and close monitoring for any signs of infection or recurrence.

10. Operative Note: Myositis secondary to bacterial infection necessitated surgical management. After administering local anesthesia, an 8 cm incision was made over the affected muscle, allowing visualization and thorough debridement of necrotic tissue. The wound was irrigated with antimicrobial solution. Hemostasis was achieved, and layered closure was performed. Postoperatively, the patient will receive appropriate antibiotics, wound care, and physiotherapy for optimal recovery and restoration of muscle function.

1. Operative Note: Surgical intervention was performed for myositis in bacterial diseases classified elsewhere with associated bone erosion. Under general anesthesia, a 6 cm incision was made, providing access to the affected muscle and the eroded bone. Necrotic tissue was debrided, and the area was thoroughly irrigated with sterile saline. Hemostasis was achieved, and bone grafting was performed to address the erosion. The wound was closed in layers. Postoperative management includes antibiotic therapy, immobilization, and close monitoring for infection and bone healing.

2. Operative Note: Patient presented with myositis and significant bone erosion secondary to bacterial infection, necessitating surgical treatment. After administering regional anesthesia, a 9 cm incision was made, exposing the affected muscle and the eroded bone. Extensive debridement of necrotic tissue was performed, followed by meticulous irrigation with antimicrobial solution. Hemostasis was ensured, and bone reconstruction was carried out using bone grafts. The wound was closed with sutures. Postoperatively, the patient will receive antibiotics, pain management, and appropriate immobilization to promote bone healing.

3. Operative Note: Surgical intervention was performed for myositis associated with bacterial infection and bone erosion. Under local anesthesia, an 8 cm incision was made, allowing visualization and debridement of necrotic tissue. The eroded bone was exposed and thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and bone reconstruction was performed using synthetic graft material. The wound was closed in layers. The patient will receive postoperative antibiotics, wound care, and close monitoring for infection and bone regeneration.

4. Operative Note: Myositis with bone erosion due to bacterial infection required surgical management. After administering general anesthesia, a 7 cm incision was made to access the affected muscle and the eroded bone. Extensive debridement of necrotic tissue was performed, followed by irrigation with antiseptic solution. Hemostasis was achieved, and bone grafting was performed to repair the erosion. The wound was closed using sutures. Postoperatively, the patient will receive antibiotics, pain control, and immobilization to facilitate bone healing.

5. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, accompanied by bone erosion. Following regional anesthesia, a 10 cm incision was made, providing exposure to the affected muscle and the eroded bone. Necrotic tissue was meticulously debrided, and the wound and bone erosion site were irrigated with antimicrobial solution. Hemostasis was achieved, and bone grafting was performed to address the erosion. The wound was closed in layers. The patient will receive intravenous antibiotics, wound care, and regular follow-up for monitoring bone healing and infection.

6. Operative Note: Surgical management was performed for myositis associated with bacterial infection and bone erosion. After administering local anesthesia, an 8 cm incision was made, allowing access to the affected muscle and the eroded bone. Extensive debridement of necrotic tissue was performed, followed by thorough irrigation with antiseptic solution. Hemostasis was achieved, and bone grafting was performed to restore the eroded bone. The wound was closed using sutures. Postoperatively, the patient will receive appropriate antibiotics, wound care, and physical therapy for optimal recovery and bone regeneration.

7. Operative Note: Myositis with bone erosion secondary to bacterial infection necessitated surgical intervention. Under general anesthesia, a 9 cm incision was made, providing exposure to the affected muscle and the eroded bone. Debridement of necrotic tissue was performed meticulously, and the wound and bone erosion site were irrigated with antimicrobial solution. Hemostasis was achieved, and bone grafting was performed to address the erosion. The wound was closed, and the patient will receive postoperative antibiotics, wound care, and close monitoring for infection and bone healing.

8. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, requiring surgical treatment for bone erosion. Following regional anesthesia, an 8 cm incision was made to access the affected muscle and the eroded bone. Thorough debridement of necrotic tissue was performed, followed by irrigation with antibiotic solution. Hemostasis was ensured, and bone reconstruction using graft material was performed. The wound was closed in layers. Postoperatively, the patient will receive antibiotics, pain management, and appropriate immobilization to promote bone healing.

9. Operative Note: Surgical intervention was carried out for myositis associated with bacterial infection and significant bone erosion. Under general anesthesia, a 7 cm incision was made, providing access to the affected muscle and the eroded bone. Necrotic tissue was meticulously debrided, and the wound and bone erosion site were irrigated with sterile saline. Hemostasis was achieved, and bone grafting was performed to address the erosion. The wound was closed using sutures. The patient will receive postoperative antibiotics, wound care, and close monitoring for infection and bone regeneration.

10. Operative Note: Myositis secondary to bacterial infection with concurrent bone erosion necessitated surgical management. After administering local anesthesia, a 9 cm incision was made, allowing visualization and debridement of necrotic tissue. The eroded bone was exposed and thoroughly irrigated with antimicrobial solution. Hemostasis was achieved, and bone reconstruction was performed using autograft material. The wound was closed in layers. Postoperatively, the patient will receive appropriate antibiotics, wound care, and physical therapy to facilitate bone healing and muscle recovery.

1. Operative Note: Surgical intervention was performed for myositis in bacterial diseases classified elsewhere with severe bone pain. Under general anesthesia, a 6 cm incision was made, providing access to the affected muscle and the painful bone area. Necrotic tissue was debrided, and the area was thoroughly irrigated with sterile saline. Hemostasis was achieved, and appropriate measures were taken to address the underlying cause of severe bone pain. The wound was closed in layers. Postoperative management includes antibiotic therapy, pain control, and close monitoring for infection and bone healing.

2. Operative Note: Patient presented with myositis and severe bone pain secondary to bacterial infection, necessitating surgical treatment. After administering regional anesthesia, a 9 cm incision was made, exposing the affected muscle and the area of intense bone pain. Extensive debridement of necrotic tissue was performed, followed by meticulous irrigation with antimicrobial solution. Hemostasis was ensured, and specific interventions were carried out to alleviate severe bone pain. The wound was closed with sutures. Postoperatively, the patient will receive antibiotics, targeted pain management, and appropriate measures to promote bone healing.

3. Operative Note: Surgical intervention was performed for myositis associated with bacterial infection and severe bone pain. Under local anesthesia, an 8 cm incision was made, allowing visualization and debridement of necrotic tissue. The area of intense bone pain was identified and addressed. The wound was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the incision was closed using sutures. The patient will receive postoperative antibiotics, targeted pain management, and close monitoring for infection, bone healing, and relief of severe bone pain.

4. Operative Note: Myositis due to bacterial infection with severe bone pain required surgical management. After administering general anesthesia, a 7 cm incision was made to access the affected muscle and the area of intense bone pain. Extensive debridement of necrotic tissue was performed, followed by irrigation with antiseptic solution. Hemostasis was achieved, and specific interventions were performed to alleviate severe bone pain. The wound was closed using sutures. Postoperatively, the patient will receive antibiotics, specialized pain control measures, and appropriate measures to promote bone healing.

5. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, accompanied by severe bone pain. Following regional anesthesia, a 10 cm incision was made, providing exposure to the affected muscle and the area of intense bone pain. Necrotic tissue was meticulously debrided, and the wound and bone area were irrigated with antimicrobial solution. Hemostasis was achieved, and specific interventions were carried out to alleviate severe bone pain. The wound was closed in layers. The patient will receive intravenous antibiotics, targeted pain management, and regular follow-up for monitoring bone healing, infection control, and relief of severe bone pain.

6. Operative Note: Surgical management was performed for myositis associated with bacterial infection and severe bone pain. After administering local anesthesia, an 8 cm incision was made, allowing access to the affected muscle and the area of intense bone pain. Extensive debridement of necrotic tissue was performed, followed by thorough irrigation with antiseptic solution. Hemostasis was achieved, and specific interventions were performed to alleviate severe bone pain. The wound was closed using sutures. Postoperatively, the patient will receive appropriate antibiotics, specialized pain management, and physical therapy for optimal recovery and relief of severe bone pain.

7. Operative Note: Myositis with severe bone pain secondary to bacterial infection necessitated surgical intervention. Under general anesthesia, a 9 cm incision was made, providing exposure to the affected muscle and the area of intense bone pain. Debridement of necrotic tissue was performed meticulously, and the wound and bone area were irrigated with antimicrobial solution. Hemostasis was achieved, and specific interventions were carried out to alleviate severe bone pain. The wound was closed, and the patient will receive postoperative antibiotics, targeted pain management, and close monitoring for infection, bone healing, and relief of severe bone pain.

8. Operative Note: Patient presented with myositis in the context of bacterial diseases classified elsewhere, requiring surgical treatment for severe bone pain. Following regional anesthesia, an 8 cm incision was made to access the affected muscle and the area of intense bone pain. Thorough debridement of necrotic tissue was performed, followed by irrigation with antibiotic solution. Hemostasis was ensured, and specific interventions were performed to alleviate severe bone pain. The wound was closed in layers. Postoperatively, the patient will receive antibiotics, specialized pain management, and appropriate measures to promote bone healing and relieve severe bone pain.

9. Operative Note: Surgical intervention was carried out for myositis associated with bacterial infection and severe bone pain. Under general anesthesia, a 7 cm incision was made, providing access to the affected muscle and the area of intense bone pain. Necrotic tissue was meticulously debrided, and the wound and bone area were irrigated with sterile saline. Hemostasis was achieved, and specific interventions were performed to alleviate severe bone pain. The wound was closed using sutures. The patient will receive postoperative antibiotics, targeted pain management, and close monitoring for infection, bone healing, and relief of severe bone pain.

10. Operative Note: Myositis secondary to bacterial infection with concurrent severe bone pain necessitated surgical management. After administering local anesthesia, a 9 cm incision was made, allowing visualization and debridement of necrotic tissue. The area of intense bone pain was identified and specific interventions were performed to alleviate the pain. The wound was thoroughly irrigated with antimicrobial solution. Hemostasis was achieved, and the incision was closed using sutures. Postoperatively, the patient will receive appropriate antibiotics, specialized pain management, and physical therapy to promote bone healing and provide relief from severe bone pain.

1. Operative Note: Surgical intervention was performed for the management of myositis in bacterial diseases classified elsewhere. Under general anesthesia, a 6 cm incision was made, providing access to the affected muscle. Extensive debridement of necrotic tissue was carried out, followed by meticulous irrigation with sterile saline. Hemostasis was achieved, and the wound was closed in layers using sutures. Postoperative care includes antibiotic therapy, wound care, and close monitoring for any signs of infection or recurrence.

2. Operative Note: Surgical intervention was performed to address myositis associated with bacterial infection. After administering regional anesthesia, a 9 cm incision was made, allowing access to the affected muscle. Necrotic tissue was thoroughly debrided, and the wound was irrigated with antimicrobial solution. Hemostasis was achieved, and the incision was closed using sutures. The patient will receive postoperative antibiotics, wound care, and physiotherapy to aid in the recovery process and restore muscle function.

3. Operative Note: Surgical intervention was carried out to manage myositis in the context of bacterial diseases classified elsewhere. Under local anesthesia, an 8 cm incision was made, providing visualization and debridement of necrotic tissue. The wound was irrigated with antiseptic solution, and hemostasis was achieved. The incision was closed using sutures. Postoperatively, the patient will receive antibiotics, wound care, and regular follow-up to monitor the healing process and ensure optimal recovery.

4. Operative Note: Surgical intervention was performed for the treatment of myositis associated with bacterial infection. Under general anesthesia, a 7 cm incision was made to access the affected muscle. Necrotic tissue was meticulously debrided, and the wound was irrigated with antiseptic solution. Hemostasis was achieved, and the incision was closed using sutures. Postoperatively, the patient will receive antibiotics, wound care, and pain management to facilitate healing and alleviate discomfort.

5. Operative Note: Surgical intervention was performed to address myositis in bacterial diseases classified elsewhere. After administering regional anesthesia, a 10 cm incision was made, allowing exposure and debridement of necrotic tissue. The wound was thoroughly irrigated with antimicrobial solution, and hemostasis was achieved. The incision was closed in layers using sutures. The patient will receive antibiotics, wound care, and physical therapy to promote healing and regain muscle strength.

6. Operative Note: Surgical intervention was carried out to manage myositis associated with bacterial infection. Under local anesthesia, an 8 cm incision was made to provide access to the affected muscle. Extensive debridement of necrotic tissue was performed, and the wound was irrigated with sterile saline. Hemostasis was achieved, and the incision was closed using sutures. Postoperatively, the patient will receive antibiotics, wound care, and close monitoring for any signs of infection or complications.

7. Operative Note: Surgical intervention was performed for the treatment of myositis in the context of bacterial diseases classified elsewhere. Under general anesthesia, a 9 cm incision was made, allowing visualization and debridement of necrotic tissue. The wound was thoroughly irrigated with antiseptic solution, and hemostasis was achieved. The incision was closed using sutures. Postoperatively, the patient will receive antibiotics, wound care, and rehabilitation exercises to facilitate recovery and improve muscle function.

8. Operative Note: Surgical intervention was performed to address myositis associated with bacterial infection. After administering regional anesthesia, a 8 cm incision was made to access the affected muscle. Necrotic tissue was meticulously debrided, and the wound was irrigated with antimicrobial solution. Hemostasis was achieved, and the incision was closed using sutures. The patient will receive postoperative antibiotics, wound care, and physical therapy to aid in the healing process and restore muscle function.

9. Operative Note: Surgical intervention was carried out to manage myositis in bacterial diseases classified elsewhere. Under local anesthesia, a 7 cm incision was made, providing visualization and debridement of necrotic tissue. The wound was irrigated with antiseptic solution, and hemostasis was achieved. The incision was closed using sutures. Postoperatively, the patient will receive antibiotics, wound care, and regular follow-up to monitor the healing process and ensure optimal recovery.

10. Operative Note: Surgical intervention was performed for the treatment of myositis associated with bacterial infection. Under general anesthesia, a 10 cm incision was made to access the affected muscle. Necrotic tissue was thoroughly debrided, and the wound was irrigated with antiseptic solution. Hemostasis was achieved, and the incision was closed using sutures. Postoperatively, the patient will receive antibiotics, wound care, and pain management to facilitate healing and alleviate discomfort.

1. Operative Note: Surgical intervention was performed to address severe myositis in bacterial diseases classified elsewhere with involvement of bone erosion. Under general anesthesia, a 6 cm incision was made, providing access to the affected muscle and the eroded bone. Necrotic tissue was meticulously debrided, and the bone erosion site was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and bone reconstruction was performed using graft material. The wound was closed in layers. Postoperatively, the patient will receive antibiotics, pain management, and close monitoring for infection, bone healing, and symptom improvement.

2. Operative Note: Surgical intervention was carried out for myositis associated with bacterial infection, presenting with severe bone pain and evident bone erosion. After administering regional anesthesia, a 9 cm incision was made, allowing visualization and debridement of necrotic tissue. The eroded bone was exposed and thoroughly irrigated with sterile saline. Hemostasis was achieved, and bone grafting was performed to address the erosion. The wound was closed using sutures. Postoperatively, the patient will receive antibiotics, specialized pain management, and appropriate measures to promote bone healing and symptom relief.

3. Operative Note: Surgical intervention was performed for myositis in bacterial diseases classified elsewhere, accompanied by severe bone pain and bone erosion. Under general anesthesia, a 8 cm incision was made, providing access to the affected muscle and the area of bone erosion. Thorough debridement of necrotic tissue was performed, followed by irrigation with antimicrobial solution. Hemostasis was ensured, and bone reconstruction was carried out using autograft material. The wound was closed in layers. Postoperatively, the patient will receive antibiotics, targeted pain management, and close monitoring for infection, bone healing, and improvement in bone pain.

4. Operative Note: Surgical intervention was performed to address myositis in bacterial diseases classified elsewhere, complicated by severe bone pain and evident bone erosion. After administering regional anesthesia, a 7 cm incision was made, allowing access to the affected muscle and the site of bone erosion. Necrotic tissue was meticulously debrided, and the eroded bone was irrigated with antiseptic solution. Hemostasis was achieved, and bone reconstruction using graft material was performed. The wound was closed using sutures. Postoperatively, the patient will receive antibiotics, targeted pain management, and close monitoring for infection, bone healing, and resolution of bone pain.

5. Operative Note: Surgical intervention was carried out for myositis associated with bacterial infection, presenting with severe bone pain and bone erosion. Under general anesthesia, a 10 cm incision was made, providing access to the affected muscle and the area of bone erosion. Extensive debridement of necrotic tissue was performed, followed by thorough irrigation with antibiotic solution. Hemostasis was achieved, and bone reconstruction was carried out using graft material. The wound was closed in layers. Postoperatively, the patient will receive antibiotics, specialized pain management, and close monitoring for infection, bone healing, and relief of severe bone pain.

6. Operative Note: Surgical intervention was performed for myositis in the context of bacterial diseases classified elsewhere, characterized by severe bone pain and bone erosion. Following regional anesthesia, an 8 cm incision was made, allowing access to the affected muscle and the area of bone erosion. Necrotic tissue was meticulously debrided, and the eroded bone was irrigated with sterile saline. Hemostasis was achieved, and bone reconstruction using graft material was performed. The wound was closed using sutures. Postoperatively, the patient will receive antibiotics, targeted pain management, and appropriate measures to promote bone healing and alleviate severe bone pain.

7. Operative Note: Surgical intervention was performed to address severe myositis associated with bacterial infection, accompanied by bone erosion and severe bone pain. Under general anesthesia, a 9 cm incision was made, providing visualization and debridement of necrotic tissue. The eroded bone was exposed and thoroughly irrigated with antimicrobial solution. Hemostasis was achieved, and bone grafting was performed to address the erosion. The wound was closed using sutures. Postoperatively, the patient will receive antibiotics, specialized pain management, and close monitoring for infection, bone healing, and improvement in bone pain.

8. Operative Note: Surgical intervention was carried out for myositis in bacterial diseases classified elsewhere, presenting with severe bone pain and evident bone erosion. After administering regional anesthesia, a 8 cm incision was made, allowing access to the affected muscle and the site of bone erosion. Thorough debridement of necrotic tissue was performed, followed by irrigation with antiseptic solution. Hemostasis was ensured, and bone reconstruction using autograft material was carried out. The wound was closed in layers. Postoperatively, the patient will receive antibiotics, targeted pain management, and close monitoring for infection, bone healing, and improvement in bone pain.

9. Operative Note: Surgical intervention was performed to address myositis in bacterial diseases classified elsewhere, complicated by severe bone pain and bone erosion. Under general anesthesia, a 7 cm incision was made, providing access to the affected muscle and the area of bone erosion. Necrotic tissue was meticulously debrided, and the eroded bone was irrigated with antiseptic solution. Hemostasis was achieved, and bone reconstruction using graft material was performed. The wound was closed using sutures. Postoperatively, the patient will receive antibiotics, targeted pain management, and close monitoring for infection, bone healing, and resolution of bone pain.

10. Operative Note: Surgical intervention was carried out for myositis associated with bacterial infection, presenting with severe bone pain and evident bone erosion. After administering regional anesthesia, a 10 cm incision was made, allowing access to the affected muscle and the area of bone erosion. Extensive debridement of necrotic tissue was performed, followed by thorough irrigation with antibiotic solution. Hemostasis was achieved, and bone reconstruction using graft material was carried out. The wound was closed in layers. Postoperatively, the patient will receive antibiotics, specialized pain management, and close monitoring for infection, bone healing, and relief of severe bone pain.

## M63.1 Myositis in protozoal and parasitic infections classified elsewhere

1. Patient presented with symptoms consistent with myositis secondary to protozoal infection. Examination revealed muscle weakness and tenderness. Diagnostic tests confirmed the presence of the parasite. Initiated treatment with appropriate antiparasitic medications.

2. Operative note for myositis caused by parasitic infection. Surgical intervention performed to obtain muscle biopsy for histopathological analysis. Findings revealed protozoal organisms within the muscle tissue. Patient initiated on targeted antiparasitic therapy post-operatively.

3. Myositis secondary to protozoal infection treated with a combination of antiparasitic agents and immunosuppressive therapy. Patient responded well with decreased muscle inflammation and improved muscle strength. Close monitoring for potential treatment-related adverse effects.

4. Operative intervention for myositis related to parasitic infection. Surgical exploration performed to identify and remove parasite cysts within the affected muscle tissue. Complete excision achieved, followed by appropriate antiparasitic treatment. Post-operative recovery was uneventful.

5. Patient presented with severe myositis attributed to protozoal infection. Electromyography (EMG) demonstrated characteristic findings of muscle inflammation. Initiated therapy with antiparasitic medications and adjunctive measures. Clinical improvement observed with reduced muscle pain and improved mobility.

6. Operative note for myositis associated with parasitic infection. Intraoperative muscle biopsy performed to confirm the presence of the protozoal organism. Histopathological analysis confirmed the diagnosis, leading to initiation of targeted antiparasitic therapy.

7. Myositis secondary to a protozoal infection managed surgically. Exploratory surgery performed to assess the extent of muscle involvement and identify any abscess formation. Debridement and drainage of the affected area completed, followed by antiparasitic treatment and wound care.

8. Operative intervention for myositis related to parasitic infection. Excisional biopsy performed to obtain tissue samples for culture and sensitivity testing. Identified the presence of protozoal organisms, guiding the initiation of appropriate antiparasitic therapy.

9. Myositis attributed to a protozoal infection managed non-surgically. Initiated treatment with antiparasitic medications and adjunctive measures such as physical therapy and pain management. Monitored closely for clinical response and potential treatment-related complications.

10. Operative note for myositis caused by parasitic infection. Incision and drainage performed to address an abscess within the affected muscle. Cultured the abscess fluid, confirming the presence of the protozoal organism. Commenced antiparasitic therapy post-operatively, with subsequent improvement in symptoms.

1. Patient diagnosed with myositis associated with protozoal infection. Electromyography (EMG) revealed characteristic patterns of muscle inflammation. Initiated antiparasitic treatment combined with immunomodulatory therapy. Close monitoring for treatment response and potential adverse effects.

2. Operative intervention for myositis secondary to parasitic infection. Surgical exploration performed to identify and remove parasite larvae from the affected muscle tissue. Complete excision achieved, followed by antiparasitic medication administration. Patient demonstrated gradual improvement in muscle strength.

3. Myositis attributed to protozoal infection managed conservatively with antiparasitic therapy and supportive measures. Regular monitoring of muscle function, pain, and systemic response. Patient reported reduced muscle weakness and decreased levels of inflammation markers.

4. Operative note for myositis related to parasitic infection. Excisional biopsy performed to obtain muscle tissue for histopathological examination. Identified the presence of protozoal cysts, guiding the initiation of targeted antiparasitic therapy.

5. Myositis secondary to protozoal infection treated with a combination of antiparasitic medications and corticosteroids. Monitored for any signs of treatment-related complications. Patient exhibited gradual improvement in muscle strength and reduction in inflammation markers.

6. Operative intervention for myositis caused by parasitic infection. Surgical debridement performed to remove necrotic muscle tissue and eliminate the parasite burden. Administered antiparasitic medications post-operatively, with subsequent resolution of symptoms.

7. Myositis associated with protozoal infection managed non-surgically. Initiated antiparasitic therapy along with physical therapy and analgesics. Regular assessments demonstrated improvement in muscle function and pain scores.

8. Operative note for myositis related to parasitic infection. Muscle biopsy performed to confirm the presence of protozoal organisms within the affected tissue. Initiated appropriate antiparasitic treatment based on the histopathological findings.

9. Myositis attributed to protozoal infection managed with a combination of antiparasitic therapy and immune-modulating agents. Monitored for treatment response and potential side effects. Patient showed clinical improvement with reduced muscle inflammation and improved mobility.

10. Operative intervention for myositis caused by parasitic infection. Excision and drainage performed to address an abscess within the affected muscle. Cultured the abscess fluid, confirming the presence of protozoal organisms. Initiated antiparasitic therapy and wound care, resulting in resolution of symptoms.

1. Patient diagnosed with myositis associated with protozoal infection underwent surgical intervention under general anesthesia. Muscle biopsy obtained for histopathological analysis. Antiparasitic therapy initiated postoperatively, with careful titration of anesthesia dosage to ensure optimal pain management and patient comfort.

2. Operative note for myositis secondary to parasitic infection. Surgery performed under regional anesthesia to obtain muscle biopsy specimens. Adjusted anesthesia dosage to maintain adequate pain control during the procedure. Antiparasitic treatment initiated postoperatively, with close monitoring of anesthesia-related side effects.

3. Myositis attributed to protozoal infection managed surgically under local anesthesia. Debridement and drainage of abscess performed with a lower anesthesia dosage to minimize systemic effects. Antiparasitic therapy initiated postoperatively, ensuring appropriate pain relief and patient satisfaction.

4. Operative intervention for myositis related to parasitic infection. Surgical exploration performed under monitored anesthesia care, allowing for lower anesthesia dosage while ensuring patient comfort and cooperation. Antiparasitic treatment initiated postoperatively, with regular assessment of anesthesia-related complications.

5. Myositis secondary to protozoal infection managed surgically under general anesthesia. Adjusted anesthesia dosage based on patient's comorbidities and hemodynamic stability. Intraoperative muscle biopsy performed, followed by antiparasitic therapy and tailored pain management postoperatively.

6. Operative note for myositis caused by parasitic infection. Surgery performed under conscious sedation, with titration of anesthesia dosage to maintain patient comfort and cooperation. Muscle biopsy obtained for diagnostic purposes, followed by initiation of antiparasitic treatment.

7. Myositis attributed to a protozoal infection managed non-surgically under local anesthesia. Adjusted anesthesia dosage to minimize discomfort during diagnostic procedures, such as electromyography and imaging. Initiated antiparasitic therapy post-procedure, ensuring optimal pain control.

8. Operative intervention for myositis related to parasitic infection. Surgery performed under balanced general anesthesia, carefully titrating anesthesia dosage to maintain stable hemodynamics and minimize postoperative complications. Antiparasitic therapy initiated postoperatively, with regular assessment of anesthesia-related side effects.

9. Myositis associated with protozoal infection managed surgically under regional anesthesia. Adjusted anesthesia dosage to provide adequate pain control and muscle relaxation during the procedure. Postoperative antiparasitic therapy initiated, with close monitoring of anesthesia-related complications.

10. Operative note for myositis caused by parasitic infection. Surgery performed under monitored anesthesia care, titrating anesthesia dosage based on patient's age and underlying medical conditions. Muscle debridement and biopsy completed, followed by antiparasitic treatment and tailored pain management.

1. Patient presented with myositis and significant bone erosion secondary to protozoal infection. Surgical intervention performed to address the bone defect and obtain tissue samples for culture. Administered antiparasitic therapy postoperatively, with close monitoring of bone healing and response to treatment.

2. Operative note for myositis related to parasitic infection with associated bone erosion. Surgical debridement and bone grafting performed to address the bony defect. Initiated antiparasitic therapy postoperatively, with regular radiographic monitoring of bone healing and regression of infection.

3. Myositis attributed to protozoal infection with extensive bone erosion managed surgically. Excisional debridement of the affected muscle and bone performed, followed by grafting and stabilization. Administered antiparasitic therapy, monitoring for bone healing and infection resolution.

4. Operative intervention for myositis caused by parasitic infection with concurrent bone erosion. Surgical exploration and debridement performed to remove infected tissue and address bone erosion. Antiparasitic therapy initiated postoperatively, with close follow-up for bone healing and treatment response.

5. Myositis associated with protozoal infection and bone erosion treated surgically. Comprehensive debridement and bone reconstruction performed, followed by antiparasitic therapy. Regular imaging assessments utilized to monitor bone healing and resolution of infection.

6. Operative note for myositis related to parasitic infection with bone erosion. Surgical intervention involved debridement of the affected muscle and bone, followed by bone grafting and stabilization. Initiated antiparasitic therapy postoperatively, with ongoing radiographic evaluation of bone healing and infection control.

7. Myositis attributed to a protozoal infection with extensive bone erosion managed surgically. Excisional debridement of necrotic tissue and bone performed, followed by reconstruction and antiparasitic therapy. Regular imaging studies employed to assess bone healing and response to treatment.

8. Operative intervention for myositis caused by parasitic infection with significant bone erosion. Surgical exploration and debridement of affected muscle and bone completed, followed by reconstruction and antiparasitic therapy. Regular clinical and radiographic monitoring for infection control and bone healing.

9. Myositis associated with protozoal infection and bone erosion addressed surgically. Debridement of infected tissue and bone performed, followed by bone grafting and stabilization. Administered antiparasitic therapy, monitoring for resolution of infection and bone remodeling.

10. Operative note for myositis related to parasitic infection with bone erosion. Surgical intervention involved extensive debridement of the affected muscle and bone, followed by bone grafting and stabilization. Initiated antiparasitic therapy postoperatively, with regular radiographic assessment of bone healing and control of infection.

1. Patient presented with severe bone pain in the context of myositis secondary to protozoal infection. Surgical intervention performed to address the underlying infection and alleviate pain. Administered antiparasitic therapy postoperatively, with close monitoring of pain relief and overall clinical improvement.

2. Operative note for myositis related to parasitic infection with severe bone pain. Surgical debridement and drainage performed to alleviate pain and control the infection. Initiated aggressive pain management strategies alongside antiparasitic therapy for comprehensive symptom relief.

3. Myositis attributed to protozoal infection accompanied by severe bone pain managed surgically. Excisional debridement of affected muscle and bone performed, followed by antiparasitic therapy and targeted pain management. Regular assessment of pain intensity and treatment response.

4. Operative intervention for myositis caused by parasitic infection with severe bone pain. Surgical exploration and debridement completed to address the underlying infection and alleviate pain. Combined antiparasitic therapy and multimodal pain management initiated postoperatively.

5. Myositis associated with protozoal infection and severe bone pain treated surgically. Extensive debridement of infected tissue and bone performed, followed by antiparasitic therapy and aggressive pain control measures. Regular pain assessments utilized to tailor pain management strategies.

6. Operative note for myositis related to parasitic infection with debilitating bone pain. Surgical intervention involved debridement of affected muscle and bone to alleviate pain and control the infection. Implemented a multimodal pain management approach alongside antiparasitic therapy.

7. Myositis attributed to a protozoal infection with severe bone pain managed surgically. Excisional debridement of necrotic tissue and bone performed to alleviate pain and prevent further spread of the infection. Combined antiparasitic therapy and targeted pain relief measures initiated postoperatively.

8. Operative intervention for myositis caused by parasitic infection with severe bone pain. Surgical exploration and debridement completed to relieve pain and address the underlying infection. Initiated comprehensive pain management strategies alongside antiparasitic therapy.

9. Myositis associated with protozoal infection and severe bone pain addressed surgically. Debridement of infected tissue and bone performed to alleviate pain and promote healing. Administered antiparasitic therapy and closely monitored pain levels for effective pain control.

10. Operative note for myositis related to parasitic infection with severe bone pain. Surgical intervention involved extensive debridement of the affected muscle and bone to relieve pain and control the infection. Implemented a combination of antiparasitic therapy and specialized pain management techniques for optimal pain relief.

1. Surgical intervention performed for myositis attributed to protozoal infection with severe bone pain. Muscle and bone debridement executed to alleviate pain and eradicate the infection source. Initiated antiparasitic therapy postoperatively, with regular assessment of pain levels and clinical improvement.

2. Operative note for myositis related to parasitic infection accompanied by severe bone pain. Surgical exploration and debridement carried out to relieve pain and address the underlying infection. Implemented a multimodal pain management approach alongside antiparasitic therapy for comprehensive symptom relief.

3. Myositis secondary to protozoal infection necessitating surgical intervention due to severe bone pain. Excisional debridement of affected muscle and bone executed to alleviate pain and control the infection. Postoperative antiparasitic therapy initiated, with close monitoring of pain levels and treatment response.

4. Surgical intervention performed for myositis caused by parasitic infection with severe bone pain. Intraoperative exploration and debridement completed to relieve pain and eradicate the infectious focus. Commenced antiparasitic therapy postoperatively, monitoring pain relief and overall clinical progress.

5. Myositis attributed to protozoal infection accompanied by severe bone pain managed surgically. Surgical debridement and drainage conducted to alleviate pain and control the infection. Administered antiparasitic therapy postoperatively, with regular pain assessments and adjustment of pain management strategies.

6. Operative note for myositis related to parasitic infection with debilitating bone pain. Surgical intervention involved extensive debridement of the affected muscle and bone to alleviate pain and control the infection. Initiated antiparasitic therapy postoperatively, with regular pain assessments and optimization of pain relief measures.

7. Surgical intervention performed for myositis secondary to protozoal infection with severe bone pain. Comprehensive debridement of infected muscle and bone executed to alleviate pain and eradicate the infectious source. Administered antiparasitic therapy postoperatively, monitoring pain levels and clinical improvement.

8. Myositis caused by parasitic infection necessitating surgical intervention due to severe bone pain. Surgical exploration and debridement conducted to relieve pain and address the underlying infection. Implemented a tailored pain management approach alongside antiparasitic therapy for effective pain control.

9. Operative note for myositis attributed to protozoal infection with severe bone pain. Surgical intervention involved debridement of affected muscle and bone to alleviate pain and eradicate the infection source. Commenced antiparasitic therapy postoperatively, with regular pain assessments and adjustment of pain management strategies.

10. Surgical intervention performed for myositis related to parasitic infection with severe bone pain. Extensive debridement and drainage executed to alleviate pain and control the infectious focus. Administered antiparasitic therapy postoperatively, monitoring pain levels and overall treatment response.

1. Surgical intervention carried out for myositis associated with protozoal infection and severe bone pain. Muscle biopsy performed to assess the extent of tissue damage. Initiated antiparasitic therapy postoperatively, with close monitoring of pain levels and functional improvement.

2. Operative note for myositis related to parasitic infection with severe bone pain. Surgical debridement and bone reconstruction performed to alleviate pain and promote healing. Implemented a multidisciplinary approach, including antiparasitic therapy and specialized pain management techniques.

3. Myositis attributed to protozoal infection with severe bone pain managed surgically. Excisional debridement of the affected muscle and bone executed to relieve pain and eradicate the infection. Initiated antiparasitic therapy postoperatively, with regular pain assessments and functional rehabilitation.

4. Surgical intervention performed for myositis caused by parasitic infection with severe bone pain. Intraoperative exploration and debridement completed to address the underlying infection and alleviate pain. Commenced antiparasitic therapy postoperatively, monitoring pain levels and clinical progress.

5. Myositis associated with protozoal infection and severe bone pain addressed surgically. Debridement of infected muscle and bone performed to alleviate pain and promote healing. Administered antiparasitic therapy, with close monitoring of pain levels and overall treatment response.

6. Operative note for myositis related to parasitic infection with severe bone pain. Surgical intervention involved extensive debridement of the affected muscle and bone to relieve pain and control the infection. Initiated antiparasitic therapy postoperatively, with regular pain assessments and functional rehabilitation.

7. Myositis attributed to a protozoal infection with severe bone pain managed surgically. Excisional debridement of necrotic tissue and bone executed to alleviate pain and eradicate the infection. Administered antiparasitic therapy postoperatively, monitoring pain levels and clinical improvement.

8. Surgical intervention performed for myositis caused by parasitic infection with severe bone pain. Surgical exploration and debridement completed to relieve pain and eradicate the infectious source. Initiated antiparasitic therapy postoperatively, with close monitoring of pain levels and treatment response.

9. Myositis associated with protozoal infection and severe bone pain necessitating surgical intervention. Debridement of infected muscle and bone performed to alleviate pain and promote healing. Administered antiparasitic therapy, with regular pain assessments and functional rehabilitation.

10. Operative note for myositis related to parasitic infection with severe bone pain. Surgical intervention involved comprehensive debridement of the affected muscle and bone to alleviate pain and control the infection. Initiated antiparasitic therapy postoperatively, with regular pain assessments and optimization of pain management strategies.

1. Surgical intervention performed for myositis associated with severe infection on the extremity joint. Joint debridement and lavage carried out to alleviate pain and control the infection. Initiated aggressive antimicrobial therapy postoperatively, with close monitoring of joint function and infection resolution.

2. Operative note for myositis related to parasitic infection with severe infection on the extreme moving joint. Surgical exploration and debridement executed to address the infectious focus and alleviate pain. Implemented a multidisciplinary approach involving antimicrobial therapy and specialized joint rehabilitation.

3. Myositis attributed to protozoal infection with severe infection on the extreme moving joint managed surgically. Comprehensive debridement of the joint performed to eradicate the infection and improve joint function. Administered targeted antimicrobial therapy, monitoring joint mobility and infection control.

4. Surgical intervention performed for myositis caused by parasitic infection with severe infection on the extreme moving joint. Joint debridement and lavage carried out to alleviate pain and eradicate the infection source. Initiated antimicrobial therapy postoperatively, monitoring joint function and infection resolution.

5. Myositis associated with protozoal infection and severe infection on the extreme moving joint addressed surgically. Debridement of the joint performed to alleviate pain and control the infection. Administered targeted antimicrobial therapy, with close monitoring of joint function and infection response.

6. Operative note for myositis related to parasitic infection with severe infection on the extreme moving joint. Surgical intervention involved extensive debridement of the joint to alleviate pain and eradicate the infection. Commenced aggressive antimicrobial therapy postoperatively, monitoring joint mobility and infection control.

7. Myositis attributed to a protozoal infection with severe infection on the extreme moving joint managed surgically. Joint debridement and irrigation executed to alleviate pain and control the infection. Administered antimicrobial therapy postoperatively, monitoring joint function and infection resolution.

8. Surgical intervention performed for myositis caused by parasitic infection with severe infection on the extreme moving joint. Joint exploration and debridement completed to alleviate pain and eradicate the infectious source. Initiated targeted antimicrobial therapy postoperatively, with close monitoring of joint function and treatment response.

9. Myositis associated with protozoal infection and severe infection on the extreme moving joint necessitating surgical intervention. Debridement of the joint performed to alleviate pain and control the infection. Administered antimicrobial therapy, monitoring joint function and infection resolution.

10. Operative note for myositis related to parasitic infection with severe infection on the extreme moving joint. Surgical intervention involved thorough debridement of the joint to alleviate pain and control the infection. Initiated targeted antimicrobial therapy postoperatively, with regular monitoring of joint function and infection control.

1. Surgical intervention performed for myositis associated with severe inflammation and infection on the extremity joint. Joint debridement and lavage carried out to alleviate pain, reduce inflammation, and control the infection. Initiated aggressive antimicrobial therapy and anti-inflammatory measures postoperatively, monitoring joint function and inflammation levels.

2. Operative note for myositis related to parasitic infection with severe inflammation and infection on the extreme moving joint. Surgical exploration and debridement executed to address the infectious focus, reduce inflammation, and promote joint healing. Implemented a multidisciplinary approach involving antimicrobial therapy, anti-inflammatory medications, and specialized joint rehabilitation.

3. Myositis attributed to protozoal infection with severe inflammation and infection on the extreme moving joint managed surgically. Comprehensive debridement of the joint performed to eradicate the infection, alleviate pain, and decrease inflammation. Administered targeted antimicrobial therapy and anti-inflammatory measures, monitoring joint mobility and inflammation control.

4. Surgical intervention performed for myositis caused by parasitic infection with severe inflammation and infection on the extreme moving joint. Joint debridement and lavage carried out to alleviate pain, reduce inflammation, and eradicate the infection source. Initiated antimicrobial therapy and implemented a tailored anti-inflammatory regimen postoperatively, monitoring joint function and inflammation response.

5. Myositis associated with protozoal infection and severe inflammation and infection on the extreme moving joint addressed surgically. Debridement of the joint performed to alleviate pain, reduce inflammation, and control the infection. Administered targeted antimicrobial therapy and implemented anti-inflammatory measures, with close monitoring of joint function and inflammation levels.

6. Operative note for myositis related to parasitic infection with severe inflammation and infection on the extreme moving joint. Surgical intervention involved extensive debridement of the joint to alleviate pain, reduce inflammation, and eradicate the infection. Commenced aggressive antimicrobial therapy and implemented a comprehensive anti-inflammatory approach postoperatively, monitoring joint mobility and inflammation control.

7. Myositis attributed to a protozoal infection with severe inflammation and infection on the extreme moving joint managed surgically. Joint debridement and irrigation executed to alleviate pain, reduce inflammation, and control the infection. Administered antimicrobial therapy and implemented anti-inflammatory measures postoperatively, monitoring joint function and inflammation resolution.

8. Surgical intervention performed for myositis caused by parasitic infection with severe inflammation and infection on the extreme moving joint. Joint exploration and debridement completed to alleviate pain, reduce inflammation, and eradicate the infectious source. Initiated targeted antimicrobial therapy and implemented an individualized anti-inflammatory regimen postoperatively, with close monitoring of joint function and treatment response.

9. Myositis associated with protozoal infection and severe inflammation and infection on the extreme moving joint necessitating surgical intervention. Debridement of the joint performed to alleviate pain, reduce inflammation, and control the infection. Administered antimicrobial therapy and implemented anti-inflammatory measures, monitoring joint function and inflammation resolution.

10. Operative note for myositis related to parasitic infection with severe inflammation and infection on the extreme moving joint. Surgical intervention involved thorough debridement of the joint to alleviate pain, reduce inflammation, and control the infection. Initiated targeted antimicrobial therapy and implemented a comprehensive anti-inflammatory approach postoperatively, with regular monitoring of joint function and inflammation control.

1. Follow-up plan based on the severity of myositis diagnosis due to protozoal infection. For mild cases, outpatient management with antiparasitic therapy and regular monitoring of symptoms and laboratory markers. Moderate cases require close follow-up with multidisciplinary team involvement for ongoing antimicrobial treatment, pain management, and physical therapy. Severe cases necessitate hospitalization, aggressive treatment, and regular reassessment of clinical response and complications.

2. Based on the severity of myositis diagnosis related to parasitic infection, follow-up will be tailored accordingly. Mild cases will have outpatient visits for antiparasitic therapy and symptom monitoring. Moderate cases will require regular follow-up with specialists for treatment adjustment, pain management, and rehabilitation. Severe cases will be closely monitored in a hospital setting, with multidisciplinary care and frequent assessments to address complications and optimize treatment outcomes.

3. Follow-up plan for myositis diagnosis attributed to protozoal infection depends on the severity. Mild cases will have outpatient visits for antiparasitic therapy and periodic evaluation. Moderate cases require regular follow-up appointments, including physical therapy and pain management interventions. Severe cases necessitate frequent hospital visits with a specialized team for aggressive treatment, wound care, and close monitoring of systemic complications.

4. Depending on the severity of myositis diagnosis caused by parasitic infection, follow-up will be tailored. Mild cases can be managed with outpatient visits for antiparasitic therapy and symptom monitoring. Moderate cases require regular follow-up appointments, pain management, and rehabilitation. Severe cases will be closely monitored in a hospital setting, involving frequent assessments, aggressive treatment, and potential surgical interventions, with ongoing rehabilitation and pain management.

5. Follow-up plan for myositis associated with protozoal infection varies based on the severity of the diagnosis. Mild cases will have periodic outpatient visits for antiparasitic therapy and symptom assessment. Moderate cases necessitate regular follow-up with a specialized team for ongoing treatment adjustments, pain management, and physical therapy. Severe cases require close monitoring in a hospital setting, with frequent evaluations, possible surgical interventions, and comprehensive care for systemic complications.

6. Depending on the severity of myositis diagnosis related to parasitic infection, follow-up will be individualized. Mild cases will have scheduled outpatient appointments for antiparasitic therapy and symptom monitoring. Moderate cases require regular follow-up visits, involving treatment optimization, pain management, and functional rehabilitation. Severe cases necessitate frequent hospital visits with an interdisciplinary team for aggressive treatment, close monitoring of complications, and potential surgical interventions.

7. Follow-up plan for myositis attributed to protozoal infection is tailored to the severity of the diagnosis. Mild cases will have periodic outpatient visits for antiparasitic therapy and clinical assessment. Moderate cases require regular follow-up with specialists for treatment adjustments, pain management, and physical therapy. Severe cases will be closely monitored in a hospital setting, involving frequent evaluations, aggressive treatment, and potential surgical interventions.

8. Depending on the severity of myositis diagnosis caused by parasitic infection, the follow-up plan will vary. Mild cases will have outpatient visits for antiparasitic therapy and periodic reassessment. Moderate cases necessitate regular follow-up appointments with a specialized team for treatment optimization, pain management, and rehabilitation. Severe cases will require frequent hospital visits, with close monitoring, potential surgical interventions, and comprehensive care for associated complications.

9. Follow-up plan for myositis associated with protozoal infection depends on the severity of the diagnosis. Mild cases will have scheduled outpatient visits for antiparasitic therapy and symptom evaluation. Moderate cases require regular follow-up appointments, including treatment adjustments, pain management strategies, and physical therapy. Severe cases necessitate frequent hospital visits with an integrated care team, involving aggressive treatment, potential surgical interventions, and close monitoring of systemic manifestations.

10. Depending on the severity of myositis diagnosis related to parasitic infection, the follow-up plan will be individualized. Mild cases will have outpatient visits for antiparasitic therapy and periodic follow-up. Moderate cases require regular follow-up appointments, involving treatment optimization, pain management, and tailored rehabilitation. Severe cases will be closely monitored in a hospital setting, with frequent evaluations, potential surgical interventions, and comprehensive care for associated complications.

## M63.2 Myositis in other infectious diseases classified elsewhere

1. Operative Note - Myositis (Viral): Patient underwent bilateral muscle biopsy due to suspected viral myositis. The procedure was performed under general anesthesia. Multiple muscle samples were obtained and sent for histopathological analysis. Intraoperative findings revealed focal myocyte necrosis and inflammatory infiltrates. Hemostasis was achieved, and the incisions were closed in layers. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

2. Operative Note - Myositis (Bacterial): The patient presented with severe bacterial myositis involving the left lower extremity. An incision was made over the affected area, and extensive debridement of necrotic muscle tissue was performed. Copious irrigation with saline solution was done to remove debris. The wound was packed with sterile dressings, and appropriate antibiotic therapy was initiated. The patient's vital signs remained stable throughout the procedure.

3. Operative Note - Myositis (Parasitic): Surgical intervention was required for a case of parasitic myositis. A muscle biopsy was performed to confirm the presence of parasites within the muscle tissue. The affected area was identified and incised, and multiple tissue samples were obtained. The incision was closed using absorbable sutures. The patient was started on antiparasitic medication postoperatively and showed signs of improvement during the recovery period.

4. Operative Note - Myositis (Fungal): The patient underwent a surgical procedure for suspected fungal myositis involving the right thigh. A muscle biopsy was performed, and intraoperative examination revealed fungal hyphae invading the muscle fibers. The affected tissue was excised, and thorough irrigation with antifungal solution was performed. The wound was closed in layers, and appropriate antifungal therapy was initiated. The patient's condition improved gradually postoperatively.

5. Operative Note - Myositis (Protozoal): A case of protozoal myositis necessitated surgical intervention. A muscle biopsy was performed to confirm the presence of protozoal organisms within the affected muscle tissue. The biopsy samples were sent for laboratory analysis. The incision was closed meticulously, and the patient was started on specific antimicrobial therapy based on the identified protozoan species. The patient tolerated the procedure well and showed signs of recovery during follow-up.

6. Operative Note - Myositis (Lyme Disease): Surgical intervention was performed for suspected myositis associated with Lyme disease. The affected muscle group was identified, and a muscle biopsy was performed. Intraoperative findings revealed inflammatory changes consistent with Lyme myositis. The biopsy samples were sent for histopathological examination. The wound was closed using sutures, and appropriate antibiotic therapy was initiated. The patient's symptoms improved gradually over time.

7. Operative Note - Myositis (Tuberculosis): A surgical procedure was performed to address myositis secondary to tuberculosis. The affected muscle group was identified, and a muscle biopsy was carried out. Histopathological examination demonstrated granulomatous inflammation consistent with tuberculous myositis. The wound was meticulously closed, and the patient was started on anti-tuberculosis treatment postoperatively. Follow-up evaluations revealed a positive response to therapy and improvement in the patient's overall condition.

8. Operative Note - Myositis (Malaria): Surgical intervention was required for suspected myositis related to malaria infection. A muscle biopsy was performed, and intraoperative examination revealed pigment-laden macrophages within the muscle tissue. The biopsy samples were sent for further analysis. The wound was closed in layers, and appropriate antimalarial therapy was initiated. The patient showed clinical improvement and resolution of symptoms following treatment.

9. Operative Note - Myositis (Toxoplasmosis): The patient underwent surgical intervention for suspected myositis associated with toxoplasmosis infection. A muscle biopsy was performed, and histopathological analysis revealed the presence of Toxoplasma gondii cysts within the muscle fibers. The wound was closed meticulously, and specific antimicrobial therapy was initiated. The patient responded well to treatment, with a decrease in muscle inflammation and improvement in overall symptoms.

10. Operative Note - Myositis (Leishmaniasis): Surgical intervention was performed for suspected myositis secondary to leishmaniasis. A muscle biopsy was conducted, and histopathological examination demonstrated intracellular parasites consistent with Leishmania species. The affected tissue was excised, and the wound was closed using sutures. The patient received appropriate antiparasitic therapy postoperatively, resulting in a favorable clinical response and resolution of myositis symptoms.

1. Operative Note - Myositis (HIV): The patient underwent muscle biopsy due to suspected myositis associated with HIV infection. The procedure was performed under local anesthesia. Multiple muscle samples were obtained and sent for laboratory analysis. Intraoperative findings revealed inflammatory changes consistent with HIV-associated myositis. The incisions were closed using sutures, and the patient was referred for further management and antiretroviral therapy.

2. Operative Note - Myositis (Syphilis): Surgical intervention was performed for suspected myositis secondary to syphilis infection. A muscle biopsy was performed, and histopathological examination demonstrated spirochete infiltration within the muscle tissue. The wound was closed meticulously, and the patient was started on appropriate antibiotic therapy for syphilis. Regular follow-up evaluations showed a positive response to treatment, with resolution of myositis symptoms.

3. Operative Note - Myositis (Brucellosis): The patient presented with suspected myositis related to brucellosis infection. A muscle biopsy was performed, and histopathological analysis revealed characteristic inflammatory changes consistent with brucellosis myositis. The incision was closed using sutures, and the patient was started on appropriate antimicrobial therapy. Follow-up examinations showed significant improvement in muscle inflammation and the patient's overall condition.

4. Operative Note - Myositis (Dengue Fever): Surgical intervention was required for suspected myositis associated with dengue fever. A muscle biopsy was performed, and intraoperative examination revealed hemorrhagic changes within the muscle tissue. The biopsy samples were sent for analysis. The wound was closed meticulously, and supportive care was provided for the dengue fever infection. The patient demonstrated gradual recovery with resolution of myositis symptoms.

5. Operative Note - Myositis (Chikungunya): The patient underwent surgical intervention for suspected myositis secondary to chikungunya infection. A muscle biopsy was performed, and histopathological examination revealed inflammatory changes consistent with chikungunya myositis. The incision was closed using sutures, and the patient was managed symptomatically with pain relief medications and supportive care. Follow-up evaluations demonstrated improvement in muscle inflammation and gradual resolution of symptoms.

6. Operative Note - Myositis (Influenza): Surgical intervention was performed for suspected myositis associated with influenza infection. A muscle biopsy was conducted, and intraoperative findings revealed myofiber necrosis and inflammatory infiltrates consistent with influenza-related myositis. The wound was closed meticulously, and the patient was started on antiviral therapy. Follow-up assessments demonstrated improvement in muscle inflammation and the patient's overall condition.

7. Operative Note - Myositis (Zika Virus): The patient presented with suspected myositis related to Zika virus infection. A muscle biopsy was performed, and histopathological analysis revealed characteristic inflammatory changes associated with Zika virus myositis. The wound was closed using sutures, and supportive care was provided for the Zika virus infection. Subsequent evaluations showed a positive response to treatment, with resolution of myositis symptoms.

8. Operative Note - Myositis (Ebola Virus): Surgical intervention was required for suspected myositis secondary to Ebola virus infection. A muscle biopsy was performed, and intraoperative examination revealed myofiber necrosis and hemorrhagic changes within the muscle tissue. The biopsy samples were sent for analysis. The wound was closed meticulously, and the patient was managed with supportive care for Ebola virus infection. Follow-up evaluations demonstrated gradual improvement in muscle inflammation.

9. Operative Note - Myositis (Rickettsial Infection): The patient underwent surgical intervention for suspected myositis associated with a rickettsial infection. A muscle biopsy was performed, and histopathological examination revealed inflammatory changes consistent with rickettsial myositis. The wound was closed using sutures, and the patient was started on appropriate antimicrobial therapy. Regular follow-up examinations showed a positive response to treatment, with resolution of myositis symptoms.

10. Operative Note - Myositis (Mycoplasma pneumoniae): Surgical intervention was performed for suspected myositis secondary to Mycoplasma pneumoniae infection. A muscle biopsy was performed, and histopathological analysis revealed inflammatory changes consistent with Mycoplasma-associated myositis. The wound was closed meticulously, and the patient was treated with appropriate antibiotics. Subsequent evaluations showed improvement in muscle inflammation and gradual resolution of symptoms.

1. Operative Note - Myositis (Viral): The patient underwent bilateral muscle biopsy for suspected viral myositis. The procedure was performed under general anesthesia with standard dosage. Multiple muscle samples were obtained for histopathological analysis. Intraoperative findings revealed focal myocyte necrosis and inflammatory infiltrates. Hemostasis was achieved, and the incisions were closed in layers. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

2. Operative Note - Myositis (Bacterial): The patient underwent surgical intervention for severe bacterial myositis. The procedure was performed under general anesthesia with an increased dosage due to the patient's comorbidities. Extensive debridement of necrotic muscle tissue was performed. Copious irrigation was done, and the wound was packed with sterile dressings. The patient's vital signs remained stable throughout the procedure, and appropriate antibiotic therapy was initiated postoperatively.

3. Operative Note - Myositis (Parasitic): Surgical intervention was performed for parasitic myositis. The procedure was performed under local anesthesia with sedation. A muscle biopsy was carried out, and multiple tissue samples were obtained. The incision was closed using sutures. The patient tolerated the procedure well and was started on specific antiparasitic medication postoperatively. Follow-up evaluations showed improvement in symptoms and resolution of myositis.

4. Operative Note - Myositis (Fungal): The patient underwent surgical intervention for suspected fungal myositis. The procedure was performed under regional anesthesia with moderate sedation. A muscle biopsy was performed, and intraoperative examination revealed fungal hyphae invading the muscle fibers. Excision of the affected tissue was performed, and the wound was closed meticulously. Antifungal therapy was initiated postoperatively. The patient remained stable throughout the procedure and showed improvement during the recovery period.

5. Operative Note - Myositis (Protozoal): Surgical intervention was required for protozoal myositis. The procedure was performed under general anesthesia with a reduced dosage to minimize the patient's risk. A muscle biopsy was performed, and the affected tissue was excised. The wound was closed using sutures. The patient tolerated the procedure well, and specific antimicrobial therapy was initiated postoperatively. Follow-up evaluations showed a positive response to treatment.

6. Operative Note - Myositis (Lyme Disease): The patient underwent surgical intervention for suspected myositis associated with Lyme disease. The procedure was performed under regional anesthesia with light sedation. A muscle biopsy was performed, and intraoperative findings revealed inflammatory changes consistent with Lyme myositis. The wound was closed meticulously, and appropriate antibiotic therapy was initiated. The patient's symptoms improved gradually over time.

7. Operative Note - Myositis (Tuberculosis): Surgical intervention was performed for myositis secondary to tuberculosis. The procedure was performed under general anesthesia with standard dosage. A muscle biopsy was conducted, and histopathological examination demonstrated granulomatous inflammation consistent with tuberculous myositis. The wound was closed using sutures, and the patient was started on anti-tuberculosis treatment postoperatively. Follow-up evaluations revealed a positive response to therapy and improvement in the patient's overall condition.

8. Operative Note - Myositis (Malaria): The patient underwent surgical intervention for myositis related to malaria infection. The procedure was performed under local anesthesia with sedation. A muscle biopsy was performed, and intraoperative examination revealed pigment-laden macrophages within the muscle tissue. The wound was closed meticulously, and appropriate antimalarial therapy was initiated. The patient showed clinical improvement and resolution of symptoms following treatment.

9. Operative Note - Myositis (Toxoplasmosis): Surgical intervention was performed for suspected myositis secondary to toxoplasmosis infection. The procedure was performed under general anesthesia with an increased dosage due to the complexity of the case. A muscle biopsy was performed, and histopathological analysis revealed the presence of Toxoplasma gondii cysts within the muscle fibers. The wound was closed meticulously, and specific antimicrobial therapy was initiated. The patient responded well to treatment, with a decrease in muscle inflammation and improvement in overall symptoms.

10. Operative Note - Myositis (HIV): The patient underwent muscle biopsy for suspected myositis associated with HIV infection. The procedure was performed under local anesthesia with sedation. Multiple muscle samples were obtained for laboratory analysis. Intraoperative findings revealed inflammatory changes consistent with HIV-associated myositis. The incisions were closed using sutures, and the patient was referred for further management and antiretroviral therapy. The anesthesia dosage was adjusted to ensure patient comfort and safety throughout the procedure.

1. Operative Note - Myositis (Viral) with Bone Erosion: The patient underwent surgical intervention for viral myositis with associated bone erosion. The procedure was performed under general anesthesia. In addition to muscle biopsy, imaging-guided bone debridement and curettage were performed to address the bone erosion. Multiple muscle samples were obtained and sent for histopathological analysis. The bone defects were carefully irrigated, and appropriate bone grafting was performed. The incisions were closed in layers, and the patient was monitored closely postoperatively.

2. Operative Note - Myositis (Bacterial) with Bone Erosion: Surgical intervention was performed for bacterial myositis with concurrent bone erosion. The procedure was performed under general anesthesia with increased dosage due to the complexity of the case. Extensive debridement of necrotic muscle tissue was carried out, along with debridement and curettage of the eroded bone. The bone defects were meticulously irrigated and filled with bone graft material. The incisions were closed meticulously, and appropriate antibiotic therapy was initiated.

3. Operative Note - Myositis (Parasitic) with Bone Erosion: The patient underwent surgical intervention for parasitic myositis with associated bone erosion. The procedure was performed under general anesthesia. Muscle biopsy was performed, and the affected bone was accessed for debridement and curettage. Multiple tissue samples were obtained and sent for laboratory analysis. The bone erosion sites were meticulously irrigated, and bone grafting was performed to promote bone healing. The patient's postoperative course was closely monitored.

4. Operative Note - Myositis (Fungal) with Bone Erosion: Surgical intervention was performed for fungal myositis with concurrent bone erosion. The procedure was performed under general anesthesia with adjusted dosage. A muscle biopsy was carried out, and intraoperative examination confirmed fungal invasion. Bone debridement and curettage were performed to address the underlying bone erosion. The affected areas were carefully irrigated, and appropriate antifungal therapy was initiated. The incisions were closed in layers, and the patient was closely followed for signs of improvement.

5. Operative Note - Myositis (Protozoal) with Bone Erosion: The patient underwent surgical intervention for protozoal myositis with associated bone erosion. The procedure was performed under regional anesthesia. A muscle biopsy was performed, and histopathological examination confirmed protozoal infection. Bone debridement and curettage were performed to address the underlying bone erosion. The bone defects were meticulously irrigated and filled with bone graft material. The patient's postoperative course was monitored closely.

6. Operative Note - Myositis (Lyme Disease) with Bone Erosion: Surgical intervention was performed for myositis associated with Lyme disease and bone erosion. The procedure was performed under general anesthesia. Muscle biopsy was performed, and intraoperative findings revealed inflammatory changes consistent with Lyme myositis. Bone debridement and curettage were carried out to address the bone erosion. The affected areas were meticulously irrigated, and appropriate antibiotic therapy was initiated. The incisions were closed meticulously, and the patient's progress was closely monitored.

7. Operative Note - Myositis (Tuberculosis) with Bone Erosion: Surgical intervention was performed for myositis secondary to tuberculosis with associated bone erosion. The procedure was performed under general anesthesia. A muscle biopsy was conducted, and histopathological examination confirmed tuberculous myositis. Bone debridement and curettage were performed to address the bone erosion. The bone defects were thoroughly irrigated, and appropriate anti-tuberculosis treatment was initiated. The patient's postoperative recovery was closely monitored.

8. Operative Note - Myositis (Malaria) with Bone Erosion: The patient underwent surgical intervention for myositis related to malaria infection with associated bone erosion. The procedure was performed under local anesthesia with sedation. A muscle biopsy was performed, and intraoperative examination confirmed the presence of malaria parasites. Bone debridement and curettage were performed to address the bone erosion. The affected areas were meticulously irrigated, and appropriate antimalarial therapy was initiated. The patient's progress was monitored closely.

9. Operative Note - Myositis (Toxoplasmosis) with Bone Erosion: Surgical intervention was performed for myositis associated with toxoplasmosis infection and bone erosion. The procedure was performed under general anesthesia with adjusted dosage. A muscle biopsy was performed, and histopathological examination confirmed toxoplasmosis myositis. Bone debridement and curettage were carried out to address the bone erosion. The bone defects were meticulously irrigated, and appropriate antimicrobial therapy was initiated. The patient's postoperative course was closely monitored.

10. Operative Note - Myositis (HIV) with Bone Erosion: The patient underwent surgical intervention for myositis associated with HIV infection and bone erosion. The procedure was performed under general anesthesia. Muscle biopsy was performed, and histopathological analysis confirmed HIV-associated myositis. Bone debridement and curettage were performed to address the bone erosion. The affected areas were thoroughly irrigated, and appropriate management was initiated. The incisions were closed meticulously, and the patient's recovery was closely monitored.

1. Operative Note - Myositis (Viral) with Severe Bone Pain: The patient underwent surgical intervention for viral myositis with severe bone pain. The procedure was performed under general anesthesia. Muscle biopsy was performed, and histopathological examination confirmed viral myositis. Intraoperative assessment revealed extensive muscle inflammation and associated bone pain. The incisions were closed meticulously, and appropriate pain management strategies were employed postoperatively. The patient's pain improved gradually during the recovery period.

2. Operative Note - Myositis (Bacterial) with Severe Bone Pain: Surgical intervention was performed for bacterial myositis with severe bone pain. The procedure was performed under general anesthesia with adjusted dosage. Muscle biopsy was conducted, and the presence of bacterial infection was confirmed. Intraoperative examination revealed significant muscle inflammation and accompanying bone pain. The incisions were closed meticulously, and the patient received appropriate antibiotic therapy and pain relief measures postoperatively.

3. Operative Note - Myositis (Parasitic) with Severe Bone Pain: The patient underwent surgical intervention for parasitic myositis with severe bone pain. The procedure was performed under general anesthesia. Muscle biopsy was performed, and histopathological analysis confirmed parasitic myositis. Intraoperatively, extensive muscle inflammation and associated bone pain were observed. The incisions were closed meticulously, and the patient received specific antiparasitic treatment and analgesics for pain management during the postoperative period.

4. Operative Note - Myositis (Fungal) with Severe Bone Pain: Surgical intervention was required for fungal myositis with severe bone pain. The procedure was performed under general anesthesia with adjusted dosage. Muscle biopsy was performed, and intraoperative examination confirmed fungal invasion. Significant muscle inflammation and accompanying bone pain were noted. The incisions were closed meticulously, and appropriate antifungal therapy and pain management strategies were implemented postoperatively.

5. Operative Note - Myositis (Protozoal) with Severe Bone Pain: The patient underwent surgical intervention for protozoal myositis with severe bone pain. The procedure was performed under regional anesthesia. Muscle biopsy was performed, and histopathological examination confirmed protozoal infection. Intraoperative findings revealed marked muscle inflammation and associated severe bone pain. The incisions were closed meticulously, and the patient received specific antimicrobial treatment and effective pain relief measures postoperatively.

6. Operative Note - Myositis (Lyme Disease) with Severe Bone Pain: Surgical intervention was performed for myositis associated with Lyme disease and severe bone pain. The procedure was performed under general anesthesia. Muscle biopsy was performed, and intraoperative examination confirmed inflammatory changes consistent with Lyme myositis. Severe muscle inflammation and accompanying bone pain were observed. The incisions were closed meticulously, and the patient received appropriate antibiotic therapy and aggressive pain management during the postoperative period.

7. Operative Note - Myositis (Tuberculosis) with Severe Bone Pain: The patient underwent surgical intervention for myositis secondary to tuberculosis with severe bone pain. The procedure was performed under general anesthesia. Muscle biopsy was conducted, and histopathological examination confirmed tuberculous myositis. Intraoperatively, significant muscle inflammation and associated severe bone pain were observed. The incisions were closed meticulously, and the patient received anti-tuberculosis treatment and intensive pain management strategies postoperatively.

8. Operative Note - Myositis (Malaria) with Severe Bone Pain: Surgical intervention was performed for myositis related to malaria infection with severe bone pain. The procedure was performed under local anesthesia with sedation. Muscle biopsy was performed, and intraoperative examination confirmed the presence of malaria parasites. Severe muscle inflammation and accompanying bone pain were observed. The incisions were closed meticulously, and the patient received appropriate antimalarial therapy and effective pain relief measures during the postoperative period.

9. Operative Note - Myositis (Toxoplasmosis) with Severe Bone Pain: The patient underwent surgical intervention for myositis associated with toxoplasmosis infection and severe bone pain. The procedure was performed under general anesthesia with adjusted dosage. Muscle biopsy was performed, and histopathological examination confirmed toxoplasmosis myositis. Intraoperatively, significant muscle inflammation and severe bone pain were noted. The incisions were closed meticulously, and the patient received specific antimicrobial therapy and aggressive pain management strategies postoperatively.

10. Operative Note - Myositis (HIV) with Severe Bone Pain: Surgical intervention was performed for myositis associated with HIV infection and severe bone pain. The procedure was performed under general anesthesia. Muscle biopsy was performed, and histopathological analysis confirmed HIV-associated myositis. Intraoperative examination revealed marked muscle inflammation and associated severe bone pain. The incisions were closed meticulously, and the patient received appropriate management for HIV infection and intensive pain relief measures during the postoperative period.

1. Operative Note - Myositis (Viral) with Severe Bone Pain: The patient underwent surgical intervention for viral myositis with severe bone pain. The procedure involved a comprehensive debridement of the affected muscle tissue and meticulous removal of any necrotic material. The bone surfaces were inspected for erosion and, if necessary, bone grafting was performed. The incisions were closed meticulously, and the patient was started on appropriate antiviral therapy and pain management regimen postoperatively.

2. Operative Note - Myositis (Bacterial) with Severe Bone Pain: Surgical intervention was performed for bacterial myositis with severe bone pain. The procedure involved extensive debridement of infected muscle tissue and meticulous exploration of the adjacent bones. Any bone erosions were addressed by debridement and bone grafting. The incisions were closed meticulously, and the patient received targeted antibiotic therapy and aggressive pain management strategies postoperatively.

3. Operative Note - Myositis (Parasitic) with Severe Bone Pain: The patient underwent surgical intervention for parasitic myositis with severe bone pain. The procedure involved thorough debridement of the affected muscle tissue, followed by meticulous inspection of the adjacent bones for any signs of erosion. In case of bone erosion, debridement and bone grafting were performed. The incisions were closed meticulously, and the patient received specific antiparasitic treatment and effective pain relief measures postoperatively.

4. Operative Note - Myositis (Fungal) with Severe Bone Pain: Surgical intervention was required for fungal myositis with severe bone pain. The procedure involved extensive debridement of infected muscle tissue and meticulous assessment of the underlying bones for any signs of erosion. Bone debridement and grafting were performed as necessary to address bone erosions. The incisions were closed meticulously, and the patient received appropriate antifungal therapy and aggressive pain management strategies postoperatively.

5. Operative Note - Myositis (Protozoal) with Severe Bone Pain: The patient underwent surgical intervention for protozoal myositis with severe bone pain. The procedure involved thorough debridement of the affected muscle tissue, along with meticulous exploration of the adjacent bones for any erosions. Bone debridement and grafting were performed as needed. The incisions were closed meticulously, and the patient received specific antimicrobial treatment and effective pain relief measures during the postoperative period.

6. Operative Note - Myositis (Lyme Disease) with Severe Bone Pain: Surgical intervention was performed for myositis associated with Lyme disease and severe bone pain. The procedure involved comprehensive debridement of the affected muscle tissue and meticulous examination of the adjacent bones for erosions. Bone debridement and grafting were performed to address any bone involvement. The incisions were closed meticulously, and the patient received appropriate antibiotic therapy and intensive pain management strategies postoperatively.

7. Operative Note - Myositis (Tuberculosis) with Severe Bone Pain: Surgical intervention was required for myositis secondary to tuberculosis with severe bone pain. The procedure involved extensive debridement of the infected muscle tissue and meticulous exploration of the adjacent bones for erosions. Bone debridement and grafting were performed as necessary. The incisions were closed meticulously, and the patient received anti-tuberculosis treatment and intensive pain management during the postoperative period.

8. Operative Note - Myositis (Malaria) with Severe Bone Pain: The patient underwent surgical intervention for myositis related to malaria infection with severe bone pain. The procedure involved thorough debridement of the affected muscle tissue, along with meticulous examination of the adjacent bones for erosions. Bone debridement and grafting were performed as needed. The incisions were closed meticulously, and the patient received appropriate antimalarial therapy and effective pain relief measures during the postoperative period.

9. Operative Note - Myositis (Toxoplasmosis) with Severe Bone Pain: Surgical intervention was performed for myositis associated with toxoplasmosis infection and severe bone pain. The procedure involved comprehensive debridement of the infected muscle tissue and meticulous exploration of the adjacent bones for any erosions. Bone debridement and grafting were performed as required. The incisions were closed meticulously, and the patient received specific antimicrobial therapy and aggressive pain management strategies postoperatively.

10. Operative Note - Myositis (HIV) with Severe Bone Pain: The patient underwent surgical intervention for myositis associated with HIV infection and severe bone pain. The procedure involved extensive debridement of the affected muscle tissue and meticulous examination of the adjacent bones for any erosions. Bone debridement and grafting were performed as necessary. The incisions were closed meticulously, and the patient received appropriate management for HIV infection and intensive pain relief measures during the postoperative period.

1. Operative Note - Myositis (Viral) with Severe Bone Pain: The patient underwent a surgical intervention for viral myositis with severe bone pain. The procedure involved an exploratory surgery to assess the extent of muscle and bone involvement. Extensive debridement of infected muscle tissue was performed, and meticulous evaluation of the bones revealed significant erosions. Bone grafting and stabilization procedures were carried out. The incisions were closed meticulously, and the patient was started on antiviral medication and received targeted pain management.

2. Operative Note - Myositis (Bacterial) with Severe Bone Pain: Surgical intervention was performed for bacterial myositis with severe bone pain. The procedure involved a thorough debridement of infected muscle tissue and meticulous assessment of the adjacent bones. Extensive bone erosions were observed, requiring debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received appropriate antibiotic therapy and aggressive pain management measures postoperatively.

3. Operative Note - Myositis (Parasitic) with Severe Bone Pain: The patient underwent surgical intervention for parasitic myositis with severe bone pain. The procedure involved an extensive debridement of the affected muscle tissue, followed by meticulous inspection of the adjacent bones. Significant bone erosions were identified and addressed through debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received specific antiparasitic treatment and effective pain relief measures postoperatively.

4. Operative Note - Myositis (Fungal) with Severe Bone Pain: Surgical intervention was required for fungal myositis with severe bone pain. The procedure involved a comprehensive debridement of infected muscle tissue and meticulous examination of the underlying bones. Extensive bone erosions were observed, necessitating debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received appropriate antifungal therapy and aggressive pain management strategies postoperatively.

5. Operative Note - Myositis (Protozoal) with Severe Bone Pain: The patient underwent surgical intervention for protozoal myositis with severe bone pain. The procedure involved thorough debridement of the affected muscle tissue, along with meticulous exploration of the adjacent bones. Extensive bone erosions were identified and addressed through debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received specific antimicrobial treatment and effective pain relief measures during the postoperative period.

6. Operative Note - Myositis (Lyme Disease) with Severe Bone Pain: Surgical intervention was performed for myositis associated with Lyme disease and severe bone pain. The procedure involved extensive debridement of the affected muscle tissue and meticulous examination of the adjacent bones. Significant bone erosions were identified and addressed through debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received appropriate antibiotic therapy and intensive pain management strategies postoperatively.

7. Operative Note - Myositis (Tuberculosis) with Severe Bone Pain: Surgical intervention was required for myositis secondary to tuberculosis with severe bone pain. The procedure involved a comprehensive debridement of the infected muscle tissue and meticulous exploration of the adjacent bones. Extensive bone erosions were observed, necessitating debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received anti-tuberculosis treatment and intensive pain management during the postoperative period.

8. Operative Note - Myositis (Malaria) with Severe Bone Pain: The patient underwent surgical intervention for myositis related to malaria infection with severe bone pain. The procedure involved thorough debridement of the affected muscle tissue, along with meticulous examination of the adjacent bones. Extensive bone erosions were identified and addressed through debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received appropriate antimalarial therapy and effective pain relief measures during the postoperative period.

9. Operative Note - Myositis (Toxoplasmosis) with Severe Bone Pain: Surgical intervention was performed for myositis associated with toxoplasmosis infection and severe bone pain. The procedure involved an extensive debridement of the infected muscle tissue and meticulous exploration of the adjacent bones. Significant bone erosions were observed, necessitating debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received specific antimicrobial therapy and aggressive pain management strategies postoperatively.

10. Operative Note - Myositis (HIV) with Severe Bone Pain: The patient underwent surgical intervention for myositis associated with HIV infection and severe bone pain. The procedure involved comprehensive debridement of the affected muscle tissue and meticulous examination of the adjacent bones. Extensive bone erosions were identified and addressed through debridement and bone grafting procedures. The incisions were closed meticulously, and the patient received appropriate management for HIV infection and intensive pain relief measures during the postoperative period.

1. Operative Note - Myositis (Viral) with Severe Infection on the Extreme Moving Joint: The patient underwent surgical intervention for viral myositis with severe infection on the extreme moving joint. The procedure involved an extensive debridement of the infected muscle tissue surrounding the joint. Intraoperative assessment revealed significant joint inflammation and purulent discharge. Thorough irrigation and drainage of the joint were performed. The incisions were closed meticulously, and the patient received appropriate antiviral therapy and aggressive infection control measures postoperatively.

2. Operative Note - Myositis (Bacterial) with Severe Infection on the Extreme Moving Joint: Surgical intervention was performed for bacterial myositis with severe infection on the extreme moving joint. The procedure involved a thorough debridement of the infected muscle tissue and meticulous exploration of the joint. Intraoperatively, significant joint inflammation and purulent material were observed. The joint was thoroughly irrigated and drained, and any necrotic tissue was removed. The incisions were closed meticulously, and the patient received targeted antibiotic therapy and intensive infection control measures postoperatively.

3. Operative Note - Myositis (Parasitic) with Severe Infection on the Extreme Moving Joint: The patient underwent surgical intervention for parasitic myositis with severe infection on the extreme moving joint. The procedure involved an extensive debridement of the infected muscle tissue surrounding the joint. Intraoperative examination revealed marked joint inflammation and the presence of parasitic organisms. The joint was meticulously irrigated, and appropriate antiparasitic treatment was administered. The incisions were closed meticulously, and the patient received effective infection control measures during the postoperative period.

4. Operative Note - Myositis (Fungal) with Severe Infection on the Extreme Moving Joint: Surgical intervention was required for fungal myositis with severe infection on the extreme moving joint. The procedure involved comprehensive debridement of the infected muscle tissue and meticulous exploration of the joint. Intraoperatively, significant joint inflammation and fungal involvement were observed. Thorough irrigation and antifungal treatment were administered. The incisions were closed meticulously, and the patient received aggressive infection control measures and appropriate antifungal therapy postoperatively.

5. Operative Note - Myositis (Protozoal) with Severe Infection on the Extreme Moving Joint: The patient underwent surgical intervention for protozoal myositis with severe infection on the extreme moving joint. The procedure involved thorough debridement of the infected muscle tissue surrounding the joint and meticulous exploration of the joint. Intraoperative assessment revealed pronounced joint inflammation and the presence of protozoal organisms. The joint was meticulously irrigated, and specific antimicrobial treatment was administered. The incisions were closed meticulously, and the patient received effective infection control measures during the postoperative period.

6. Operative Note - Myositis (Lyme Disease) with Severe Infection on the Extreme Moving Joint: Surgical intervention was performed for myositis associated with Lyme disease and severe infection on the extreme moving joint. The procedure involved extensive debridement of the infected muscle tissue and meticulous exploration of the joint. Intraoperative examination revealed marked joint inflammation and the presence of Lyme disease-related organisms. Thorough joint irrigation and appropriate antibiotic therapy were administered. The incisions were closed meticulously, and the patient received intensive infection control measures and targeted pain management postoperatively.

7. Operative Note - Myositis (Tuberculosis) with Severe Infection on the Extreme Moving Joint: Surgical intervention was required for myositis secondary to tuberculosis with severe infection on the extreme moving joint. The procedure involved comprehensive debridement of the infected muscle tissue surrounding the joint and meticulous exploration of the joint. Intraoperatively, significant joint inflammation and the presence of tuberculosis-related infection were observed. The joint was meticulously irrigated, and anti-tuberculosis treatment was administered. The incisions were closed meticulously, and the patient received intensive infection control measures and pain management during the postoperative period.

8. Operative Note - Myositis (Malaria) with Severe Infection on the Extreme Moving Joint: The patient underwent surgical intervention for myositis related to malaria infection with severe infection on the extreme moving joint. The procedure involved thorough debridement of the infected muscle tissue surrounding the joint and meticulous exploration of the joint. Intraoperative examination revealed marked joint inflammation and the presence of malaria-related infection. Thorough joint irrigation and appropriate antimalarial therapy were administered. The incisions were closed meticulously, and the patient received effective infection control measures and intensive pain relief measures during the postoperative period.

9. Operative Note - Myositis (Toxoplasmosis) with Severe Infection on the Extreme Moving Joint: Surgical intervention was performed for myositis associated with toxoplasmosis infection with severe infection on the extreme moving joint. The procedure involved extensive debridement of the infected muscle tissue surrounding the joint and meticulous exploration of the joint. Intraoperative assessment revealed significant joint inflammation and the presence of toxoplasmosis-related infection. The joint was thoroughly irrigated, and specific antimicrobial therapy was administered. The incisions were closed meticulously, and the patient received aggressive infection control measures and targeted pain management postoperatively.

10. Operative Note - Myositis (HIV) with Severe Infection on the Extreme Moving Joint: The patient underwent surgical intervention for myositis associated with HIV infection with severe infection on the extreme moving joint. The procedure involved comprehensive debridement of the infected muscle tissue surrounding the joint and meticulous exploration of the joint. Intraoperatively, pronounced joint inflammation and the presence of HIV-related infection were observed. Thorough joint irrigation and appropriate management for HIV infection were administered. The incisions were closed meticulously, and the patient received intensive infection control measures and effective pain relief measures during the postoperative period.

1. Operative Note - Myositis (Viral) with Severe Infection and Profound Inflammation: The patient underwent surgical intervention for viral myositis with severe infection and profound inflammation. The procedure involved an extensive debridement of the infected muscle tissue, which exhibited significant swelling and erythema. Intraoperative assessment revealed pronounced inflammation extending to the surrounding tissues. Thorough irrigation and drainage were performed, followed by appropriate antiviral therapy. The incisions were closed meticulously, and the patient received aggressive inflammation control measures and targeted pain management postoperatively.

2. Operative Note - Myositis (Bacterial) with Severe Infection and Persistent Inflammation: Surgical intervention was performed for bacterial myositis with severe infection and persistent inflammation. The procedure involved a thorough debridement of the infected muscle tissue, which displayed marked edema and inflammation. Intraoperatively, extensive inflammatory changes were noted, affecting the surrounding tissues. Thorough irrigation, debridement, and targeted antibiotic therapy were administered. The incisions were closed meticulously, and the patient received intensive inflammation control measures and aggressive pain management strategies postoperatively.

3. Operative Note - Myositis (Parasitic) with Severe Infection and Diffuse Inflammation: The patient underwent surgical intervention for parasitic myositis with severe infection and diffuse inflammation. The procedure involved an extensive debridement of the infected muscle tissue, which showed diffuse swelling and inflammation. Intraoperative assessment revealed widespread inflammatory changes affecting the adjacent tissues. Thorough irrigation, debridement, and specific antiparasitic treatment were administered. The incisions were closed meticulously, and the patient received comprehensive inflammation control measures and effective pain relief measures during the postoperative period.

4. Operative Note - Myositis (Fungal) with Severe Infection and Persistent Inflammation: Surgical intervention was required for fungal myositis with severe infection and persistent inflammation. The procedure involved comprehensive debridement of the infected muscle tissue, which exhibited prolonged inflammation and induration. Intraoperatively, significant inflammatory changes were observed, extending to the surrounding tissues. Thorough irrigation, debridement, and targeted antifungal therapy were administered. The incisions were closed meticulously, and the patient received intensive inflammation control measures and appropriate antifungal treatment postoperatively.

5. Operative Note - Myositis (Protozoal) with Severe Infection and Recurrent Inflammation: The patient underwent surgical intervention for protozoal myositis with severe infection and recurrent inflammation. The procedure involved thorough debridement of the infected muscle tissue, which exhibited recurring episodes of inflammation. Intraoperative assessment revealed persistent inflammatory changes affecting the adjacent tissues. Thorough irrigation, debridement, and specific antimicrobial treatment were administered. The incisions were closed meticulously, and the patient received comprehensive inflammation control measures and effective pain relief measures during the postoperative period.

6. Operative Note - Myositis (Lyme Disease) with Severe Infection and Chronic Inflammation: Surgical intervention was performed for myositis associated with Lyme disease, severe infection, and chronic inflammation. The procedure involved extensive debridement of the infected muscle tissue, which displayed long-standing inflammation and fibrosis. Intraoperatively, chronic inflammatory changes were observed, affecting the surrounding tissues. Thorough irrigation, debridement, and appropriate antibiotic therapy were administered. The incisions were closed meticulously, and the patient received comprehensive inflammation control measures and targeted pain management strategies postoperatively.

7. Operative Note - Myositis (Tuberculosis) with Severe Infection and Inflammatory Exacerbation: Surgical intervention was required for myositis secondary to tuberculosis with severe infection and inflammatory exacerbation. The procedure involved comprehensive debridement of the infected muscle tissue, which exhibited an acute inflammatory flare-up. Intraoperatively, exacerbation of inflammation was noted, extending to the surrounding tissues. Thorough irrigation, debridement, and anti-tuberculosis treatment were administered. The incisions were closed meticulously, and the patient received intensive inflammation control measures and appropriate pain management during the postoperative period.

8. Operative Note - Myositis (Malaria) with Severe Infection and Intense Inflammation: The patient underwent surgical intervention for myositis related to malaria infection with severe infection and intense inflammation. The procedure involved thorough debridement of the infected muscle tissue, which showed pronounced inflammation and edema. Intraoperative assessment revealed intense inflammatory changes affecting the adjacent tissues. Thorough irrigation, debridement, and specific antimalarial therapy were administered. The incisions were closed meticulously, and the patient received aggressive inflammation control measures and effective pain relief measures postoperatively.

9. Operative Note - Myositis (Toxoplasmosis) with Severe Infection and Persistent Inflammation: Surgical intervention was performed for myositis associated with toxoplasmosis infection, severe infection, and persistent inflammation. The procedure involved extensive debridement of the infected muscle tissue, which exhibited ongoing inflammation and induration. Intraoperatively, persistent inflammatory changes were observed, affecting the surrounding tissues. Thorough irrigation, debridement, and specific antimicrobial therapy were administered. The incisions were closed meticulously, and the patient received comprehensive inflammation control measures and targeted pain management during the postoperative period.

10. Operative Note - Myositis (HIV) with Severe Infection and Severe Inflammation: The patient underwent surgical intervention for myositis associated with HIV infection, severe infection, and severe inflammation. The procedure involved comprehensive debridement of the infected muscle tissue, which displayed intense inflammation and tissue destruction. Intraoperatively, severe inflammatory changes were noted, extending to the surrounding tissues. Thorough irrigation, debridement, and appropriate management for HIV infection were administered. The incisions were closed meticulously, and the patient received intensive inflammation control measures and effective pain relief measures during the postoperative period.

1. Operative Note - Myositis (Viral) with Severe Infection: The patient underwent surgical intervention for viral myositis with severe infection. The procedure involved an extensive debridement of the infected muscle tissue. Intraoperative assessment revealed significant tissue damage and inflammation. The patient will be closely monitored postoperatively, and follow-up will depend on the response to treatment, with a possibility of further surgical intervention if necessary.

2. Operative Note - Myositis (Bacterial) with Severe Infection: Surgical intervention was performed for bacterial myositis with severe infection. The procedure involved thorough debridement of the infected muscle tissue. Intraoperative examination revealed substantial tissue inflammation and purulent material. The patient will be closely monitored postoperatively, and follow-up will be determined based on the response to antibiotics and the resolution of infection.

3. Operative Note - Myositis (Parasitic) with Severe Infection: The patient underwent surgical intervention for parasitic myositis with severe infection. The procedure involved extensive debridement of the infected muscle tissue. Intraoperative assessment revealed pronounced tissue inflammation and the presence of parasitic organisms. The patient will be closely monitored postoperatively, and follow-up will involve further evaluation of the parasitic infection and consideration of additional treatments if needed.

4. Operative Note - Myositis (Fungal) with Severe Infection: Surgical intervention was required for fungal myositis with severe infection. The procedure involved comprehensive debridement of the infected muscle tissue. Intraoperatively, significant tissue inflammation and fungal involvement were observed. The patient will be closely monitored postoperatively, and follow-up will depend on the response to antifungal therapy, with a possibility of additional interventions if the infection persists.

5. Operative Note - Myositis (Protozoal) with Severe Infection: The patient underwent surgical intervention for protozoal myositis with severe infection. The procedure involved thorough debridement of the infected muscle tissue. Intraoperative assessment revealed marked tissue inflammation and the presence of protozoal organisms. The patient will be closely monitored postoperatively, and follow-up will include further evaluation of the protozoal infection and consideration of additional treatment modalities as necessary.

6. Operative Note - Myositis (Lyme Disease) with Severe Infection: Surgical intervention was performed for myositis associated with Lyme disease and severe infection. The procedure involved extensive debridement of the infected muscle tissue. Intraoperatively, significant tissue inflammation and the presence of Lyme disease-related organisms were observed. The patient will be closely monitored postoperatively, and follow-up will involve ongoing assessment of Lyme disease progression and consideration of additional treatment options.

7. Operative Note - Myositis (Tuberculosis) with Severe Infection: Surgical intervention was required for myositis secondary to tuberculosis with severe infection. The procedure involved comprehensive debridement of the infected muscle tissue. Intraoperatively, significant tissue inflammation and tuberculosis-related infection were observed. The patient will be closely monitored postoperatively, and follow-up will include regular evaluation of the tuberculosis infection and adjustment of the anti-tuberculosis therapy if needed.

8. Operative Note - Myositis (Malaria) with Severe Infection: The patient underwent surgical intervention for myositis related to malaria infection with severe infection. The procedure involved thorough debridement of the infected muscle tissue. Intraoperative assessment revealed significant tissue inflammation and the presence of malaria-related infection. The patient will be closely monitored postoperatively, and follow-up will involve regular evaluation of the malaria infection and adjustment of the antimalarial therapy as required.

9. Operative Note - Myositis (Toxoplasmosis) with Severe Infection: Surgical intervention was performed for myositis associated with toxoplasmosis infection with severe infection. The procedure involved extensive debridement of the infected muscle tissue. Intraoperative assessment revealed pronounced tissue inflammation and the presence of toxoplasmosis-related infection. The patient will be closely monitored postoperatively, and follow-up will include ongoing evaluation of the toxoplasmosis infection and consideration of additional treatment modalities if necessary.

10. Operative Note - Myositis (HIV) with Severe Infection: The patient underwent surgical intervention for myositis associated with HIV infection with severe infection. The procedure involved comprehensive debridement of the infected muscle tissue. Intraoperatively, severe tissue inflammation and the presence of HIV-related infection were observed. The patient will be closely monitored postoperatively, and follow-up will involve regular assessment of the HIV infection and adjustment of the antiretroviral therapy if needed.

## M63.3 Myositis in sarcoidosis

Operative Note 1:Patient underwent a diagnostic muscle biopsy for suspected myositis in sarcoidosis. A muscle specimen was obtained from the right quadriceps muscle through a small incision. The tissue was sent for histopathological examination to confirm the presence of granulomas and assess for inflammatory changes. The incision was closed with sutures, and the patient tolerated the procedure well without any immediate complications.

Operative Note 2:Patient presented with worsening myositis in sarcoidosis, necessitating a therapeutic muscle biopsy. A muscle sample was taken from the left deltoid muscle using a percutaneous needle biopsy technique. The specimen was sent for analysis to evaluate the extent of inflammation and to guide subsequent treatment. The patient tolerated the procedure without any immediate complications, and the biopsy site was dressed appropriately.

Operative Note 3: Patient with myositis in sarcoidosis underwent a muscle biopsy with concurrent muscle fasciotomy. The biopsy specimen was obtained from the left thigh muscles to evaluate the extent of inflammatory changes. Simultaneously, a fasciotomy was performed to release compartmental pressure. The procedures were completed without complications, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 4: Patient underwent a surgical debridement of myositis in sarcoidosis due to worsening symptoms and unresponsiveness to medical therapy. The affected muscle group was identified, and a thorough debridement was performed to remove necrotic tissue and reduce inflammation. The procedure was uneventful, and the patient was instructed on postoperative care and scheduled for follow-up evaluation.

Operative Note 5: Patient presented with refractory myositis in sarcoidosis, requiring a muscle biopsy and subsequent corticosteroid injection. A muscle sample was obtained from the right biceps muscle using an open biopsy technique. After confirming the presence of granulomas, a corticosteroid solution was injected directly into the affected muscle. The patient tolerated the procedure well, and appropriate post-injection care was provided.

Operative Note 6: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis with concomitant muscle release procedure. The right calf muscles were approached through a small incision, and a muscle specimen was obtained for histopathological examination. Concurrently, a release procedure was performed to alleviate compartmental pressure. The procedures were completed successfully, and the patient was transferred to the postoperative recovery area.

Operative Note 7: Patient presented with severe myositis in sarcoidosis, requiring a muscle biopsy and muscle biopsy site closure. A muscle sample was obtained from the left hamstring muscles using a percutaneous needle biopsy technique. After confirming the diagnosis, the biopsy site was meticulously closed using sutures. The patient tolerated the procedure without complications, and appropriate wound care instructions were provided.

Operative Note 8: Patient with myositis in sarcoidosis underwent an open muscle biopsy of the right upper arm muscles. The muscle specimen was obtained to assess the degree of inflammation and presence of granulomas. The procedure was performed without complications, and the incision was closed with sutures. The patient was transferred to the recovery area for monitoring and subsequent management.

Operative Note 9: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis. A muscle sample was obtained from the left quadriceps muscle through a small incision. The specimen was sent for histopathological examination to confirm the presence of granulomas and assess the extent of inflammation. The procedure was well-tolerated, and the patient was discharged with appropriate instructions for follow-up and management.

Operative Note 10: Patient presented with recurrent myositis in sarcoidosis, necessitating a repeat muscle biopsy. The left triceps muscle was approached using a percutaneous needle biopsy technique. The obtained muscle sample was sent for analysis to evaluate the response to previous treatments and guide further management. The procedure was completed without complications, and the patient was scheduled for a follow-up appointment to discuss the results.

Operative Note 11: Patient with myositis in sarcoidosis underwent a muscle biopsy and concurrent muscle release procedure. A muscle specimen was obtained from the right forearm muscles to assess the degree of inflammation. Simultaneously, a release procedure was performed to relieve compartmental pressure and improve muscle function. The procedures were successfully completed, and the patient was provided with postoperative instructions and scheduled for a follow-up evaluation.

Operative Note 12: Patient presented with persistent myositis in sarcoidosis, necessitating a muscle biopsy and subsequent muscle flap reconstruction. A muscle sample was obtained from the left thigh muscles using an open biopsy technique. Following the biopsy, a muscle flap was harvested from the contralateral thigh to reconstruct the affected area. The procedures were performed without complications, and the patient was transferred to the recovery unit for postoperative care.

Operative Note 13: Patient underwent a repeat muscle biopsy for recurrent myositis in sarcoidosis. The right quadriceps muscle was approached using a percutaneous needle biopsy technique. The obtained muscle specimen was sent for histopathological examination to evaluate the response to previous treatments and assess the disease progression. The procedure was uneventful, and the patient was scheduled for a follow-up appointment to discuss the results and plan further management.

Operative Note 14: Patient with myositis in sarcoidosis underwent a muscle biopsy and concurrent muscle tenotomy. A muscle sample was obtained from the left calf muscles for histopathological analysis. Simultaneously, a tenotomy was performed to release the affected muscle from its tendon attachment, aiming to alleviate symptoms and improve muscle function. The procedures were completed without complications, and appropriate postoperative care was provided.

Operative Note 15: Patient presented with acute exacerbation of myositis in sarcoidosis, requiring an urgent muscle biopsy and subsequent corticosteroid infusion. A muscle sample was obtained from the right deltoid muscle using an open biopsy technique. After confirming the diagnosis, a corticosteroid solution was infused directly into the affected muscle to manage the acute inflammation. The patient tolerated the procedure well, and appropriate monitoring was initiated.

Operative Note 16: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis. A muscle sample was obtained from the left gluteus maximus muscle through a small incision. The obtained specimen was sent for histopathological examination to confirm the presence of granulomas and assess the severity of inflammation. The procedure was uneventful, and the patient was discharged with instructions for follow-up and appropriate management.

Operative Note 17: Patient with myositis in sarcoidosis underwent a muscle biopsy and simultaneous muscle augmentation. A muscle specimen was obtained from the right biceps muscle for pathological analysis. Concurrently, muscle augmentation was performed using an autologous graft to improve muscle strength and function. The procedures were successfully completed, and the patient was provided with postoperative instructions and scheduled for follow-up evaluation.

Operative Note 18: Patient presented with chronic myositis in sarcoidosis, necessitating a muscle biopsy and subsequent muscle resection. A muscle sample was obtained from the left forearm muscles using an open biopsy technique. Following the biopsy, a portion of the affected muscle was resected to remove diseased tissue and promote healing. The procedures were performed without complications, and appropriate wound care was initiated.

Operative Note 19: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis. A muscle specimen was obtained from the right gastrocnemius muscle through a percutaneous needle biopsy technique. The specimen was sent for histopathological examination to confirm the diagnosis and assess the degree of inflammation. The procedure was well-tolerated, and the patient was discharged with instructions for postoperative care and scheduled for follow-up evaluation.

Operative Note 20: Patient with myositis in sarcoidosis underwent a muscle biopsy and concurrent muscle transfer procedure. A muscle sample was obtained from the right thigh muscles to evaluate the extent of inflammation. Simultaneously, a muscle transfer was performed, utilizing a healthy muscle to replace the affected muscle and restore function. The procedures were completed successfully, and the patient was transferred to the postoperative recovery area for monitoring and subsequent rehabilitation.

Operative Note 21: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis under local anesthesia. A muscle specimen was obtained from the left quadriceps muscle through a small incision. The patient remained cooperative and comfortable throughout the procedure, and the incision was closed with sutures. The patient was discharged with appropriate postoperative instructions and scheduled for follow-up evaluation.

Operative Note 22: Patient with myositis in sarcoidosis underwent a muscle biopsy and muscle release procedure under general anesthesia. The right forearm muscles were approached, and a muscle specimen was obtained for histopathological analysis. Concurrently, a release procedure was performed to alleviate compartmental pressure. The patient remained stable throughout the surgery, and appropriate postoperative care was initiated.

Operative Note 23: Patient presented with severe myositis in sarcoidosis, necessitating a muscle biopsy and corticosteroid injection under moderate sedation. A muscle sample was obtained from the left deltoid muscle using a percutaneous needle biopsy technique. After confirming the diagnosis, a corticosteroid solution was injected directly into the affected muscle. The patient tolerated the procedure well and was closely monitored during the sedation.

Operative Note 24: Patient with myositis in sarcoidosis underwent a muscle biopsy and muscle flap reconstruction under regional anesthesia. The left thigh muscles were approached, and a muscle specimen was obtained for pathological examination. Following the biopsy, a muscle flap was harvested from the contralateral thigh and used to reconstruct the affected area. The patient remained comfortable and stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 25: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis under monitored anesthesia care (MAC). The right triceps muscle was approached, and a muscle sample was obtained for histopathological analysis. The patient remained relaxed and pain-free throughout the procedure, and the biopsy site was appropriately dressed. Postoperative instructions were provided, and the patient was scheduled for a follow-up appointment.

Operative Note 26: Patient presented with recurrent myositis in sarcoidosis, requiring a repeat muscle biopsy under deep sedation. The left calf muscles were approached, and a muscle specimen was obtained for further evaluation. The patient maintained a stable level of sedation throughout the procedure, and the biopsy was performed without complications. Post-procedural monitoring was conducted, and the patient was transferred to the recovery unit.

Operative Note 27: Patient with myositis in sarcoidosis underwent a muscle biopsy and simultaneous muscle tenotomy under general anesthesia. A muscle sample was obtained from the right thigh muscles, and a tenotomy was performed to release the affected muscle. The patient remained anesthetized and hemodynamically stable throughout the procedure, and appropriate postoperative pain management was initiated.

Operative Note 28: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis under spinal anesthesia. The left hamstring muscles were approached, and a muscle specimen was obtained for histopathological examination. The patient experienced sensory and motor block below the level of the spinal anesthesia, and the biopsy was performed without discomfort. The patient was transferred to the recovery area and monitored for any complications.

Operative Note 29: Patient presented with acute exacerbation of myositis in sarcoidosis, requiring an urgent muscle biopsy and corticosteroid infusion under general anesthesia. A muscle sample was obtained from the right biceps muscle, and a corticosteroid solution was infused directly into the affected muscle. The patient remained stable throughout the procedure, and appropriate ventilation and hemodynamic support were provided.

Operative Note 30: Patient with myositis in sarcoidosis underwent a muscle biopsy and muscle resection under local anesthesia with intravenous sedation. The right forearm muscles were approached, and a muscle specimen was obtained for pathological analysis. Following the biopsy, a portion of the affected muscle was resected to remove diseased tissue. The patient remained comfortable and cooperative during the procedure, and postoperative wound care instructions were given.

Operative Note 31: Patient with myositis in sarcoidosis and bone erosion underwent a muscle biopsy and concurrent bone debridement under general anesthesia. The affected site, located in the left lower leg, was approached. A muscle sample was obtained for histopathological analysis, and concurrent debridement of the eroded bone was performed to remove diseased tissue. The procedures were completed without complications, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 32: Patient presented with advanced myositis in sarcoidosis and extensive bone erosion, necessitating a muscle biopsy and bone grafting procedure under general anesthesia. The right upper arm muscles were approached, and a muscle specimen was obtained for pathological examination. Simultaneously, a bone graft was harvested and used to fill the eroded area. The patient remained stable throughout the surgery, and appropriate postoperative care was initiated.

Operative Note 33: Patient with myositis in sarcoidosis and bone erosion underwent a muscle biopsy and bone curettage under regional anesthesia. The left thigh muscles were approached, and a muscle specimen was obtained for histopathological analysis. Concurrently, curettage of the eroded bone was performed to remove diseased tissue. The patient remained comfortable and stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 34: Patient presented with severe myositis in sarcoidosis and significant bone erosion, requiring a muscle biopsy and bone graft placement under general anesthesia. The left forearm muscles were approached, and a muscle sample was obtained for further evaluation. Subsequently, a bone graft was carefully placed to fill the eroded area and promote healing. The patient tolerated the procedure well, and appropriate postoperative monitoring was initiated.

Operative Note 35: Patient with myositis in sarcoidosis and bone erosion underwent a muscle biopsy and concurrent bone stabilization procedure under general anesthesia. The right lower leg muscles were approached, and a muscle specimen was obtained for histopathological analysis. Simultaneously, the eroded bone was stabilized using internal fixation techniques. The procedures were completed without complications, and appropriate postoperative care was provided.

Operative Note 36: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and associated bone erosion under local anesthesia. The affected site, located in the right shoulder region, was approached, and a muscle sample was obtained for pathological examination. The patient remained cooperative and comfortable throughout the procedure, and the biopsy site was closed appropriately. The patient was discharged with postoperative instructions and scheduled for follow-up evaluation.

Operative Note 37: Patient presented with recurrent myositis in sarcoidosis and worsening bone erosion, requiring a repeat muscle biopsy and bone debridement under general anesthesia. The left calf muscles and the adjacent eroded bone were approached. A muscle specimen was obtained for histopathological analysis, and the eroded bone was meticulously debrided. The procedures were performed without complications, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 38: Patient with myositis in sarcoidosis and extensive bone erosion underwent a muscle biopsy and concurrent bone grafting procedure under spinal anesthesia. The right thigh muscles were approached, and a muscle sample was obtained for further evaluation. Simultaneously, a bone graft was harvested and carefully placed to fill the eroded area. The patient remained stable throughout the procedure, and appropriate postoperative care was initiated.

Operative Note 39: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and associated bone erosion under general anesthesia. The left gluteus maximus muscles and the adjacent eroded bone were approached. A muscle specimen was obtained for histopathological examination, and the eroded bone was debrided. The patient tolerated the procedure well, and appropriate postoperative wound care instructions were given.

Operative Note 40: Patient with myositis in sarcoidosis and bone erosion underwent a muscle biopsy and bone stabilization procedure under regional anesthesia. The right upper arm muscles and the adjacent eroded bone were approached. A muscle sample was obtained for pathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. The patient remained comfortable and stable throughout the surgery, and postoperative care was initiated accordingly.

Operative Note 41: Patient with severe bone pain due to myositis in sarcoidosis underwent a muscle biopsy and bone radiofrequency ablation under general anesthesia. The affected site, located in the left hip region, was approached. A muscle sample was obtained for histopathological analysis, and concurrent radiofrequency ablation was performed to provide pain relief by targeting the sensory nerves around the eroded bone. The procedures were completed successfully, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 42: Patient presented with debilitating bone pain associated with myositis in sarcoidosis, necessitating a muscle biopsy and concurrent bone cementation under general anesthesia. The right lower leg muscles were approached, and a muscle specimen was obtained for pathological examination. Simultaneously, bone cement was carefully injected into the eroded area to provide stabilization and alleviate pain. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 43: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and bone decompression procedure under regional anesthesia. The left forearm muscles were approached, and a muscle sample was obtained for histopathological analysis. Concurrently, a decompression procedure was performed to relieve pressure and alleviate pain in the eroded bone. The patient remained stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 44: Patient presented with intractable bone pain associated with myositis in sarcoidosis and bone erosion, requiring a muscle biopsy and nerve block under monitored anesthesia care (MAC). The affected site, located in the right shoulder region, was approached, and a muscle sample was obtained for further evaluation. Simultaneously, a nerve block was performed to target the sensory nerves supplying the eroded bone and provide pain relief. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

Operative Note 45: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and concurrent bone fusion procedure under general anesthesia. The left thigh muscles were approached, and a muscle sample was obtained for histopathological analysis. Simultaneously, a bone fusion procedure was performed to stabilize the eroded bone and alleviate pain. The procedures were completed without complications, and appropriate postoperative care was provided.

Operative Note 46: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and severe bone pain under local anesthesia with intravenous sedation. The affected site, located in the right ankle region, was approached, and a muscle sample was obtained for pathological examination. The patient remained cooperative and comfortable throughout the procedure, and appropriate postoperative pain management was initiated. The patient was discharged with instructions for follow-up evaluation.

Operative Note 47: Patient presented with recurrent myositis in sarcoidosis and worsening bone pain, requiring a repeat muscle biopsy and bone stabilization procedure under general anesthesia. The left calf muscles and the adjacent eroded bone were approached. A muscle specimen was obtained for histopathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. The procedures were performed without complications, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 48: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and bone grafting procedure under spinal anesthesia. The right forearm muscles were approached, and a muscle sample was obtained for further evaluation. Simultaneously, a bone graft was harvested and carefully placed to fill the eroded area, aiming to alleviate pain and promote healing. The patient remained stable throughout the procedure, and appropriate postoperative care was initiated.

Operative Note 49: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and severe bone pain under general anesthesia. The left thigh muscles and the adjacent eroded bone were approached. A muscle sample was obtained for histopathological examination, and the eroded bone was debrided. The patient tolerated the procedure well, and appropriate postoperative pain management was provided.

Operative Note 50: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and bone stabilization procedure under regional anesthesia. The right upper arm muscles and the adjacent eroded bone were approached. A muscle specimen was obtained for pathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. The patient remained comfortable and stable throughout the surgery, and postoperative pain control measures were implemented.

Operative Note 51: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone resection under general anesthesia. The affected site, located in the left knee region, was approached. A muscle sample was obtained for histopathological analysis, and a portion of the eroded bone was surgically resected to alleviate pain and improve function. The procedures were completed successfully, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 52: Patient presented with debilitating bone pain associated with myositis in sarcoidosis, necessitating a muscle biopsy and surgical intervention in the form of bone grafting under general anesthesia. The right forearm muscles were approached, and a muscle specimen was obtained for pathological examination. Simultaneously, a bone graft was harvested and meticulously placed to fill the eroded area and promote healing. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 53: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone fixation under regional anesthesia. The left thigh muscles and the adjacent eroded bone were approached. A muscle sample was obtained for histopathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. The patient remained stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 54: Patient presented with intractable bone pain associated with myositis in sarcoidosis and bone erosion, requiring a muscle biopsy and surgical intervention in the form of bone cementation under monitored anesthesia care (MAC). The affected site, located in the right shoulder region, was approached, and a muscle sample was obtained for further evaluation. Simultaneously, bone cement was carefully injected into the eroded area to provide stabilization and alleviate pain. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

Operative Note 55: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone fusion under general anesthesia. The left thigh muscles were approached, and a muscle sample was obtained for histopathological analysis. Simultaneously, a bone fusion procedure was performed to stabilize the eroded bone and alleviate pain. The procedures were completed without complications, and appropriate postoperative care was provided.

Operative Note 56: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and severe bone pain under local anesthesia with intravenous sedation. The affected site, located in the right ankle region, was approached, and a muscle sample was obtained for pathological examination. The patient remained cooperative and comfortable throughout the procedure, and appropriate postoperative pain management was initiated. The patient was discharged with instructions for follow-up evaluation.

Operative Note 57: Patient presented with recurrent myositis in sarcoidosis and worsening bone pain, requiring a repeat muscle biopsy and surgical intervention in the form of bone stabilization under general anesthesia. The left calf muscles and the adjacent eroded bone were approached. A muscle specimen was obtained for histopathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. The procedures were performed without complications, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 58: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone grafting under spinal anesthesia. The right forearm muscles were approached, and a muscle sample was obtained for further evaluation. Simultaneously, a bone graft was harvested and carefully placed to fill the eroded area, aiming to alleviate pain and promote healing. The patient remained stable throughout the procedure, and appropriate postoperative care was initiated.

Operative Note 59: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and severe bone pain under general anesthesia. The left thigh muscles and the adjacent eroded bone were approached. A muscle sample was obtained for histopathological examination, and the eroded bone was surgically managed. The patient tolerated the procedure well, and appropriate postoperative pain management was provided.

Operative Note 60: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone stabilization under regional anesthesia. The right upper arm muscles and the adjacent eroded bone were approached. A muscle sample was obtained for pathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. The patient remained comfortable and stable throughout the surgery, and postoperative pain control measures were implemented.

Operative Note 61: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone resection and joint arthroplasty under general anesthesia. The affected site, located in the left hip joint, was approached. A muscle sample was obtained for histopathological analysis, and a portion of the eroded bone was surgically resected. Additionally, a joint arthroplasty procedure was performed to alleviate pain and improve joint function. The procedures were completed successfully, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 62: Patient presented with debilitating bone pain associated with myositis in sarcoidosis, necessitating a muscle biopsy and surgical intervention in the form of bone grafting and osteotomy under general anesthesia. The right forearm muscles were approached, and a muscle specimen was obtained for pathological examination. Simultaneously, a bone graft was harvested and meticulously placed to fill the eroded area. Furthermore, an osteotomy procedure was performed to correct the bone alignment and alleviate pain. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 63: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone decompression and nerve decompression under regional anesthesia. The left thigh muscles and the adjacent eroded bone were approached. A muscle sample was obtained for histopathological analysis, and a decompression procedure was performed to relieve pressure and alleviate pain in the eroded bone. Concurrently, nerve decompression was carried out to relieve any nerve impingement. The patient remained stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 64: Patient presented with intractable bone pain associated with myositis in sarcoidosis and bone erosion, requiring a muscle biopsy and surgical intervention in the form of bone stabilization and external fixation under monitored anesthesia care (MAC). The affected site, located in the right shoulder region, was approached, and a muscle sample was obtained for further evaluation. Simultaneously, bone stabilization was performed using internal fixation techniques and external fixation devices to provide stability and alleviate pain. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

Operative Note 65: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone fusion and bone grafting under general anesthesia. The left thigh muscles were approached, and a muscle sample was obtained for histopathological analysis. Simultaneously, a bone fusion procedure was performed to stabilize the eroded bone, and bone grafting was carried out to promote healing and alleviate pain. The procedures were completed without complications, and appropriate postoperative care was provided.

Operative Note 66: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and severe bone pain under local anesthesia with intravenous sedation. The affected site, located in the right ankle region, was approached, and a muscle sample was obtained for pathological examination. The patient remained cooperative and comfortable throughout the procedure, and appropriate postoperative pain management was initiated. The patient was discharged with instructions for follow-up evaluation.

Operative Note 67: Patient presented with recurrent myositis in sarcoidosis and worsening bone pain, requiring a repeat muscle biopsy and surgical intervention in the form of bone stabilization and internal fixation under general anesthesia. The left calf muscles and the adjacent eroded bone were approached. A muscle specimen was obtained for histopathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. The procedures were performed without complications, and the patient was transferred to the recovery unit for postoperative management.

Operative Note 68: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone grafting and bone resurfacing under spinal anesthesia. The right forearm muscles were approached, and a muscle sample was obtained for further evaluation. Simultaneously, a bone graft was harvested and carefully placed to fill the eroded area, aiming to alleviate pain and promote healing. Additionally, bone resurfacing was performed to restore the damaged bone surface. The patient remained stable throughout the procedure, and appropriate postoperative care was initiated.

Operative Note 69: Patient underwent a muscle biopsy for suspected myositis in sarcoidosis and severe bone pain under general anesthesia. The left thigh muscles and the adjacent eroded bone were approached. A muscle sample was obtained for histopathological examination, and the eroded bone was surgically managed with bone resection and reconstruction. The patient tolerated the procedure well, and appropriate postoperative pain management was provided.

Operative Note 70: Patient with myositis in sarcoidosis and severe bone pain underwent a muscle biopsy and surgical intervention in the form of bone stabilization and joint fusion under regional anesthesia. The right upper arm muscles and the adjacent eroded bone were approached. A muscle sample was obtained for pathological analysis, and the eroded bone was stabilized using appropriate fixation techniques. Additionally, joint fusion was performed to eliminate joint movement and alleviate pain. The patient remained comfortable and stable throughout the surgery, and postoperative pain control measures were implemented.

Operative Note 71: Patient with severe infection on the extreme moving joint due to myositis in sarcoidosis underwent a joint debridement and muscle biopsy procedure under general anesthesia. The affected joint, located in the right shoulder region, was approached. Thorough debridement of infected tissues was performed, and a muscle sample was obtained for pathological analysis. The procedure aimed to control the infection and obtain diagnostic information. The patient tolerated the procedure well, and appropriate postoperative antibiotic therapy was initiated.

Operative Note 72: Patient presented with severe infection on the extreme moving joint associated with myositis in sarcoidosis, requiring a joint irrigation and debridement procedure along with a muscle biopsy under general anesthesia. The affected joint, located in the left knee region, was approached. Extensive irrigation of the joint was performed to eliminate infection, followed by meticulous debridement of necrotic tissues. A muscle sample was obtained for histopathological examination. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 73: Patient with myositis in sarcoidosis and severe infection on the extreme moving joint underwent a joint exploration and muscle biopsy procedure under regional anesthesia. The affected joint, located in the right hip region, was approached. Thorough exploration of the joint was carried out to assess the extent of infection, and a muscle sample was obtained for pathological analysis. The procedure aimed to identify the source of infection and guide further management. The patient remained stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 74: Patient presented with severe infection on the extreme moving joint associated with myositis in sarcoidosis, necessitating a joint drainage and muscle biopsy procedure under monitored anesthesia care (MAC). The affected joint, located in the left elbow region, was approached, and pus was drained from the joint space. Concurrently, a muscle sample was obtained for further evaluation. The procedure aimed to relieve the infection and obtain diagnostic information. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

Operative Note 75: Patient with myositis in sarcoidosis and severe infection on the extreme moving joint underwent a joint washout and muscle biopsy procedure under general anesthesia. The affected joint, located in the right ankle region, was approached. Thorough washout of the joint was performed to eliminate infection, and a muscle sample was obtained for histopathological analysis. The procedure aimed to control the infection and provide diagnostic information. The patient tolerated the procedure well, and appropriate postoperative antibiotic therapy was initiated.

Operative Note 76: Patient presented with severe infection on the extreme moving joint associated with myositis in sarcoidosis, requiring a joint irrigation and muscle biopsy procedure under local anesthesia with intravenous sedation. The affected joint, located in the left shoulder region, was approached. Extensive irrigation of the joint was performed to remove the infection, followed by a muscle biopsy to aid in diagnosis. The patient remained cooperative and comfortable throughout the procedure, and appropriate postoperative care was initiated. The patient was discharged with instructions for follow-up evaluation.

Operative Note 77: Patient with myositis in sarcoidosis and severe infection on the extreme moving joint underwent a joint debridement and muscle biopsy procedure under general anesthesia. The affected joint, located in the right wrist region, was approached. Thorough debridement of infected tissues was performed, and a muscle sample was obtained for pathological analysis. The procedure aimed to control the infection and obtain diagnostic information. The patient tolerated the procedure well, and appropriate postoperative antibiotic therapy was initiated.

Operative Note 78: Patient presented with severe infection on the extreme moving joint associated with myositis in sarcoidosis, necessitating a joint irrigation and debridement procedure along with a muscle biopsy under regional anesthesia. The affected joint, located in the left hip region, was approached. Extensive irrigation of the joint was performed to eliminate infection, followed by meticulous debridement of necrotic tissues. A muscle sample was obtained for histopathological examination. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 79: Patient with myositis in sarcoidosis and severe infection on the extreme moving joint underwent a joint exploration and muscle biopsy procedure under general anesthesia. The affected joint, located in the right knee region, was approached. Thorough exploration of the joint was carried out to assess the extent of infection, and a muscle sample was obtained for pathological analysis. The procedure aimed to identify the source of infection and guide further management. The patient remained stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 80: Patient presented with severe infection on the extreme moving joint associated with myositis in sarcoidosis, necessitating a joint drainage and muscle biopsy procedure under monitored anesthesia care (MAC). The affected joint, located in the left ankle region, was approached, and pus was drained from the joint space. Concurrently, a muscle sample was obtained for further evaluation. The procedure aimed to relieve the infection and obtain diagnostic information. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

Operative Note 81: Patient with myositis in sarcoidosis and significant joint inflammation underwent a synovectomy and muscle biopsy procedure under general anesthesia. The affected joint, located in the right shoulder region, was approached. The synovial tissue was carefully excised to alleviate inflammation and obtain a muscle sample for pathological analysis. The procedure aimed to reduce joint inflammation and provide diagnostic information. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 82: Patient presented with severe joint inflammation associated with myositis in sarcoidosis, necessitating a joint lavage and muscle biopsy procedure under regional anesthesia. The affected joint, located in the left knee region, was approached. Thorough lavage of the joint was performed to reduce inflammation, followed by the collection of a muscle sample for further evaluation. The procedure aimed to alleviate joint inflammation and aid in diagnosis. The patient remained stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 83: Patient with myositis in sarcoidosis and moderate joint inflammation underwent a joint irrigation and muscle biopsy procedure under general anesthesia. The affected joint, located in the right hip region, was approached. Thorough irrigation of the joint was performed to reduce inflammation, and a muscle sample was obtained for histopathological analysis. The procedure aimed to alleviate joint inflammation and provide diagnostic information. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 84: Patient presented with significant joint inflammation associated with myositis in sarcoidosis, requiring a joint debridement and muscle biopsy procedure under monitored anesthesia care (MAC). The affected joint, located in the left shoulder region, was approached, and meticulous debridement of inflamed tissues was performed. Simultaneously, a muscle sample was obtained for further evaluation. The procedure aimed to alleviate joint inflammation and obtain diagnostic information. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

Operative Note 85: Patient with myositis in sarcoidosis and severe joint inflammation underwent a joint washout and muscle biopsy procedure under general anesthesia. The affected joint, located in the right ankle region, was approached. Thorough washout of the joint was performed to reduce inflammation, and a muscle sample was obtained for histopathological analysis. The procedure aimed to alleviate joint inflammation and provide diagnostic information. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 86: Patient presented with significant joint inflammation associated with myositis in sarcoidosis, necessitating a joint irrigation and muscle biopsy procedure under local anesthesia with intravenous sedation. The affected joint, located in the left elbow region, was approached. Extensive irrigation of the joint was performed to reduce inflammation, followed by a muscle biopsy to aid in diagnosis. The patient remained cooperative and comfortable throughout the procedure, and appropriate postoperative care was initiated. The patient was discharged with instructions for follow-up evaluation.

Operative Note 87: Patient with myositis in sarcoidosis and moderate joint inflammation underwent a synovectomy and muscle biopsy procedure under general anesthesia. The affected joint, located in the right wrist region, was approached. The inflamed synovial tissue was meticulously excised to alleviate inflammation, and a muscle sample was obtained for pathological analysis. The procedure aimed to reduce joint inflammation and provide diagnostic information. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 88: Patient presented with severe joint inflammation associated with myositis in sarcoidosis, necessitating a joint lavage and muscle biopsy procedure under regional anesthesia. The affected joint, located in the left hip region, was approached. Thorough lavage of the joint was performed to reduce inflammation, followed by the collection of a muscle sample for further evaluation. The procedure aimed to alleviate joint inflammation and aid in diagnosis. The patient remained stable throughout the procedure, and appropriate postoperative monitoring was conducted.

Operative Note 89: Patient with myositis in sarcoidosis and significant joint inflammation underwent a joint irrigation and muscle biopsy procedure under general anesthesia. The affected joint, located in the right ankle region, was approached. Thorough irrigation of the joint was performed to reduce inflammation, and a muscle sample was obtained for histopathological analysis. The procedure aimed to alleviate joint inflammation and provide diagnostic information. The patient tolerated the procedure well, and appropriate postoperative care was initiated.

Operative Note 90: Patient presented with significant joint inflammation associated with myositis in sarcoidosis, requiring a joint debridement and muscle biopsy procedure under monitored anesthesia care (MAC). The affected joint, located in the left shoulder region, was approached, and meticulous debridement of inflamed tissues was performed. Simultaneously, a muscle sample was obtained for further evaluation. The procedure aimed to alleviate joint inflammation and obtain diagnostic information. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

Operative Note 91: Patient with myositis in sarcoidosis underwent a muscle biopsy procedure under local anesthesia. The left thigh muscles were approached, and a muscle sample was obtained for histopathological analysis. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every three months for moderate cases to monthly for severe cases. The patient was educated about the importance of follow-up appointments and the need for close monitoring of symptoms. Instructions for medication management and lifestyle modifications were provided.

Operative Note 92: Patient presented with myositis in sarcoidosis and underwent a muscle biopsy procedure under general anesthesia. The right upper arm muscles were approached, and a muscle sample was obtained for further evaluation. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every six months for mild cases to bi-monthly for severe cases. The patient was advised to maintain regular follow-ups to monitor disease progression, adjust treatment if necessary, and address any new symptoms or concerns.

Operative Note 93: Patient with sarcoidosis-related myositis underwent a muscle biopsy procedure under regional anesthesia. The left calf muscles were approached, and a muscle sample was obtained for pathological analysis. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from annually for mild cases to quarterly for severe cases. The patient was instructed to schedule follow-up appointments accordingly to monitor disease activity, assess treatment response, and manage any potential complications or new symptoms.

Operative Note 94: Patient presented with myositis in sarcoidosis and underwent a muscle biopsy procedure under general anesthesia. The right forearm muscles were approached, and a muscle sample was obtained for histopathological examination. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every four months for moderate cases to bi-monthly for severe cases. The patient was counseled on the importance of regular follow-up appointments to evaluate disease progression, optimize treatment strategies, and address any emerging issues.

Operative Note 95: Patient with sarcoidosis-related myositis underwent a muscle biopsy procedure under local anesthesia. The left shoulder muscles were approached, and a muscle sample was obtained for further evaluation. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every three months for mild cases to monthly for severe cases. The patient was advised to adhere to the recommended follow-up schedule to closely monitor disease activity, assess treatment efficacy, and manage any complications or new symptoms.

Operative Note 96: Patient presented with myositis in sarcoidosis and underwent a muscle biopsy procedure under general anesthesia. The right thigh muscles were approached, and a muscle sample was obtained for pathological analysis. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every six months for mild cases to quarterly for severe cases. The patient was instructed to maintain regular follow-up appointments to monitor disease progression, adjust treatment as needed, and address any emerging concerns or symptoms.

Operative Note 97: Patient with sarcoidosis-related myositis underwent a muscle biopsy procedure under regional anesthesia. The left upper arm muscles were approached, and a muscle sample was obtained for histopathological examination. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from annually for mild cases to bi-monthly for severe cases. The patient was counseled on the importance of consistent follow-up to evaluate disease activity, optimize treatment strategies, and manage any potential complications or new symptoms.

Operative Note 98: Patient presented with myositis in sarcoidosis and underwent a muscle biopsy procedure under general anesthesia. The right calf muscles were approached, and a muscle sample was obtained for further evaluation. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every four months for moderate cases to monthly for severe cases. The patient was educated on the significance of regular follow-up appointments to monitor disease progression, assess treatment response, and address any emerging issues or concerns.

Operative Note 99: Patient with sarcoidosis-related myositis underwent a muscle biopsy procedure under local anesthesia. The left forearm muscles were approached, and a muscle sample was obtained for pathological analysis. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every three months for mild cases to quarterly for severe cases. The patient was advised to adhere to the recommended follow-up schedule to closely monitor disease activity, assess treatment efficacy, and manage any complications or new symptoms.

Operative Note 100: Patient presented with myositis in sarcoidosis and underwent a muscle biopsy procedure under general anesthesia. The right shoulder muscles were approached, and a muscle sample was obtained for histopathological examination. The severity of the diagnosis will determine the frequency of follow-up visits, ranging from every six months for mild cases to bi-monthly for severe cases. The patient was instructed to maintain regular follow-up appointments to monitor disease progression, adjust treatment as needed, and address any emerging concerns or symptoms.

## M65.0 Abscess of tendon sheath

Operative Note 1: Patient underwent surgical intervention for abscess of the tendon sheath. A dorsal incision was made over the affected area, and dissection was carried down to expose the abscess cavity. The abscess was carefully drained, and copious irrigation with saline solution was performed. The wound was thoroughly debrided, removing any necrotic tissue. A drain was placed, and the wound was closed in layers using absorbable sutures. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

Operative Note 2: Patient underwent surgical management for abscess of the tendon sheath. A volar approach was utilized to gain access to the affected area. The abscess cavity was identified and carefully drained under direct visualization. Extensive irrigation was performed, ensuring adequate removal of purulent material. Necrotic tissue was debrided meticulously. The wound was then meticulously closed in layers using absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure without complications and was transferred to the postoperative care unit in stable condition.

Operative Note 3: Surgical intervention was performed for abscess of the tendon sheath. An oblique incision was made over the affected area, and meticulous dissection was carried out to expose the abscess cavity. The abscess was drained completely, and thorough irrigation with sterile saline was performed. Debridement of any necrotic tissue was done meticulously. The wound was closed in layers using absorbable sutures, and a sterile dressing was applied. The patient's vital signs remained stable throughout the procedure, and there were no intraoperative complications.

Operative Note 4: The patient underwent surgery for abscess of the tendon sheath. A curvilinear incision was made over the affected area, and the abscess was visualized. The cavity was carefully drained, and copious irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, ensuring proper approximation. A sterile dressing was applied to the surgical site. The patient tolerated the procedure well, and no immediate postoperative complications were observed.

Operative Note 5: Surgical management was performed for abscess of the tendon sheath. A longitudinal incision was made over the affected area, and meticulous dissection was carried out to expose the abscess cavity. The abscess was drained thoroughly, and extensive irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, achieving appropriate wound approximation. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure.

Operative Note 6: The patient underwent surgery for abscess of the tendon sheath. A transverse incision was made over the affected area, providing optimal exposure. The abscess cavity was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's postoperative course was uneventful with no immediate complications.

Operative Note 7: Surgical intervention was performed for abscess of the tendon sheath. A radial incision was made over the affected area, and meticulous dissection was carried out to expose the abscess cavity. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure without any intraoperative complications.

Operative Note 8: The patient underwent surgery for abscess of the tendon sheath. A ulnar incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure with no immediate postoperative complications.

Operative Note 9: Surgical management was performed for abscess of the tendon sheath. A transverse elliptical incision was made over the affected area, and meticulous dissection was carried out to expose the abscess cavity. The abscess was drained thoroughly, and extensive irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 10: The patient underwent surgery for abscess of the tendon sheath. A midline incision was made over the affected area, and meticulous dissection was carried out to expose the abscess cavity. The abscess was drained completely, and copious irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure with no immediate postoperative complications.

Operative Note 11: Surgical intervention was performed for abscess of the tendon sheath. A transverse curved incision was made over the affected area, allowing optimal exposure. The abscess cavity was carefully drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 12: The patient underwent surgery for abscess of the tendon sheath. A zigzag incision was made over the affected area, providing excellent access to the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure with no immediate postoperative complications.

Operative Note 13: Surgical management was performed for abscess of the tendon sheath. An oblique transverse incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 14: The patient underwent surgery for abscess of the tendon sheath. A curvilinear transverse incision was made over the affected area, providing adequate access to the abscess cavity. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure with no immediate postoperative complications.

Operative Note 15: Surgical intervention was performed for abscess of the tendon sheath. A longitudinal curved incision was made over the affected area, providing excellent exposure of the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 16: The patient underwent surgery for abscess of the tendon sheath. A radial transverse incision was made over the affected area, allowing optimal access to the abscess cavity. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure with no immediate postoperative complications.

Operative Note 17: Surgical management was performed for abscess of the tendon sheath. A dorsal longitudinal incision was made over the affected area, providing adequate exposure of the abscess cavity. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 18: The patient underwent surgery for abscess of the tendon sheath. A volar transverse incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure with no immediate postoperative complications.

Operative Note 19: Surgical intervention was performed for abscess of the tendon sheath. A midline transverse incision was made over the affected area, allowing excellent exposure of the abscess cavity. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 20: The patient underwent surgery for abscess of the tendon sheath. A diagonal incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure with no immediate postoperative complications.

Operative Note 21: Surgical management was performed for abscess of the tendon sheath. Under general anesthesia, a transverse incision was made over the affected area, providing optimal exposure. The abscess was drained completely, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. An appropriate dose of anesthesia was administered throughout the surgery, maintaining the patient's hemodynamic stability.

Operative Note 22: The patient underwent surgery for abscess of the tendon sheath. Local anesthesia was administered, and a longitudinal incision was made over the affected area. The abscess cavity was carefully drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The administered anesthesia dosage was adjusted to ensure patient comfort and adequate pain control.

Operative Note 23: Surgical intervention was performed for abscess of the tendon sheath. Regional anesthesia was administered, and a curvilinear incision was made over the affected area. The abscess was drained thoroughly, and extensive irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The dosage of regional anesthesia was carefully monitored and adjusted throughout the surgery.

Operative Note 24: The patient underwent surgery for abscess of the tendon sheath. Combined anesthesia was administered, including general anesthesia and local anesthesia at the surgical site. A radial incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient's vital signs remained stable throughout the procedure. The anesthesia dosage was adjusted accordingly to ensure patient comfort and safety.

Operative Note 25: Surgical management was performed for abscess of the tendon sheath. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained completely, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The anesthesia dosage was carefully monitored to maintain patient comfort and safety.

Operative Note 26: The patient underwent surgery for abscess of the tendon sheath. Spinal anesthesia was administered, and a transverse incision was made over the affected area. The abscess cavity was carefully drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The spinal anesthesia dosage was adjusted to ensure optimal pain control and patient comfort.

Operative Note 27: Surgical intervention was performed for abscess of the tendon sheath. Moderate sedation and local anesthesia were administered. A volar incision was made over the affected area, providing excellent access to the abscess cavity. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The anesthesia dosage was carefully monitored throughout the surgery.

Operative Note 28: The patient underwent surgery for abscess of the tendon sheath. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The anesthesia dosage was adjusted and monitored closely throughout the surgery.

Operative Note 29: Surgical management was performed for abscess of the tendon sheath. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The anesthesia dosage was carefully titrated to ensure patient comfort and safety.

Operative Note 30: The patient underwent surgery for abscess of the tendon sheath. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained completely, and copious irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The anesthesia dosage was adjusted and monitored throughout the surgery to maintain patient comfort and safety.

Operative Note 31: Surgical intervention was performed for abscess of the tendon sheath with associated bone erosion. Under general anesthesia, a longitudinal incision was made over the affected area, providing optimal exposure. The abscess cavity was drained thoroughly, and extensive irrigation with sterile saline was performed. Necrotic tissue and bone fragments were meticulously debrided. The bone erosion was carefully assessed and managed. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 32:

The patient underwent surgery for abscess of the tendon sheath with concurrent bone erosion. Local anesthesia was administered, and a curvilinear incision was made over the affected area. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue and areas of bone erosion were carefully debrided. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications. The bone erosion was assessed and addressed appropriately during the surgery.

Operative Note 33: Surgical management was performed for abscess of the tendon sheath with significant bone erosion. Regional anesthesia was administered, and a transverse incision was made over the affected area. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue and areas of bone erosion were meticulously debrided. The bone erosion was carefully assessed, and appropriate measures were taken to address the condition. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 34: The patient underwent surgery for abscess of the tendon sheath with associated bone erosion. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A radial incision was made over the affected area, providing optimal access to the abscess cavity and the site of bone erosion. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue and bone fragments were meticulously debrided. The bone erosion was carefully evaluated and managed during the procedure. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure.

Operative Note 35: Surgical intervention was performed for abscess of the tendon sheath with concurrent bone erosion. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity and the site of bone erosion. The abscess was drained completely, and thorough irrigation with sterile saline was performed. Necrotic tissue and areas of bone erosion were meticulously debrided. The bone erosion was carefully assessed and addressed during the procedure. The wound was closed in layers using absorbable sutures, ensuring proper wound closure.

Operative Note 36: The patient underwent surgery for abscess of the tendon sheath with significant bone erosion. Spinal anesthesia was administered, and a longitudinal incision was made over the affected area. The abscess cavity was carefully drained, and extensive irrigation with sterile saline was performed. Necrotic tissue and areas of bone erosion were meticulously debrided. The bone erosion was thoroughly evaluated and managed during the procedure. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 37: Surgical management was performed for abscess of the tendon sheath with concurrent bone erosion. Moderate sedation and local anesthesia were administered. A volar incision was made over the affected area, providing excellent access to the abscess cavity and the site of bone erosion. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue and areas of bone erosion were excised meticulously. The bone erosion was carefully assessed and managed during the procedure. The wound was closed in layers using absorbable sutures, ensuring proper wound closure.

Operative Note 38: The patient underwent surgery for abscess of the tendon sheath with associated bone erosion. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the abscess cavity and the site of bone erosion. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue and bone fragments were excised meticulously. The bone erosion was carefully evaluated and addressed during the procedure. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure.

Operative Note 39: Surgical intervention was performed for abscess of the tendon sheath with concurrent bone erosion. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the abscess cavity and the site of bone erosion. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue and areas of bone erosion were meticulously debrided. The bone erosion was carefully assessed and managed during the procedure. The wound was closed in layers using absorbable sutures, ensuring proper wound closure.

Operative Note 40: The patient underwent surgery for abscess of the tendon sheath with significant bone erosion. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity and the site of bone erosion. The abscess was drained completely, and copious irrigation with sterile saline was performed. Necrotic tissue and areas of bone erosion were meticulously debrided. The bone erosion was carefully evaluated and addressed during the procedure. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure.

Operative Note 41: Surgical intervention was performed for abscess of the tendon sheath with severe bone pain. Under general anesthesia, a longitudinal incision was made over the affected area, providing optimal exposure. The abscess cavity was drained thoroughly, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided, taking special care to address the severe bone pain. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 42: The patient underwent surgery for abscess of the tendon sheath with associated severe bone pain. Local anesthesia was administered, and a curvilinear incision was made over the affected area. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was excised meticulously, with extra attention given to alleviate the severe bone pain. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 43: Surgical management was performed for abscess of the tendon sheath with severe bone pain. Regional anesthesia was administered, and a transverse incision was made over the affected area. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided, with careful consideration given to relieve the severe bone pain. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 44: The patient underwent surgery for abscess of the tendon sheath with severe bone pain. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A radial incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was excised meticulously, paying close attention to alleviate the severe bone pain. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure.

Operative Note 45: Surgical intervention was performed for abscess of the tendon sheath with severe bone pain. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained completely, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided, with special focus on relieving the severe bone pain. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 46: The patient underwent surgery for abscess of the tendon sheath with severe bone pain. Spinal anesthesia was administered, and a longitudinal incision was made over the affected area. The abscess cavity was carefully drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was debrided meticulously, with extra attention given to alleviate the severe bone pain. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 47: Surgical management was performed for abscess of the tendon sheath with associated severe bone pain. Moderate sedation and local anesthesia were administered. A volar incision was made over the affected area, providing excellent access to the abscess cavity. The abscess was drained thoroughly, and copious irrigation with sterile saline was performed. Necrotic tissue was excised meticulously, taking special care to address the severe bone pain. The wound was closed in layers using absorbable sutures, ensuring proper wound closure.

Operative Note 48: The patient underwent surgery for abscess of the tendon sheath with severe bone pain. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained completely, and meticulous irrigation with sterile saline was performed. Necrotic tissue was excised meticulously, with particular attention given to alleviate the severe bone pain. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure.

Operative Note 49: Surgical intervention was performed for abscess of the tendon sheath with severe bone pain. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously debrided, paying close attention to alleviate the severe bone pain. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 50: The patient underwent surgery for abscess of the tendon sheath with severe bone pain. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained completely, and copious irrigation with sterile saline was performed. Necrotic tissue was excised meticulously, with special focus on relieving the severe bone pain. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. A sterile dressing was applied, and the patient tolerated the procedure well without any intraoperative complications.

Operative Note 51: A surgical intervention was performed for the management of abscess of the tendon sheath. Under general anesthesia, a longitudinal incision was made over the affected area, providing optimal exposure. The abscess cavity was meticulously drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The surgical intervention allowed for effective debridement and removal of the abscess, ensuring proper healing. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 52: The patient underwent a surgical intervention for the treatment of abscess of the tendon sheath. Local anesthesia was administered, and a curvilinear incision was made over the affected area. The abscess was completely drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention facilitated thorough debridement of the abscess, promoting optimal healing. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 53: Surgical intervention was performed to address abscess of the tendon sheath. Regional anesthesia was administered, and a transverse incision was made over the affected area. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement and removal of the abscess, promoting proper healing. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 54: A surgical intervention was performed for the management of abscess of the tendon sheath. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A radial incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was thoroughly drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention facilitated comprehensive debridement of the abscess, ensuring optimal healing. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 55: The patient underwent a surgical intervention for the treatment of abscess of the tendon sheath. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was drained completely, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, promoting proper healing. The wound was closed using absorbable sutures in layers, ensuring adequate closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 56: Surgical intervention was performed to address abscess of the tendon sheath. Spinal anesthesia was administered, and a longitudinal incision was made over the affected area. The abscess cavity was meticulously drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for comprehensive debridement of the abscess, facilitating optimal healing. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 57: A surgical intervention was performed for the management of abscess of the tendon sheath. Moderate sedation and local anesthesia were administered. A volar incision was made over the affected area, providing excellent access to the abscess cavity. The abscess was completely drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The surgical intervention facilitated thorough debridement and removal of the abscess, promoting optimal healing. The wound was closed using absorbable sutures in layers, ensuring proper closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 58: The patient underwent a surgical intervention for the treatment of abscess of the tendon sheath. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was thoroughly drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement and removal of the abscess, promoting proper healing. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 59: Surgical intervention was performed to address abscess of the tendon sheath. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement and removal of the abscess, ensuring optimal healing. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 60: The patient underwent a surgical intervention for the treatment of abscess of the tendon sheath. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was completely drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention facilitated comprehensive debridement and removal of the abscess, promoting proper healing. The wound was closed using absorbable sutures in layers, ensuring adequate closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 61: Surgical intervention was performed to address abscess of the tendon sheath. Under general anesthesia, a longitudinal incision was made over the affected area, providing optimal exposure. The abscess cavity was thoroughly drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement and removal of the abscess, promoting optimal healing. Additionally, the surrounding structures were carefully evaluated for any signs of bone erosion. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 62: The patient underwent a surgical intervention for the treatment of abscess of the tendon sheath. Local anesthesia was administered, and a curvilinear incision was made over the affected area. The abscess was completely drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement and removal of the abscess, promoting proper healing. Furthermore, careful examination of the surrounding bones revealed evidence of bone erosion, which was addressed accordingly. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 63: Surgical intervention was performed to address abscess of the tendon sheath with severe bone pain and evidence of bone erosion. Regional anesthesia was administered, and a transverse incision was made over the affected area. The abscess was meticulously drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement and removal of the abscess, promoting optimal healing. Additionally, thorough assessment of the bone erosion was conducted, and appropriate measures were taken to address it during the procedure. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 64: A surgical intervention was performed for the management of abscess of the tendon sheath with severe bone pain and evidence of bone erosion. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A radial incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was thoroughly drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for comprehensive debridement of the abscess and effective management of the bone erosion. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 65: The patient underwent a surgical intervention for the treatment of abscess of the tendon sheath with severe bone pain and evidence of bone erosion. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was completely drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, addressing the severe bone pain, and managing the bone erosion. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 66: Surgical intervention was performed to address abscess of the tendon sheath with severe bone pain and evidence of bone erosion. Spinal anesthesia was administered, and a longitudinal incision was made over the affected area. The abscess cavity was meticulously drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, alleviating the severe bone pain, and addressing the bone erosion. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 67: A surgical intervention was performed for the management of abscess of the tendon sheath with severe bone pain and evidence of bone erosion. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was thoroughly drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, addressing the severe bone pain, and managing the bone erosion. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 68: Surgical intervention was performed to address abscess of the tendon sheath with severe bone pain and evidence of bone erosion. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was completely drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, relieving the severe bone pain, and addressing the bone erosion. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 69: The patient underwent a surgical intervention for the treatment of abscess of the tendon sheath with severe bone pain and evidence of bone erosion. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was completely drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for thorough debridement of the abscess, addressing the severe bone pain, and managing the bone erosion. The wound was closed using absorbable sutures in layers, ensuring adequate closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 70: Surgical intervention was performed to address abscess of the tendon sheath with severe bone pain and evidence of bone erosion. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A volar incision was made over the affected area, providing excellent access to the abscess cavity. The abscess was thoroughly drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for comprehensive debridement of the abscess, relieving the severe bone pain, and addressing the bone erosion. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.  
Operative Note 71: A surgical intervention was performed to address an abscess of the tendon sheath with severe infection on the extreme moving joint. Under general anesthesia, a longitudinal incision was made over the affected area, providing optimal exposure. The abscess cavity was meticulously drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The surgical intervention allowed for effective debridement of the abscess, addressing the severe infection on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 72: The patient underwent a surgical intervention for the treatment of an abscess of the tendon sheath with severe infection on the extreme moving joint. Local anesthesia was administered, and a curvilinear incision was made over the affected area. The abscess was completely drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, addressing the severe infection on the extreme moving joint. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 73: Surgical intervention was performed to address an abscess of the tendon sheath with severe infection on the extreme moving joint. Regional anesthesia was administered, and a transverse incision was made over the affected area. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 74: A surgical intervention was performed for the management of an abscess of the tendon sheath with severe infection on the extreme moving joint. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A radial incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was thoroughly drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for comprehensive debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 75: The patient underwent a surgical intervention for the treatment of an abscess of the tendon sheath with severe infection on the extreme moving joint. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was completely drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 76: Surgical intervention was performed to address an abscess of the tendon sheath with severe infection on the extreme moving joint. Spinal anesthesia was administered, and a longitudinal incision was made over the affected area. The abscess cavity was meticulously drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed in layers using absorbable sutures, ensuring proper wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 77: A surgical intervention was performed for the management of an abscess of the tendon sheath with severe infection on the extreme moving joint. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was thoroughly drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 78: Surgical intervention was performed to address an abscess of the tendon sheath with severe infection on the extreme moving joint. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was completely drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 79: The patient underwent a surgical intervention for the treatment of an abscess of the tendon sheath with severe infection on the extreme moving joint. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was completely drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for thorough debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 80: Surgical intervention was performed to address an abscess of the tendon sheath with severe infection on the extreme moving joint. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A volar incision was made over the affected area, providing excellent access to the abscess cavity. The abscess was thoroughly drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for comprehensive debridement of the abscess, targeting the severe infection on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 81: A surgical intervention was performed to address an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Under general anesthesia, a longitudinal incision was made over the affected area, providing optimal exposure. The inflamed abscess cavity was meticulously drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. The surgical intervention allowed for effective debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 82: The patient underwent a surgical intervention for the treatment of an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Local anesthesia was administered, and a curvilinear incision was made over the affected area. The inflamed abscess was completely drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 83: Surgical intervention was performed to address an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Regional anesthesia was administered, and a transverse incision was made over the affected area. The inflamed abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 84: A surgical intervention was performed for the management of an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A radial incision was made over the affected area, providing optimal access to the inflamed abscess cavity. The abscess was thoroughly drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for comprehensive debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 85: The patient underwent a surgical intervention for the treatment of an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the inflamed abscess cavity. The abscess was completely drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 86: Surgical intervention was performed to address an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Spinal anesthesia was administered, and a longitudinal incision was made over the affected area. The inflamed abscess cavity was meticulously drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 87: A surgical intervention was performed to address an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the inflamed abscess cavity. The abscess was thoroughly drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for effective debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 88: Surgical intervention was performed to address an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the inflamed abscess cavity. The abscess was completely drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. The surgical intervention allowed for thorough debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 89: The patient underwent a surgical intervention for the treatment of an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the inflamed abscess cavity. The abscess was completely drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for thorough debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed using absorbable sutures in layers, ensuring proper closure. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 90: Surgical intervention was performed to address an inflamed abscess of the tendon sheath with severe infection on the extreme moving joint. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A volar incision was made over the affected area, providing excellent access to the inflamed abscess cavity. The abscess was thoroughly drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. The surgical intervention allowed for comprehensive debridement of the abscess, targeting the severe infection and inflammation on the extreme moving joint. The wound was closed in layers using absorbable sutures, achieving satisfactory wound closure. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 91: A surgical intervention was performed to address a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Under general anesthesia, a longitudinal incision was made over the affected area, providing optimal exposure. The abscess cavity was meticulously drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was excised meticulously. Given the severity of the diagnosis, post-operative follow-up will include frequent wound examinations, antibiotic therapy, and close monitoring for any signs of recurrent infection. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 92: The patient underwent a surgical intervention for the treatment of a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Local anesthesia was administered, and a curvilinear incision was made over the affected area. The abscess was completely drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was carefully excised. Given the severity of the diagnosis, post-operative follow-up will involve regular wound care, antibiotic therapy, and close monitoring for any signs of worsening infection. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 93: Surgical intervention was performed to address a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Regional anesthesia was administered, and a transverse incision was made over the affected area. The abscess was drained completely, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. Given the severity of the diagnosis, post-operative follow-up will include frequent wound assessments, aggressive antibiotic therapy, and close observation for any signs of recurrent infection. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 94: A surgical intervention was performed for the management of a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A radial incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was thoroughly drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. Given the severity of the diagnosis, post-operative follow-up will involve regular wound examinations, intense antibiotic therapy, and vigilant monitoring for any signs of deteriorating infection. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 95: The patient underwent a surgical intervention for the treatment of a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Minimal sedation and local anesthesia were administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was completely drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. Given the severity of the diagnosis, post-operative follow-up will include meticulous wound care, aggressive antibiotic therapy, and close monitoring for any signs of worsening infection. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 96: Surgical intervention was performed to address a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Spinal anesthesia was administered, and a longitudinal incision was made over the affected area. The abscess cavity was meticulously drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was carefully excised. Given the severity of the diagnosis, post-operative follow-up will involve frequent wound assessments, potent antibiotic therapy, and vigilant observation for any signs of recurrent infection. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 97: A surgical intervention was performed to address a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. General anesthesia with endotracheal intubation was administered. A dorsal incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was thoroughly drained, and meticulous irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. Given the severity of the diagnosis, post-operative follow-up will include close wound monitoring, aggressive antibiotic therapy, and frequent assessments for any signs of recurrent infection. The patient tolerated the procedure well, and no intraoperative complications were encountered.

Operative Note 98: Surgical intervention was performed to address a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Local anesthesia with conscious sedation was administered. A transverse incision was made over the affected area, providing optimal access to the abscess cavity. The abscess was completely drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. Given the severity of the diagnosis, post-operative follow-up will involve regular wound care, potent antibiotic therapy, and vigilant monitoring for any signs of worsening infection. The patient tolerated the procedure well, and no intraoperative complications were observed.

Operative Note 99: The patient underwent a surgical intervention for the treatment of a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Regional anesthesia with intravenous sedation was administered. An oblique incision was made over the affected area, allowing optimal exposure of the abscess cavity. The abscess was completely drained, and copious irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. Given the severity of the diagnosis, post-operative follow-up will include meticulous wound care, intensive antibiotic therapy, and close monitoring for any signs of deteriorating infection. The procedure was well-tolerated by the patient, and no intraoperative complications were encountered.

Operative Note 100: Surgical intervention was performed to address a severe abscess of the tendon sheath with extensive infection on the extreme moving joint. Combined anesthesia, including general anesthesia and local anesthesia, was administered. A volar incision was made over the affected area, providing excellent access to the abscess cavity. The abscess was thoroughly drained, and extensive irrigation with sterile saline was performed. Necrotic tissue was meticulously excised. Given the severity of the diagnosis, post-operative follow-up will involve close wound monitoring, aggressive antibiotic therapy, and vigilant observation for any signs of worsening infection. The patient tolerated the procedure well, and no intraoperative complications were encountered.

## M65.1 Other infective (teno)synovitis

1. Operative Note - Other Infective (Teno)Synovitis: A dorsal incision was made over the affected joint. The synovial sheath was carefully dissected and explored. Pus was encountered, indicating infective synovitis. The joint was thoroughly irrigated with sterile saline solution. Cultures were obtained for further analysis. A drain was inserted, and the wound was closed in layers. Postoperative care included antibiotics and immobilization of the joint.

2. Operative Note - Other Infective (Teno)Synovitis: An arthroscopic approach was employed to treat the infective (teno)synovitis. Two portals were created for visualization and instrumentation. The infected synovium was identified and debrided using arthroscopic instruments. Copious irrigation was performed, ensuring removal of debris and pus. The portals were closed with sutures, and a sterile dressing was applied. Antibiotics and postoperative rehabilitation were prescribed.

3. Operative Note - Other Infective (Teno)Synovitis: A volar approach was utilized to access the affected joint. The flexor tendon sheath was opened, and purulent fluid was drained. The infected synovium was meticulously excised to achieve complete debridement. Copious irrigation was performed, and the sheath was closed with absorbable sutures. A sterile dressing and splint were applied. Postoperative care involved antibiotics and hand therapy.

4. Operative Note - Other Infective (Teno)Synovitis: Through a medial incision, the joint capsule was accessed. The infected synovial tissue was identified and thoroughly excised. The joint was lavaged with sterile saline solution to remove pus and debris. The capsule was repaired, and the wound was closed in layers. A sterile dressing was applied, and the patient was prescribed antibiotics and instructed for immobilization.

5. Operative Note - Other Infective (Teno)Synovitis: A lateral approach was chosen to reach the affected joint. The extensor tendon sheath was incised, revealing purulent fluid. The infected synovium was excised, ensuring complete debridement. The joint was lavaged extensively, and the sheath was sutured closed. A sterile dressing was applied, and the patient was started on a course of antibiotics. Postoperative immobilization was recommended.

6. Operative Note - Other Infective (Teno)Synovitis: A dorsal midline incision was made to access the joint. The extensor tendon sheath was opened, and purulent material was drained. The infected synovium was meticulously removed, and the joint was irrigated with saline solution. The sheath was closed with sutures, and the wound was closed in layers. Antibiotics were initiated, and postoperative immobilization was advised.

7. Operative Note - Other Infective (Teno)Synovitis: An ulnar approach was employed to reach the affected joint. The extensor tendon sheath was incised, revealing infected synovium. Thorough debridement was performed, and the joint was irrigated with sterile solution. The sheath was repaired using absorbable sutures. A sterile dressing was applied, and the patient was prescribed antibiotics. Postoperative immobilization and hand therapy were recommended.

8. Operative Note - Other Infective (Teno)Synovitis: Through a volar incision, the joint capsule was accessed. Pus was encountered upon opening the capsule. The infected synovium was excised, and the joint was lavaged with sterile saline solution. The capsule was repaired, and the wound was closed in layers. A sterile dressing and splint were applied. Antibiotics were prescribed, and postoperative immobilization was advised.

9. Operative Note - Other Infective (Teno)Synovitis: An arthroscopic-assisted approach was used to address the infective (teno)synovitis. The joint was visualized through arthroscopy, and infected synovial tissue was identified. Debridement was performed using arthroscopic instruments, followed by thorough irrigation. The portals were closed with sutures, and a sterile dressing was applied. Antibiotics were initiated, and the patient was referred for postoperative rehabilitation.

10. Operative Note - Other Infective (Teno)Synovitis: A medial approach was employed to access the affected joint. The flexor tendon sheath was opened, revealing purulent fluid. The infected synovium was meticulously excised, and the joint was lavaged with sterile saline solution. The sheath was repaired, and the wound was closed in layers. A sterile dressing and splint were applied. Antibiotics and hand therapy were prescribed.

1. Operative Note - Other Infective (Teno)Synovitis: A dorsal longitudinal incision was made over the joint. The infected synovium was identified and meticulously excised. Copious irrigation with sterile saline solution was performed to cleanse the joint. The wound was closed in layers, and a sterile dressing was applied. The patient was prescribed antibiotics and advised to immobilize the joint postoperatively.

2. Operative Note - Other Infective (Teno)Synovitis: An arthroscopic approach was utilized to address the infective synovitis. Multiple portals were created for visualization and instrumentation. The infected synovium was meticulously debrided using arthroscopic tools. The joint was thoroughly irrigated, and the portals were closed with sutures. A sterile dressing was applied, and the patient was initiated on a course of antibiotics.

3. Operative Note - Other Infective (Teno)Synovitis: A volar incision was made to access the joint. Purulent fluid was encountered upon opening the sheath. The infected synovium was excised, and the joint was irrigated with sterile saline solution. The sheath was meticulously closed using absorbable sutures. A sterile dressing and splint were applied, and the patient was started on antibiotics with postoperative immobilization.

4. Operative Note - Other Infective (Teno)Synovitis: Through a lateral approach, the joint capsule was exposed. Infected synovial tissue was identified and carefully excised. The joint was lavaged with sterile saline solution to remove pus and debris. The capsule was repaired, and the wound was closed in layers. A sterile dressing was applied, and the patient was prescribed antibiotics and advised for postoperative immobilization.

5. Operative Note - Other Infective (Teno)Synovitis: An anterolateral incision was made to access the joint. Purulent fluid was encountered upon opening the sheath. The infected synovium was meticulously removed, and the joint was thoroughly irrigated. The sheath was closed using absorbable sutures. A sterile dressing and splint were applied, and the patient was initiated on a course of antibiotics.

6. Operative Note - Other Infective (Teno)Synovitis: A volar approach was employed to reach the affected joint. The flexor tendon sheath was opened, revealing purulent fluid. The infected synovium was excised meticulously, and the joint was lavaged with sterile saline solution. The sheath was repaired using absorbable sutures. A sterile dressing was applied, and the patient was prescribed antibiotics and instructed for postoperative immobilization.

7. Operative Note - Other Infective (Teno)Synovitis: A medial incision was made over the joint to access the affected area. Purulent fluid was drained upon opening the sheath. The infected synovium was meticulously excised, and the joint was irrigated with sterile saline solution. The sheath was closed with sutures, and the wound was closed in layers. Antibiotics were initiated, and postoperative immobilization was advised.

8. Operative Note - Other Infective (Teno)Synovitis: Through a dorsal approach, the joint capsule was accessed. Pus was encountered upon opening the capsule. The infected synovium was meticulously excised, and the joint was lavaged with sterile saline solution. The capsule was repaired, and the wound was closed in layers. A sterile dressing was applied, and the patient was prescribed antibiotics and instructed for immobilization.

9. Operative Note - Other Infective (Teno)Synovitis: An ulnar incision was made to access the joint. Purulent fluid was encountered upon opening the sheath. The infected synovium was carefully excised, and the joint was thoroughly irrigated. The sheath was repaired using absorbable sutures. A sterile dressing and splint were applied, and the patient was initiated on antibiotics. Postoperative immobilization and hand therapy were recommended.

10. Operative Note - Other Infective (Teno)Synovitis: A dorsal midline incision was made to access the joint. Purulent material was drained upon opening the extensor tendon sheath. The infected synovium was meticulously removed, and the joint was irrigated with sterile saline solution. The sheath was closed with sutures, and the wound was closed in layers. Antibiotics were initiated, and postoperative immobilization was advised.

1. Operative Note - Other Infective (Teno)Synovitis: Under general anesthesia, a dorsal incision was made over the affected joint. The synovial sheath was dissected, and purulent material was drained. The infected synovium was meticulously excised, and the joint was irrigated. The wound was closed in layers, and the patient was given appropriate postoperative pain management.

2. Operative Note - Other Infective (Teno)Synovitis: Using regional anesthesia, a volar approach was employed to access the joint. The flexor tendon sheath was opened, and purulent fluid was drained. The infected synovium was carefully excised, and the joint was lavaged. The sheath was closed, and the wound was closed in layers. Postoperative pain was managed with a combination of regional anesthesia and oral analgesics.

3. Operative Note - Other Infective (Teno)Synovitis: Under local anesthesia, an arthroscopic-assisted approach was utilized. The infected synovium was debrided using arthroscopic instruments, and the joint was thoroughly irrigated. The portals were closed, and the wound was dressed. Postoperative pain was managed with local anesthesia infiltration and oral analgesics.

4. Operative Note - Other Infective (Teno)Synovitis: Under spinal anesthesia, a dorsal incision was made over the joint. The infected synovium was excised, and the joint was irrigated. The wound was closed in layers, and appropriate postoperative pain control was provided. The patient remained comfortable throughout the procedure with stable vital signs.

5. Operative Note - Other Infective (Teno)Synovitis: Administered with general anesthesia, an arthroscopic approach was employed. The infected synovium was meticulously debrided, and the joint was lavaged. The portals were closed, and the wound was dressed. Adequate pain management was ensured postoperatively, using a combination of intravenous and oral analgesics.

6. Operative Note - Other Infective (Teno)Synovitis: With regional anesthesia, a medial incision was made to access the joint. The infected synovium was carefully excised, and the joint was thoroughly irrigated. The wound was closed in layers, and appropriate postoperative pain relief was achieved through a combination of regional anesthesia and oral analgesics.

7. Operative Note - Other Infective (Teno)Synovitis: Under local anesthesia, an ulnar approach was employed to reach the affected joint. The extensor tendon sheath was opened, and purulent fluid was drained. The infected synovium was meticulously excised, and the joint was lavaged. The sheath was repaired, and the wound was closed in layers. Postoperative pain was managed with local anesthesia infiltration and oral analgesics.

8. Operative Note - Other Infective (Teno)Synovitis: Administered with spinal anesthesia, a dorsal longitudinal incision was made over the joint. The infected synovium was excised, and the joint was irrigated. The wound was closed in layers, and postoperative pain control was achieved using a combination of spinal anesthesia and intravenous analgesics.

9. Operative Note - Other Infective (Teno)Synovitis: Under general anesthesia, an anterolateral incision was made to access the joint. The infected synovium was meticulously removed, and the joint was thoroughly irrigated. The wound was closed in layers, and the patient was provided with appropriate postoperative pain management.

10. Operative Note - Other Infective (Teno)Synovitis: Using regional anesthesia, a volar incision was made over the joint. Purulent material was drained, and the infected synovium was carefully excised. The joint was lavaged, and the wound was closed in layers. Postoperative pain was managed with a combination of regional anesthesia and oral analgesics, ensuring patient comfort.

1. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: A dorsal incision was made over the joint, revealing purulent material and evidence of bone erosion upon exploration. The infected synovium was meticulously excised, and the joint was thoroughly irrigated. Additional debridement of the eroded bone was performed. The wound was closed in layers, and appropriate postoperative care was provided to address both the infective synovitis and bone erosion.

2. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: Under general anesthesia, an arthroscopic-assisted approach was utilized. Erosion of the joint surfaces was observed along with infected synovium. Arthroscopic debridement was performed, addressing both the infective synovitis and bone erosion. Copious irrigation was performed, and the portals were closed. The patient was prescribed antibiotics and postoperative measures to address bone erosion.

3. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: A volar incision was made to access the joint. Evidence of bone erosion was noted during surgical exploration. The infected synovium was meticulously excised, and the joint was irrigated. Additional debridement of the eroded bone was performed. The wound was closed in layers, and postoperative management included antibiotics and measures to address the underlying bone erosion.

4. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: Through a lateral approach, erosion of the joint surface and infected synovium were identified. The joint was meticulously debrided, addressing both the infective synovitis and bone erosion. Thorough irrigation was performed, and the wound was closed. The patient received appropriate antibiotics and was provided with postoperative measures to promote bone healing and prevent further erosion.

5. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: Under regional anesthesia, a medial incision was made to access the joint. Bone erosion was observed along with infected synovium. The infected synovium was excised, and the joint was thoroughly irrigated. Debridement of the eroded bone was performed, and the wound was closed. The patient received antibiotics and postoperative measures to address bone erosion.

6. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: A dorsal incision was made over the joint, revealing evidence of bone erosion and infected synovium. Meticulous excision of the infected synovium was performed, followed by thorough irrigation. Additional debridement of the eroded bone was carried out. The wound was closed, and the patient was managed with antibiotics and appropriate measures to address the bone erosion.

7. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: Using regional anesthesia, an arthroscopic approach was employed. Erosion of the joint surfaces and infected synovium were observed. Arthroscopic debridement was performed, addressing both the infective synovitis and bone erosion. Copious irrigation was carried out, and the portals were closed. The patient received antibiotics and postoperative measures to address the underlying bone erosion.

8. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: A volar approach was utilized to access the joint. Evidence of bone erosion was noted upon surgical exploration. The infected synovium was meticulously excised, and the joint was irrigated. Additional de bridement of the eroded bone was performed. The wound was closed, and the patient was managed with antibiotics and appropriate measures to address the bone erosion.

9. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: Under general anesthesia, a lateral incision was made to access the joint. Bone erosion and infected synovium were observed intraoperatively. The joint was meticulously debrided, addressing both the infective synovitis and bone erosion. Thorough irrigation was performed, and the wound was closed. The patient received appropriate antibiotics and postoperative measures to address the underlying bone erosion.

10. Operative Note - Other Infective (Teno)Synovitis with Bone Erosion: A medial approach was employed to access the joint, revealing evidence of bone erosion and infected synovium. The infected synovium was meticulously excised, and the joint was irrigated. Debridement of the eroded bone was performed, and the wound was closed. The patient received antibiotics and postoperative measures to address the bone erosion and promote healing.

1. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: A dorsal incision was made over the joint, and upon exploration, severe bone pain was noted along with infected synovium. The infected synovium was meticulously excised, and the joint was thoroughly irrigated. Additional measures were taken to address the severe bone pain, including local anesthetic infiltration and appropriate postoperative pain management.

2. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: Under general anesthesia, an arthroscopic-assisted approach was utilized. Severe bone pain was observed along with infected synovium. Arthroscopic debridement was performed, addressing both the infective synovitis and severe bone pain. Copious irrigation was performed, and the portals were closed. The patient received appropriate postoperative pain management to address the underlying bone pain.

3. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: A volar incision was made to access the joint, revealing evidence of severe bone pain and infected synovium. The infected synovium was meticulously excised, and the joint was irrigated. Additional measures were taken intraoperatively to address the severe bone pain, including local anesthetic infiltration. The wound was closed, and the patient received postoperative pain management to alleviate the bone pain.

4. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: Through a lateral approach, severe bone pain and infected synovium were identified. The joint was meticulously debrided, addressing both the infective synovitis and severe bone pain. Thorough irrigation was performed, and the wound was closed. The patient received appropriate postoperative pain management to alleviate the bone pain.

5. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: Under regional anesthesia, a medial incision was made to access the joint. Severe bone pain was noted intraoperatively along with infected synovium. The infected synovium was meticulously excised, and the joint was irrigated. Additional measures were taken to address the severe bone pain, including local anesthetic infiltration. The wound was closed, and the patient received postoperative pain management to alleviate the bone pain.

6. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: A dorsal incision was made over the joint, revealing evidence of severe bone pain and infected synovium. Meticulous excision of the infected synovium was performed, followed by thorough irrigation. Additional measures were taken intraoperatively to address the severe bone pain, including local anesthetic infiltration. The wound was closed, and the patient received postoperative pain management to alleviate the bone pain.

7. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: Using regional anesthesia, an arthroscopic approach was employed. Severe bone pain and infected synovium were observed. Arthroscopic debridement was performed, addressing both the infective synovitis and severe bone pain. Copious irrigation was carried out, and the portals were closed. The patient received appropriate postoperative pain management to alleviate the bone pain.

8. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: A volar approach was utilized to access the joint, revealing evidence of severe bone pain along with infected synovium. The infected synovium was meticulously excised, and the joint was irrigated. Additional measures were taken intraoperatively to address the severe bone pain, including local anesthetic infiltration. The wound was closed, and the patient received postoperative pain management to alleviate the bone pain.

9. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: Under general anesthesia, a lateral incision was made to access the joint. Severe bone pain and infected synovium were observed intraoperatively. The joint was meticulously debrided, addressing both the infective synovitis and severe bone pain. Thorough irrigation was performed, and the wound was closed. The patient received appropriate postoperative pain management to alleviate the bone pain.

10. Operative Note - Other Infective (Teno)Synovitis with Severe Bone Pain: A medial approach was employed to access the joint, revealing evidence of severe bone pain and infected synovium. The infected synovium was meticulously excised, and the joint was irrigated. Additional measures were taken intraoperatively to address the severe bone pain, including local anesthetic infiltration. The wound was closed, and the patient received postoperative pain management to alleviate the bone pain.:

1. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: Under general anesthesia, a dorsal incision was made over the joint. Surgical exploration revealed infected synovium and extensive inflammation. Surgical intervention involved meticulous excision of the infected synovium and thorough joint irrigation. The wound was closed in layers, and appropriate postoperative care was provided to promote healing and prevent recurrence.

2. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: Using regional anesthesia, an arthroscopic approach was employed. Arthroscopic intervention involved debridement of the infected synovium and lavage of the joint. The portals were closed, and the patient received postoperative measures to support recovery and optimize outcomes.

3. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: A volar incision was made to access the joint, revealing infected synovium and signs of inflammation. Surgical intervention consisted of meticulous excision of the infected synovium and thorough joint irrigation. The wound was closed, and the patient received appropriate postoperative management, including antibiotics and immobilization.

4. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: Under general anesthesia, an open surgical approach was utilized. The joint was exposed, and infected synovium was identified. Surgical intervention involved excision of the infected synovium and thorough irrigation of the joint. The wound was closed in layers, and the patient was prescribed postoperative antibiotics and instructed on proper wound care.

5. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: Using regional anesthesia, a medial incision was made to access the joint. Surgical intervention consisted of meticulous excision of the infected synovium and thorough irrigation. Additional measures were taken to address any underlying joint pathology. The wound was closed, and the patient received postoperative instructions to ensure optimal recovery.

6. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: A dorsal incision was made over the joint, revealing infected synovium and signs of inflammation. Surgical intervention involved excision of the infected synovium and thorough joint irrigation. Additional procedures were performed to address associated joint pathology. The wound was closed, and appropriate postoperative measures were implemented.

7. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: Under general anesthesia, a lateral incision was made to access the joint. Surgical intervention involved meticulous excision of the infected synovium and thorough joint irrigation. Additional procedures were performed to address any concomitant joint pathology. The wound was closed in layers, and postoperative management was initiated.

8. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: Using regional anesthesia, an arthroscopic-assisted approach was employed. Arthroscopic intervention involved debridement of the infected synovium and thorough joint lavage. Surgical procedures were performed to address concurrent joint pathologies. The portals were closed, and the patient was given postoperative instructions for optimal recovery.

9. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: A volar approach was utilized to access the joint, revealing infected synovium and signs of inflammation. Surgical intervention involved meticulous excision of the infected synovium and thorough joint irrigation. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and postoperative measures were implemented to support healing and recovery.

10. Operative Note - Other Infective (Teno)Synovitis with Surgical Intervention: Under general anesthesia, an open surgical approach was employed. The joint was exposed, and infected synovium was identified. Surgical intervention consisted of excision of the infected synovium and thorough irrigation. Additional procedures were performed to address concomitant joint pathology. The wound was closed in layers, and the patient received postoperative instructions for proper wound care and rehabilitation.

1. Operative Note - Other Infective (Teno)Synovitis: A volar incision was made to access the joint. Infected synovium was visualized, and meticulous excision was performed. The joint was irrigated thoroughly, and closure was done in layers. Postoperative care included immobilization and administration of appropriate antibiotics.

2. Operative Note - Other Infective (Teno)Synovitis: Under general anesthesia, an arthroscopic approach was used. Infected synovium was identified and meticulously excised. The joint was lavaged, and portals were closed. The patient received postoperative instructions for rehabilitation and was prescribed antibiotics.

3. Operative Note - Other Infective (Teno)Synovitis: A dorsal incision was made to expose the joint. Infected synovium was excised, and the joint was thoroughly irrigated. Closure was performed, and the patient was given postoperative pain management and antibiotics.

4. Operative Note - Other Infective (Teno)Synovitis: Using regional anesthesia, an open approach was employed. The infected synovium was excised meticulously, and the joint was irrigated with antimicrobial solution. Closure was done, and the patient was instructed on postoperative care and follow-up.

5. Operative Note - Other Infective (Teno)Synovitis: Through a medial incision, infected synovium was visualized and meticulously excised. The joint was lavaged, and closure was performed. The patient was given antibiotics and instructed on joint protection and rehabilitation.

6. Operative Note - Other Infective (Teno)Synovitis: A lateral incision was made, exposing infected synovium. Meticulous excision was performed, and the joint was irrigated thoroughly. Closure was done, and postoperative pain management was initiated.

7. Operative Note - Other Infective (Teno)Synovitis: Under general anesthesia, an arthroscopic-assisted approach was utilized. Infected synovium was excised using arthroscopic instruments. Lavage was performed, and the portals were closed. The patient received postoperative instructions for wound care and was prescribed antibiotics.

8. Operative Note - Other Infective (Teno)Synovitis: An open approach was used, and infected synovium was excised meticulously. Thorough irrigation was done, and closure was performed. Postoperative care included pain management and initiation of antibiotics.

9. Operative Note - Other Infective (Teno)Synovitis: Using regional anesthesia, an arthroscopic approach was employed. Arthroscopic excision of infected synovium was performed, followed by joint lavage. The portals were closed, and the patient received postoperative instructions for activity modification and wound care.

10. Operative Note - Other Infective (Teno)Synovitis: A volar incision was made to access the joint. Infected synovium was meticulously excised, and the joint was lavaged thoroughly. Closure was performed, and the patient was given antibiotics and instructed on postoperative pain management.

1. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: Under general anesthesia, a dorsal incision was made over the joint. Severe infection involving the extreme moving joint was noted. Meticulous excision of the infected synovium was performed, followed by thorough joint irrigation. The wound was closed, and appropriate postoperative measures were initiated to address the severe infection and promote healing.

2. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: Using regional anesthesia, an arthroscopic approach was employed. Severe infection involving the extreme moving joint was identified. Arthroscopic debridement of the infected synovium was performed, followed by lavage of the joint. The portals were closed, and postoperative measures were implemented to address the severe infection and support recovery.

3. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: A volar incision was made to access the joint, revealing severe infection on the extreme moving joint. Meticulous excision of the infected synovium was performed, and the joint was thoroughly irrigated. Additional measures were taken intraoperatively to address the severe infection. The wound was closed, and the patient received appropriate postoperative management.

4. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: Under general anesthesia, an open surgical approach was utilized. Severe infection involving the extreme moving joint was observed. Surgical intervention included meticulous excision of the infected synovium and thorough irrigation of the joint. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and appropriate postoperative measures were initiated to manage the severe infection.

5. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: Using regional anesthesia, a medial incision was made to access the joint. Severe infection on the extreme moving joint was identified. Meticulous excision of the infected synovium was performed, followed by thorough joint irrigation. Additional measures were taken intraoperatively to address the severe infection. The wound was closed, and the patient received appropriate postoperative management.

6. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: A dorsal incision was made over the joint, revealing severe infection on the extreme moving joint. Meticulous excision of the infected synovium was performed, and the joint was thoroughly irrigated. Additional measures were taken intraoperatively to address the severe infection. The wound was closed, and the patient received appropriate postoperative management.

7. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: Under general anesthesia, a lateral incision was made to access the joint. Severe infection involving the extreme moving joint was noted. Meticulous excision of the infected synovium was performed, followed by thorough joint irrigation. The wound was closed, and appropriate postoperative measures were initiated to address the severe infection and promote healing.

8. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: Using regional anesthesia, an arthroscopic-assisted approach was employed. Severe infection on the extreme moving joint was identified. Arthroscopic debridement of the infected synovium was performed, followed by lavage of the joint.

The portals were closed, and postoperative measures were implemented to address the severe infection and support recovery.

9. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: A volar approach was utilized to access the joint, revealing severe infection on the extreme moving joint. Meticulous excision of the infected synovium was performed, and the joint was thoroughly irrigated. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and appropriate postoperative measures were initiated to manage the severe infection.

10. Operative Note - Other Infective (Teno)Synovitis with Severe Infection on Extreme Moving Joint: Under general anesthesia, an open surgical approach was employed. Severe infection involving the extreme moving joint was observed. Surgical intervention included meticulous excision of the infected synovium and thorough irrigation of the joint. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and appropriate postoperative measures were initiated to manage the severe infection.

1. Operative Note - Other Infective (Teno)Synovitis with Severe Inflammation: Under general anesthesia, a dorsal incision was made over the joint. Severe inflammation involving the synovium was noted. Meticulous excision of the inflamed synovium was performed, followed by thorough joint irrigation. The wound was closed, and appropriate postoperative measures were initiated to address the severe inflammation and promote healing.

2. Operative Note - Other Infective (Teno)Synovitis with Chronic Inflammation: Using regional anesthesia, an arthroscopic approach was employed. Chronic inflammation of the synovium was identified. Arthroscopic debridement of the inflamed synovium was performed, followed by lavage of the joint. The portals were closed, and postoperative measures were implemented to address the chronic inflammation and support recovery.

3. Operative Note - Other Infective (Teno)Synovitis with Acute Inflammation: A volar incision was made to access the joint, revealing acute inflammation of the synovium. Meticulous excision of the inflamed synovium was performed, and the joint was thoroughly irrigated. Additional measures were taken intraoperatively to address the acute inflammation. The wound was closed, and the patient received appropriate postoperative management.

4. Operative Note - Other Infective (Teno)Synovitis with Mild Inflammation: Under general anesthesia, an open surgical approach was utilized. Mild inflammation involving the synovium was observed. Surgical intervention included meticulous excision of the inflamed synovium and thorough irrigation of the joint. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and appropriate postoperative measures were initiated to manage the mild inflammation.

5. Operative Note - Other Infective (Teno)Synovitis with Moderate Inflammation: Using regional anesthesia, a medial incision was made to access the joint. Moderate inflammation of the synovium was identified. Meticulous excision of the inflamed synovium was performed, followed by thorough joint irrigation. Additional measures were taken intraoperatively to address the moderate inflammation. The wound was closed, and the patient received appropriate postoperative management.

6. Operative Note - Other Infective (Teno)Synovitis with Severe Inflammation: A dorsal incision was made over the joint, revealing severe inflammation of the synovium. Meticulous excision of the inflamed synovium was performed, and the joint was thoroughly irrigated. Additional measures were taken intraoperatively to address the severe inflammation. The wound was closed, and the patient received appropriate postoperative management.

7. Operative Note - Other Infective (Teno)Synovitis with Mild Inflammation: Under general anesthesia, a lateral incision was made to access the joint. Mild inflammation involving the synovium was noted. Meticulous excision of the inflamed synovium was performed, followed by thorough joint irrigation. The wound was closed, and appropriate postoperative measures were initiated to address the mild inflammation and promote healing.

8. Operative Note - Other Infective (Teno)Synovitis with Acute Inflammation: Using regional anesthesia, an arthroscopic-assisted approach was employed. Acute inflammation of the synovium was identified. Arthroscopic debridement of the inflamed synovium was performed, followed by lavage of the joint. The portals were closed, and postoperative measures were implemented to address the acute inflammation and support recovery.

9. Operative Note - Other Infective (Teno)Synovitis with Chronic Inflammation: A volar approach was utilized to access the joint, revealing chronic inflammation of the synovium. Meticulous excision of the inflamed synovium was performed, and the joint was thoroughly irrigated. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and appropriate postoperative measures were initiated to manage the chronic inflammation.

10. Operative Note - Other Infective (Teno)Synovitis with Moderate Inflammation: Under general anesthesia, an open surgical approach was employed. Moderate inflammation involving the synovium was observed. Surgical intervention included meticulous excision of the inflamed synovium and thorough irrigation of the joint. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and appropriate postoperative measures were initiated to manage the moderate inflammation.

1. Operative Note - Other Infective (Teno)Synovitis with Severe Diagnosis: Under general anesthesia, a dorsal incision was made over the joint. Severe infective (teno)synovitis was diagnosed. Meticulous excision of the infected synovium was performed, followed by thorough joint irrigation. The wound was closed, and the patient was scheduled for frequent follow-up visits to monitor response to treatment and adjust antibiotics accordingly.

2. Operative Note - Other Infective (Teno)Synovitis with Moderate Diagnosis: Using regional anesthesia, an arthroscopic approach was employed. Moderate infective (teno)synovitis was diagnosed. Arthroscopic debridement of the infected synovium was performed, followed by lavage of the joint. The portals were closed, and the patient was instructed to follow up in the clinic for wound check and further evaluation of symptoms.

3. Operative Note - Other Infective (Teno)Synovitis with Mild Diagnosis: A volar incision was made to access the joint, revealing mild infective (teno)synovitis. Meticulous excision of the infected synovium was performed, and the joint was thoroughly irrigated. Additional measures were taken intraoperatively to address the mild infection. The wound was closed, and the patient was advised to schedule a follow-up appointment for assessment of symptoms and possible adjustment of treatment plan.

4. Operative Note - Other Infective (Teno)Synovitis with Severe Diagnosis: Under general anesthesia, an open surgical approach was utilized. Severe infective (teno)synovitis was observed. Surgical intervention included meticulous excision of the infected synovium and thorough irrigation of the joint. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and the patient was scheduled for regular follow-up visits to monitor the response to treatment and assess the need for further intervention.

5. Operative Note - Other Infective (Teno)Synovitis with Moderate Diagnosis: Using regional anesthesia, a medial incision was made to access the joint. Moderate infective (teno)synovitis was identified. Meticulous excision of the infected synovium was performed, followed by thorough joint irrigation. Additional measures were taken intraoperatively to address the moderate infection. The wound was closed, and the patient was instructed to return for a follow-up examination to evaluate the progress of treatment.

6. Operative Note - Other Infective (Teno)Synovitis with Severe Diagnosis: A dorsal incision was made over the joint, revealing severe infective (teno)synovitis. Meticulous excision of the infected synovium was performed, and the joint was thoroughly irrigated. Additional measures were taken intraoperatively to address the severe infection. The wound was closed, and the patient was advised to schedule frequent follow-up visits to closely monitor the response to treatment and consider additional interventions if needed.

7. Operative Note - Other Infective (Teno)Synovitis with Mild Diagnosis: Under general anesthesia, a lateral incision was made to access the joint. Mild infective (teno)synovitis involving the joint was noted. Meticulous excision of the infected synovium was performed, followed by thorough joint irrigation. The wound was closed, and the patient was instructed to return for a follow-up evaluation to assess the response to treatment and consider further management options.

8. Operative Note - Other Infective (Teno)Synovitis with Moderate Diagnosis: Using regional anesthesia

, an arthroscopic-assisted approach was employed. Moderate infective (teno)synovitis was diagnosed. Arthroscopic debridement of the infected synovium was performed, followed by lavage of the joint. The portals were closed, and the patient was advised to schedule regular follow-up appointments to monitor the progress of treatment and adjust the management plan accordingly.

9. Operative Note - Other Infective (Teno)Synovitis with Severe Diagnosis: A volar approach was utilized to access the joint, revealing severe infective (teno)synovitis. Meticulous excision of the infected synovium was performed, and the joint was thoroughly irrigated. Additional procedures were performed to address any associated joint abnormalities. The wound was closed, and the patient was scheduled for frequent follow-up visits to closely monitor the response to treatment and consider further interventions as necessary.

10. Operative Note - Other Infective (Teno)Synovitis with Mild Diagnosis: Under general anesthesia, an open surgical approach was employed. Mild infective (teno)synovitis involving the joint was observed. Surgical intervention included meticulous excision of the infected synovium and thorough irrigation of the joint. Additional procedures were performed as needed. The wound was closed, and the patient was advised to schedule a follow-up appointment for evaluation of symptoms and consideration of further treatment options based on response to initial intervention.

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## M65.2 Calcific tendinitis

1. Patient presented with severe shoulder pain and limited range of motion. Diagnosis of calcific tendinitis confirmed through X-ray imaging, revealing calcium deposits in the supraspinatus tendon. Ultrasound-guided needle aspiration performed to extract calcific deposits, followed by corticosteroid injection for pain relief. Patient advised on shoulder rest and prescribed nonsteroidal anti-inflammatory drugs (NSAIDs) for inflammation control. Recommended physical therapy for gradual rehabilitation.

2. Operative note: Arthroscopic procedure performed to address chronic calcific tendinitis in the patient's shoulder joint. Multiple small incisions made to insert arthroscope and specialized instruments. Calcium deposits meticulously removed using a combination of mechanical debridement and lavage. Tendon integrity assessed and found to be intact. Postoperative care includes sling immobilization, pain management with analgesics, and physical therapy for optimal recovery.

3. Patient underwent open surgical intervention for symptomatic calcific tendinitis in the shoulder. A small longitudinal incision made over the affected tendon, allowing direct access to the calcium deposits. Deposits excised using a combination of curettage and irrigation. Tendon integrity inspected and found to be preserved. Wound closed meticulously. Patient instructed on postoperative shoulder immobilization, pain management, and gradual return to activity under the supervision of a physical therapist.

4. Intraoperative report: Patient with chronic calcific tendinitis underwent ultrasound-guided extracorporeal shock wave therapy (ESWT). High-energy shock waves delivered to the calcific deposit under real-time ultrasound guidance. Procedure well-tolerated, with no immediate complications. Post-procedural care includes pain management, shoulder rest, and subsequent follow-up to evaluate treatment response. Patient advised on potential transient discomfort and encouraged to engage in gentle range of motion exercises.

5. Percutaneous needle tenotomy performed on the patient's calcific tendinitis in the shoulder. Ultrasound-guided localization of the calcium deposit allowed precise needle insertion into the affected tendon. The needle was then moved in a back-and-forth motion to disrupt the calcium deposit. Post-procedure, the patient was advised on pain management, immobilization with a sling, and initiation of physical therapy to optimize functional recovery.

6. Operative note: Patient underwent ultrasound-guided percutaneous lavage and aspiration for calcific tendinitis. A small incision made over the tendon, and a cannula inserted under ultrasound guidance. Lavage performed using saline solution to wash out the calcium deposits. Simultaneously, needle aspiration used to extract the dissolved calcium material. Procedure successfully completed without complications. Postoperative care includes pain management, shoulder immobilization, and gradual progression to physical therapy.

7. Patient underwent minimally invasive arthroscopic debridement for symptomatic calcific tendinitis. Arthroscope introduced through small incisions, providing a clear view of the calcific deposit within the tendon. Mechanical debridement performed using specialized instruments to carefully remove the calcium deposits. Tendon inspected and found to be intact. Portals closed, and postoperative instructions given for pain management, shoulder immobilization, and subsequent physical therapy for restoration of full shoulder function.

8. Intraoperative report: Ultrasound-guided barbotage procedure performed on the patient's calcific tendinitis. Needle inserted into the calcific deposit, and repeated injections of a local anesthetic and saline solution carried out. Barbotage technique employed to disrupt and fragment the calcium deposits. Post-procedural care includes pain control, shoulder immobilization, and a gradual return to activity with a supervised rehabilitation program.

9. Open surgical excision of calcific tendinitis performed on the patient's shoulder. A longitudinal incision made directly over the affected tendon, allowing visualization and removal of the calcific deposits. Care taken to preserve tendon integrity. Wound closed meticulously in layers. Postoperative care includes pain management, immobilization, and subsequent referral to physical therapy for progressive shoulder strengthening and range of motion exercises.

10. Patient underwent ultrasound-guided needle aspiration with lavage for symptomatic calcific tendinitis. Under real-time ultrasound imaging, a needle inserted into the calcific deposit, aspirating the calcific material. Lavage performed using a saline solution to flush out remaining debris. The procedure was well-tolerated, with no immediate complications. Post-procedure, the patient was advised on pain management, shoulder rest, and initiation of physical therapy to promote tendon healing and functional recovery.

1. Patient presented with persistent shoulder pain and restricted mobility. Diagnostic imaging confirmed calcific tendinitis in the supraspinatus tendon. Ultrasound-guided needle lavage performed, utilizing a saline solution to irrigate and dislodge the calcific deposits. Gentle aspiration carried out to remove the dissolved material. Patient prescribed pain medication and advised on gradual resumption of activities alongside physical therapy for rehabilitation.

2. Operative note: Patient underwent ultrasound-guided percutaneous needling for calcific tendinitis. A small incision made to access the affected tendon. Under ultrasound guidance, a needle inserted into the calcium deposit, gently breaking it up to promote dissolution. The procedure was completed successfully without complications. Postoperative care included pain management, immobilization, and a structured rehabilitation program.

3. Patient underwent minimally invasive arthroscopic debridement and subacromial decompression for symptomatic calcific tendinitis. Arthroscope inserted through small incisions, providing a clear view of the tendon and associated structures. Mechanical debridement utilized to meticulously remove the calcium deposits. Concurrent subacromial decompression performed to alleviate impingement symptoms. Tendon integrity confirmed. Postoperative instructions provided for pain control, shoulder immobilization, and subsequent physiotherapy for functional recovery.

4. Intraoperative report: Patient with chronic calcific tendinitis underwent ultrasound-guided extracorporeal piezoelectric shock wave therapy (EPST). Precisely targeted shock waves administered to the calcific deposit using specialized equipment. Procedure well-tolerated, with no immediate complications. Post-procedural care included pain management, activity modification, and close monitoring of treatment response.

5. Open surgical intervention performed for refractory calcific tendinitis. A longitudinal incision made directly over the affected tendon, providing direct access to the calcium deposits. Thorough debridement performed to remove the calcific material. Tendon integrity assessed and found to be intact. Wound closed meticulously in layers. Patient advised on postoperative pain control, shoulder immobilization, and subsequent physiotherapy for optimal recovery.

6. Operative note: Patient underwent ultrasound-guided percutaneous needle aspiration with lavage and platelet-rich plasma (PRP) injection for calcific tendinitis. Needle inserted into the calcific deposit, aspirating the material, followed by lavage with a saline solution. PRP injection administered to promote tendon healing. Procedure completed without complications. Postoperative care included pain management, immobilization, and gradual initiation of physical therapy.

7. Patient underwent ultrasound-guided percutaneous needle fragmentation for calcific tendinitis. Needle inserted into the deposit, and gentle oscillations applied to break up the calcific material. Sequential needle movements allowed for comprehensive fragmentation. Post-procedure, the patient received instructions for pain management, shoulder rest, and initiation of physical therapy for functional recovery.

8. Intraoperative report: Patient underwent ultrasound-guided aspiration and lavage with the addition of an enzymatic solution for calcific tendinitis. Needle inserted into the deposit, aspirating the material, followed by lavage using an enzymatic solution to dissolve remaining calcifications. Procedure well-tolerated, with no immediate complications. Post-procedural care included pain control, shoulder immobilization, and subsequent physiotherapy to restore full shoulder functionality.

9. Patient underwent minimally invasive arthroscopic needle lavage and irrigation for calcific tendinitis. Arthroscope inserted through small incisions, providing visualization of the calcium deposits. Needle introduced into the deposit, and a saline solution used to lavage and dislodge the calcific material. Procedure successfully completed without complications. Postoperative care involved pain management, shoulder immobilization, and progressive rehabilitation exercises.

10. Operative note: Patient with chronic calcific tendinitis underwent ultrasound-guided percutaneous irrigation and corticosteroid injection. Needle inserted into the deposit, and a saline solution employed to flush out the calcific material. Corticosteroid injected to reduce inflammation and pain. Procedure concluded uneventfully. Postoperative instructions included pain control, immobilization, and gradual reintroduction of shoulder activities with the guidance of a physical therapist.

1. Patient underwent ultrasound-guided percutaneous needle lavage and aspiration for calcific tendinitis under local anesthesia. Adequate local anesthesia administered to ensure patient comfort during the procedure. Needle inserted into the deposit, and saline solution used for lavage and aspiration. Procedure completed without complications. Postoperative care included pain management, immobilization, and initiation of physical therapy for optimal recovery.

2. Operative note: Patient underwent arthroscopic debridement for calcific tendinitis under general anesthesia. General anesthesia induced and maintained throughout the procedure to ensure complete patient comfort and immobility. Arthroscope inserted through small incisions, allowing visualization and meticulous removal of the calcium deposits. Tendon integrity assessed and found to be intact. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for functional recovery.

3. Patient underwent minimally invasive ultrasound-guided percutaneous needle fragmentation for calcific tendinitis under conscious sedation. Conscious sedation administered to achieve a relaxed and pain-free state. Needle inserted into the deposit, and gentle oscillations applied to break up the calcific material. Procedure completed successfully without complications. Post-procedure, the patient received instructions for pain management, shoulder rest, and initiation of physical therapy for optimal recovery.

4. Intraoperative report: Patient with chronic calcific tendinitis underwent ultrasound-guided barbotage procedure under regional anesthesia. Regional anesthesia administered to numb the affected area, providing pain relief during the procedure. Needle inserted into the deposit, and repeated injections of a local anesthetic and saline solution carried out. Barbotage technique employed to disrupt and fragment the calcium deposits. Post-procedural care included pain control, shoulder immobilization, and subsequent physiotherapy for functional restoration.

5. Open surgical excision of calcific tendinitis performed under monitored anesthesia care (MAC). MAC provided to ensure patient comfort and safety throughout the procedure. Longitudinal incision made over the affected tendon, allowing direct access to the calcium deposits. Deposits meticulously excised, preserving tendon integrity. Wound closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for gradual shoulder rehabilitation.

6. Operative note: Patient underwent ultrasound-guided percutaneous needle aspiration with lavage for calcific tendinitis under moderate sedation. Moderate sedation administered to maintain a relaxed and pain-free state while allowing patient responsiveness. Needle inserted into the calcific deposit, aspirating the material, followed by lavage with a saline solution. Procedure completed without complications. Postoperative care included pain management, immobilization, and gradual initiation of physical therapy.

7. Patient underwent minimally invasive arthroscopic debridement and subacromial decompression for calcific tendinitis under general anesthesia. General anesthesia induced and maintained throughout the procedure to ensure patient comfort and immobility. Arthroscope inserted through small incisions, providing a clear view of the tendon and associated structures. Mechanical debridement utilized to meticulously remove the calcium deposits. Concurrent subacromial decompression performed to alleviate impingement symptoms. Tendon integrity confirmed. Postoperative instructions provided for pain control, shoulder immobilization, and subsequent physiotherapy for functional recovery.

8. Intraoperative report: Patient with chronic calcific tendinitis underwent ultrasound-guided extracorporeal piezoelectric shock wave therapy (EPST) under local anesthesia. Local anesthesia administered to numb the affected area and ensure patient comfort during the procedure. Precisely targeted shock waves administered to the calcific deposit using specialized equipment. Procedure well-tolerated, with no immediate complications. Post-procedural care included pain management, activity

modification, and close monitoring of treatment response.

9. Patient underwent open surgical intervention for refractory calcific tendinitis under general anesthesia. General anesthesia induced and maintained to ensure patient comfort and immobility throughout the procedure. A longitudinal incision made directly over the affected tendon, providing direct access to the calcium deposits. Thorough debridement performed to remove the calcific material. Tendon integrity assessed and found to be intact. Wound closed meticulously in layers. Postoperative care included pain management, immobilization, and subsequent physiotherapy for optimal recovery.

10. Operative note: Patient underwent ultrasound-guided percutaneous needle aspiration with lavage and platelet-rich plasma (PRP) injection for calcific tendinitis under conscious sedation. Conscious sedation administered to maintain a relaxed and pain-free state. Needle inserted into the calcific deposit, aspirating the material, followed by lavage with a saline solution. PRP injection administered to promote tendon healing. Procedure completed without complications. Postoperative care included pain management, immobilization, and gradual initiation of physical therapy.

1. Patient presented with severe shoulder pain and radiographic evidence of calcific tendinitis with associated bone erosion. Open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, revealing extensive calcific deposits and erosion of the underlying bone. Complete excision of calcific material and meticulous debridement of the eroded bone performed. Tendon integrity assessed and found to be compromised. Reconstruction of the eroded area with bone grafting carried out. Wound closed meticulously. Postoperative care included pain management, shoulder immobilization, and subsequent physical therapy for functional recovery.

2. Operative note: Patient underwent arthroscopic debridement and subacromial decompression for calcific tendinitis with bone erosion. General anesthesia induced and maintained throughout the procedure. Arthroscope inserted through small incisions, providing visualization of extensive calcific deposits and associated bone erosion. Mechanical debridement utilized to meticulously remove the calcium deposits and address the eroded bone surface. Concurrent subacromial decompression performed. Tendon integrity assessed and found to be compromised. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

3. Patient with symptomatic calcific tendinitis and bone erosion underwent ultrasound-guided percutaneous needle aspiration with lavage and corticosteroid injection under local anesthesia. Needle inserted into the calcific deposit, aspirating the material, followed by lavage and injection of corticosteroid solution to address inflammation. Bone erosion noted during the procedure. Procedure completed without complications. Postoperative care included pain management, immobilization, and gradual initiation of physical therapy for functional recovery.

4. Intraoperative report: Patient with calcific tendinitis and bone erosion underwent open surgical debridement and bone grafting under general anesthesia. Longitudinal incision made directly over the affected tendon, revealing extensive calcific deposits and erosion of the underlying bone. Thorough debridement of calcific material and eroded bone performed. Bone grafting carried out to reconstruct the eroded area. Tendon integrity assessed and found to be compromised. Wound closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

5. Patient underwent minimally invasive ultrasound-guided percutaneous needle fragmentation and bone substitute injection for calcific tendinitis with bone erosion. Procedure performed under conscious sedation. Needle inserted into the calcific deposit, and gentle oscillations applied to fragment the calcific material. Bone erosion noted during the procedure. Bone substitute injected to fill the eroded area. Post-procedure, the patient received instructions for pain management, shoulder rest, and initiation of physical therapy for functional recovery.

6. Operative note: Patient with chronic calcific tendinitis and bone erosion underwent arthroscopic debridement, bone curettage, and autografting under general anesthesia. Arthroscope inserted through small incisions, providing visualization of extensive calcific deposits and erosion of the underlying bone. Mechanical debridement utilized to meticulously remove the calcium deposits. Bone curettage performed to address the eroded bone surface. Autografting carried out to promote bone healing. Tendon integrity assessed and found to be compromised. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

7. Intraoperative report: Patient with calcific tendinitis and extensive bone erosion underwent open surgical debridement, bone grafting, and tendon repair under general anesthesia. Longitudinal incision made directly over the affected tendon, revealing significant calcific deposits and erosion of the underlying bone. Thorough debridement of calcific material and eroded bone performed. Bone grafting and tendon repair carried out to restore structural integrity. Wound closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

8. Patient presented with recurrent calcific tendinitis and bone erosion. Open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, exposing extensive calcific deposits and erosion of the underlying bone. Complete excision of calcific material and meticulous debridement of the eroded bone performed. Tendon integrity assessed and found to be compromised. Reconstruction of the eroded area with bone grafting carried out. Simultaneous tendon repair and reinforcement with synthetic graft performed. Wound closed meticulously. Postoperative care included pain management, shoulder immobilization, and subsequent physical therapy for functional recovery.

9. Operative note: Patient with chronic calcific tendinitis and bone erosion underwent arthroscopic debridement, bone curettage, and augmentation with bone substitute under general anesthesia. Arthroscope inserted through small incisions, providing visualization of extensive calcific deposits and erosion of the underlying bone. Mechanical debridement utilized to meticulously remove the calcium deposits. Bone curettage performed to address the eroded bone surface. Augmentation with bone substitute carried out to enhance bone healing. Tendon integrity assessed and found to be compromised. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

10. Intraoperative report: Patient with calcific tendinitis and significant bone erosion underwent open surgical debridement, bone grafting, and tendon reconstruction under general anesthesia. Longitudinal incision made directly over the affected tendon, revealing extensive calcific deposits and erosion of the underlying bone. Thorough debridement of calcific material and eroded bone performed. Bone grafting and tendon reconstruction carried out to restore structural integrity. Wound closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

1. Patient presented with debilitating shoulder pain and severe bone pain associated with calcific tendinitis. Open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, revealing extensive calcific deposits and eroded bone with severe bone pain. Complete excision of calcific material and meticulous debridement of the eroded bone performed. Tendon integrity assessed and found to be compromised. Reconstruction of the eroded area with bone grafting carried out. Wound closed meticulously. Postoperative care included aggressive pain management, shoulder immobilization, and subsequent physical therapy for functional recovery.

2. Operative note: Patient with chronic calcific tendinitis and severe bone pain underwent arthroscopic debridement and subacromial decompression under general anesthesia. Arthroscope inserted through small incisions, providing visualization of extensive calcific deposits and eroded bone with severe bone pain. Mechanical debridement utilized to meticulously remove the calcium deposits and address the eroded bone surface. Concurrent subacromial decompression performed. Tendon integrity assessed and found to be compromised. Postoperative instructions provided for aggressive pain control, immobilization, and subsequent physiotherapy for optimal recovery.

3. Patient with severe bone pain due to calcific tendinitis underwent ultrasound-guided percutaneous needle aspiration with lavage, corticosteroid injection, and regional anesthesia. Needle inserted into the calcific deposit, aspirating the material, followed by lavage and injection of corticosteroid solution to address inflammation and severe bone pain. Regional anesthesia administered to numb the affected area and provide targeted pain relief. Procedure completed without complications. Postoperative care included aggressive pain management, immobilization, and gradual initiation of physical therapy for functional recovery.

4. Intraoperative report: Patient with calcific tendinitis and severe bone pain underwent open surgical debridement, bone grafting, and aggressive pain control under general anesthesia. Longitudinal incision made directly over the affected tendon, revealing extensive calcific deposits and eroded bone with severe bone pain. Thorough debridement of calcific material and eroded bone performed. Bone grafting carried out to reconstruct the eroded area. Aggressive pain control measures implemented during and after the procedure. Tendon integrity assessed and found to be compromised. Wound closed meticulously. Postoperative care included intensive pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

5. Patient with severe bone pain related to calcific tendinitis underwent minimally invasive ultrasound-guided percutaneous needle fragmentation and bone substitute injection under conscious sedation. Procedure performed with a focus on aggressive pain control. Needle inserted into the calcific deposit, and gentle oscillations applied to fragment the calcific material. Bone substitute injected to address the eroded bone and alleviate severe bone pain. Post-procedure, the patient received instructions for intensive pain management, shoulder rest, and initiation of physical therapy for functional recovery.

6. Operative note: Patient with chronic calcific tendinitis and severe bone pain underwent arthroscopic debridement, bone curettage, bone grafting, and nerve block under general anesthesia. Arthroscope inserted through small incisions, providing visualization of extensive calcific deposits and eroded bone with severe bone pain. Mechanical debridement utilized to meticulously remove the calcium deposits. Bone curettage performed to address the eroded bone surface. Bone grafting carried out to enhance bone healing. Nerve block administered to provide targeted pain relief. Tendon integrity assessed and found to be compromised. Postoperative instructions provided for intensive pain management, immobilization, and subsequent physiotherapy for optimal recovery.

7. Intraoperative report: Patient with calcific tendinitis and severe bone pain underwent open surgical debridement, bone grafting, and intensive pain management under general anesthesia. Longitudinal incision made directly over the affected tendon, revealing extensive calcific deposits and eroded bone with severe bone pain. Thorough debridement of calcific material and eroded bone performed. Bone grafting carried out to reconstruct the eroded area. Intensive pain management measures implemented during and after the procedure. Tendon integrity assessed and found to be compromised. Wound closed meticulously. Postoperative care included aggressive pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

8. Patient presented with severe bone pain associated with calcific tendinitis. Open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, exposing extensive calcific deposits and eroded bone with severe bone pain. Complete excision of calcific material and meticulous debridement of the eroded bone performed. Tendon integrity assessed and found to be compromised. Reconstruction of the eroded area with bone grafting carried out. Simultaneous tendon repair and reinforcement with synthetic graft performed. Wound closed meticulously. Postoperative care included intensive pain management, shoulder immobilization, and subsequent physical therapy for functional recovery.

9. Operative note: Patient with chronic calcific tendinitis and severe bone pain underwent arthroscopic debridement, bone curettage, bone grafting, and aggressive pain control under general anesthesia. Arthroscope inserted through small incisions, providing visualization of extensive calcific deposits and eroded bone with severe bone pain. Mechanical debridement utilized to meticulously remove the calcium deposits. Bone curettage performed to address the eroded bone surface. Bone grafting carried out to enhance bone healing. Aggressive pain control measures implemented during and after the procedure. Tendon integrity assessed and found to be compromised. Postoperative instructions provided for intensive pain management, immobilization, and subsequent physiotherapy for optimal recovery.

10. Intraoperative report: Patient with calcific tendinitis and severe bone pain underwent open surgical debridement, bone grafting, tendon reconstruction, and intensive pain management under general anesthesia. Longitudinal incision made directly over the affected tendon, revealing extensive calcific deposits and eroded bone with severe bone pain. Thorough debridement of calcific material and eroded bone performed. Bone grafting and tendon reconstruction carried out to restore structural integrity. Intensive pain management measures implemented during and after the procedure. Tendon integrity assessed and found to be compromised. Wound closed meticulously. Postoperative care included aggressive pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

1. Patient underwent open surgical intervention for refractory calcific tendinitis under general anesthesia. A longitudinal incision was made directly over the affected tendon, providing direct access to the calcific deposits. Thorough debridement was performed to remove the calcium deposits. Tendon integrity was assessed and found to be intact. The wound was closed meticulously in layers. Postoperative care included pain management, immobilization, and subsequent physiotherapy for optimal recovery.

2. Operative note: Patient underwent arthroscopic intervention for calcific tendinitis under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits. Mechanical debridement was performed to remove the calcium deposits. Concurrent procedures, such as subacromial decompression, were carried out as necessary. Tendon integrity was assessed and found to be intact. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

3. Patient underwent ultrasound-guided percutaneous needle aspiration with lavage and corticosteroid injection under local anesthesia. Needle inserted into the calcific deposit, aspirating the material, followed by lavage and injection of corticosteroid solution to address inflammation. The procedure was completed without complications. Postoperative care included pain management, immobilization, and gradual initiation of physical therapy for optimal recovery.

4. Intraoperative report: Patient underwent open surgical intervention for chronic calcific tendinitis under general anesthesia. A longitudinal incision was made directly over the affected tendon, revealing extensive calcific deposits. Thorough debridement of calcific material was performed. Concurrent procedures, such as bone grafting or tendon repair, were carried out as necessary. Tendon integrity was assessed and found to be intact. The wound was closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

5. Patient underwent minimally invasive intervention for calcific tendinitis under local anesthesia. The procedure involved ultrasound-guided percutaneous needle fragmentation and lavage. Needle inserted into the calcific deposit, and gentle oscillations were applied to fragment the calcific material. Lavage was performed to remove the fragmented debris. The procedure was completed without complications. Post-procedure, the patient received instructions for pain management, shoulder rest, and initiation of physical therapy for optimal recovery.

6. Operative note: Patient underwent arthroscopic intervention with debridement and bone curettage under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits. Mechanical debridement and bone curettage were performed to remove the calcium deposits and address any eroded bone surfaces. Tendon integrity was assessed and found to be intact. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

7. Intraoperative report: Patient underwent open surgical intervention for calcific tendinitis with associated bone erosion under general anesthesia. A longitudinal incision was made over the affected tendon, exposing the calcific deposits and eroded bone. Thorough debridement of the calcific material and eroded bone was performed. Concurrent procedures, such as bone grafting or tendon reconstruction, were carried out as necessary. Tendon integrity was assessed and found to be compromised. The wound was closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

8. Patient underwent arthroscopic intervention with debridement, bone curettage, and autografting under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits and eroded bone. Mechanical debridement and bone curettage were performed to remove the calcium deposits and address the eroded bone surfaces. Autografting with the patient's own tissue was carried out to enhance bone healing. Tendon integrity was assessed and found to be intact. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

9. Operative note: Patient underwent open surgical intervention for severe calcific tendinitis under general anesthesia. A longitudinal incision was made directly over the affected tendon, exposing the calcific deposits. Thorough debridement of the calcific material was performed. Concurrent procedures, such as tendon repair or reinforcement, were carried out as necessary. Tendon integrity was assessed and found to be intact. The wound was closed meticulously. Postoperative care included pain management, immobilization, and subsequent physiotherapy for optimal recovery.

10. Intraoperative report: Patient underwent arthroscopic intervention with debridement, bone curettage, and synthetic grafting under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits and eroded bone. Mechanical debridement and bone curettage were performed to remove the calcium deposits and address the eroded bone surfaces. Synthetic grafting was carried out to enhance bone healing. Tendon integrity was assessed and found to be intact. The procedure was completed without complications. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

1. Patient underwent ultrasound-guided percutaneous needle aspiration with lavage, corticosteroid injection, and local anesthesia. Needle inserted into the calcific deposit, aspirating the material, followed by lavage and injection of corticosteroid solution to address inflammation. The procedure was well-tolerated without complications. Postoperative care included pain management, shoulder rest, and subsequent physical therapy for optimal recovery.

2. Operative note: Patient underwent arthroscopic intervention with debridement and subacromial decompression under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits. Mechanical debridement was performed to remove the calcium deposits. Concurrent subacromial decompression was carried out to address impingement. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

3. Patient underwent minimally invasive intervention for calcific tendinitis with ultrasound-guided needle fragmentation and lavage under local anesthesia. Needle inserted into the calcific deposit, and gentle oscillations were applied to fragment the calcific material. Lavage was performed to remove the fragmented debris. The procedure was well-tolerated without complications. Post-procedure, the patient received instructions for pain management, shoulder rest, and initiation of physical therapy for optimal recovery.

4. Intraoperative report: Patient underwent open surgical intervention for chronic calcific tendinitis with associated bone erosion under general anesthesia. A longitudinal incision was made directly over the affected tendon, exposing the calcific deposits and eroded bone. Thorough debridement of the calcific material and eroded bone was performed. Concurrent procedures, such as bone grafting or tendon repair, were carried out as necessary. Tendon integrity was assessed and found to be intact. The wound was closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

5. Patient underwent arthroscopic intervention with debridement, bone curettage, and autografting under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits and eroded bone. Mechanical debridement and bone curettage were performed to remove the calcium deposits and address the eroded bone surfaces. Autografting with the patient's own tissue was carried out to enhance bone healing. Tendon integrity was assessed and found to be intact. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

6. Operative note: Patient underwent open surgical intervention for severe calcific tendinitis with associated bone erosion under general anesthesia. A longitudinal incision was made over the affected tendon, exposing the calcific deposits and eroded bone. Thorough debridement of the calcific material and eroded bone was performed. Concurrent procedures, such as bone grafting or tendon reconstruction, were carried out as necessary. Tendon integrity was assessed and found to be compromised. The wound was closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

7. Intraoperative report: Patient underwent arthroscopic intervention with debridement, bone curettage, and synthetic grafting under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits and eroded bone. Mechanical debridement and bone curettage were performed to remove the calcium deposits and address the eroded bone surfaces. Synthetic grafting was carried out to enhance bone healing. Tendon integrity was assessed and found to be intact. The procedure was completed without complications. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

8. Patient underwent open surgical intervention for refractory calcific tendinitis with associated bone erosion under general anesthesia. A longitudinal incision was made directly over the affected tendon, exposing the calcific deposits and eroded bone. Thorough debridement of the calcific material and eroded bone was performed. Concurrent procedures, such as tendon repair or reinforcement, were carried out as necessary. Tendon integrity was assessed and found to be intact. The wound was closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

9. Operative note: Patient underwent arthroscopic intervention with debridement, bone curettage, and augmentation using allograft under general anesthesia. Arthroscope inserted through small incisions, providing visualization of the calcific deposits and eroded bone. Mechanical debridement and bone curettage were performed to remove the calcium deposits and address the eroded bone surfaces. Augmentation with allograft was carried out to enhance bone healing. Tendon integrity was assessed and found to be intact. Postoperative instructions provided for pain control, immobilization, and subsequent physiotherapy for optimal recovery.

10. Intraoperative report: Patient underwent open surgical intervention for calcific tendinitis with severe bone erosion and tendon rupture under general anesthesia. A longitudinal incision was made directly over the affected tendon, exposing the calcific deposits, eroded bone, and the disrupted tendon. Thorough debridement of the calcific material and eroded bone was performed. Tendon repair and reinforcement with synthetic graft were carried out to restore tendon integrity. The wound was closed meticulously. Postoperative care included pain management, immobilization, and subsequent referral to physical therapy for optimal recovery.

1. Patient with severe infection on the extreme moving joint due to calcific tendinitis underwent urgent open surgical intervention, extensive debridement, irrigation with antibiotic solution, and placement of antibiotic-impregnated beads under general anesthesia. A longitudinal incision was made over the affected tendon, revealing the calcific deposits and signs of infection. Thorough debridement of infected tissues and removal of calcific material were performed. The joint was irrigated with antibiotic solution, and antibiotic-impregnated beads were placed to deliver localized antibiotic therapy. Postoperative care included intravenous antibiotics, wound care, and subsequent referral to infectious disease specialists for optimal management.

2. Operative note: Patient presented with severe infection on the extreme moving joint associated with calcific tendinitis. Urgent arthroscopic intervention performed under general anesthesia. Arthroscope inserted through small incisions, confirming the presence of calcific deposits and signs of infection. Mechanical debridement of the infected tissues and thorough removal of calcific material were carried out. Joint irrigation with antibiotic solution was performed. Postoperative care included intravenous antibiotics, immobilization, and subsequent infectious disease consultation for optimal management.

3. Patient with severe infection on the extreme moving joint secondary to calcific tendinitis underwent emergent open surgical intervention, extensive debridement, joint lavage with antiseptic solution, and placement of antibiotic-impregnated spacers under general anesthesia. Longitudinal incision made over the affected tendon, exposing the calcific deposits and infected tissues. Thorough debridement of infected tissues and removal of calcific material performed. Joint lavage with antiseptic solution and placement of antibiotic-impregnated spacers carried out for targeted antibiotic therapy. Postoperative care included intravenous antibiotics, wound care, and subsequent infectious disease consultation for optimal management.

4. Intraoperative report: Patient presented with severe infection on the extreme moving joint associated with calcific tendinitis. Urgent open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, revealing the calcific deposits and signs of infection. Thorough debridement of infected tissues and meticulous removal of calcific material performed. Joint irrigation with antibiotic solution and placement of antibiotic-impregnated dressings done for localized antibiotic therapy. Postoperative care included intravenous antibiotics, wound care, and subsequent infectious disease consultation for optimal management.

5. Patient with severe infection on the extreme moving joint due to calcific tendinitis underwent arthroscopic intervention, debridement of infected tissues, joint lavage with antiseptic solution, and placement of antibiotic-impregnated spacers under general anesthesia. Arthroscope inserted through small incisions, confirming the presence of calcific deposits and signs of infection. Debridement of infected tissues and removal of calcific material performed. Joint lavage with antiseptic solution and placement of antibiotic-impregnated spacers carried out for targeted antibiotic therapy. Postoperative care included intravenous antibiotics, immobilization, and subsequent infectious disease consultation for optimal management.

6. Operative note: Patient presented with severe infection on the extreme moving joint associated with calcific tendinitis. Urgent open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, exposing the calcific deposits and infected tissues. Thorough debridement of infected tissues and removal of calcific material performed. Joint irrigation with antibiotic solution and placement of antibiotic-impregnated beads carried out for localized antibiotic therapy. Postoperative care included intravenous antibiotics, wound care, and subsequent infectious disease consultation for optimal management.

7. Intraoperative report: Patient with severe infection on the

extreme moving joint secondary to calcific tendinitis underwent emergent open surgical intervention, extensive debridement, joint lavage with antiseptic solution, and placement of antibiotic-impregnated spacers under general anesthesia. Longitudinal incision made over the affected tendon, revealing the calcific deposits and signs of infection. Thorough debridement of infected tissues and removal of calcific material performed. Joint lavage with antiseptic solution and placement of antibiotic-impregnated spacers carried out for targeted antibiotic therapy. Postoperative care included intravenous antibiotics, wound care, and subsequent infectious disease consultation for optimal management.

8. Patient with severe infection on the extreme moving joint due to calcific tendinitis underwent urgent arthroscopic intervention, debridement of infected tissues, joint lavage with antiseptic solution, and placement of antibiotic-impregnated spacers under general anesthesia. Arthroscope inserted through small incisions, confirming the presence of calcific deposits and signs of infection. Debridement of infected tissues and removal of calcific material performed. Joint lavage with antiseptic solution and placement of antibiotic-impregnated spacers carried out for targeted antibiotic therapy. Postoperative care included intravenous antibiotics, immobilization, and subsequent infectious disease consultation for optimal management.

9. Operative note: Patient presented with severe infection on the extreme moving joint associated with calcific tendinitis. Urgent open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, exposing the calcific deposits and infected tissues. Thorough debridement of infected tissues and meticulous removal of calcific material performed. Joint irrigation with antibiotic solution and placement of antibiotic-impregnated dressings done for localized antibiotic therapy. Postoperative care included intravenous antibiotics, wound care, and subsequent infectious disease consultation for optimal management.

10. Intraoperative report: Patient with severe infection on the extreme moving joint secondary to calcific tendinitis underwent emergent arthroscopic intervention, debridement of infected tissues, joint lavage with antiseptic solution, and placement of antibiotic-impregnated spacers under general anesthesia. Arthroscope inserted through small incisions, confirming the presence of calcific deposits and signs of infection. Debridement of infected tissues and removal of calcific material performed. Joint lavage with antiseptic solution and placement of antibiotic-impregnated spacers carried out for targeted antibiotic therapy. Postoperative care included intravenous antibiotics, immobilization, and subsequent infectious disease consultation for optimal management.

1. Patient with severe inflammation associated with calcific tendinitis underwent arthroscopic intervention, extensive debridement, irrigation with anti-inflammatory solution, and corticosteroid injection under general anesthesia. Arthroscope inserted through small incisions, confirming the presence of calcific deposits and signs of inflammation. Mechanical debridement of the inflamed tissues and removal of calcific material performed. Joint irrigation with anti-inflammatory solution and corticosteroid injection administered for targeted anti-inflammatory therapy. Postoperative care included pain management, immobilization, and subsequent physiotherapy for optimal recovery.

2. Operative note: Patient presented with moderate inflammation on the affected joint due to calcific tendinitis. Open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, revealing the calcific deposits and inflamed tissues. Thorough debridement of inflamed tissues and removal of calcific material performed. Joint irrigation with anti-inflammatory solution carried out. Postoperative care included anti-inflammatory medication, immobilization, and subsequent referral to physical therapy for optimal recovery.

3. Patient with mild inflammation associated with calcific tendinitis underwent ultrasound-guided percutaneous needle aspiration, lavage with anti-inflammatory solution, and corticosteroid injection under local anesthesia. Needle inserted into the calcific deposit, aspirating the material, followed by lavage with anti-inflammatory solution and corticosteroid injection for inflammation control. The procedure was well-tolerated without complications. Postoperative care included pain management, rest, and subsequent physical therapy for optimal recovery.

4. Intraoperative report: Patient presented with severe inflammation on the affected joint secondary to calcific tendinitis. Open surgical intervention performed under general anesthesia. Longitudinal incision made over the affected tendon, exposing the calcific deposits and inflamed tissues. Thorough debridement of inflamed tissues and meticulous removal of calcific material performed. Joint irrigation with anti-inflammatory solution carried out. Postoperative care included anti-inflammatory medication, immobilization, and subsequent referral to physical therapy for optimal recovery.

5. Patient with moderate inflammation associated with calcific tendinitis underwent minimally invasive intervention, ultrasound-guided needle fragmentation, lavage with anti-inflammatory solution, and corticosteroid injection under local anesthesia. Needle inserted into the calcific deposit, applying gentle oscillations to fragment the material. Lavage with anti-inflammatory solution and corticosteroid injection administered for inflammation control. The procedure was well-tolerated without complications. Post-procedure, the patient received instructions for pain management, rest, and initiation of physical therapy for optimal recovery.

6. Operative note: Patient presented with mild inflammation on the affected joint due to calcific tendinitis. Open surgical intervention performed under local anesthesia. Longitudinal incision made over the affected tendon, revealing the calcific deposits and inflamed tissues. Thorough debridement of inflamed tissues and removal of calcific material performed. Joint irrigation with anti-inflammatory solution carried out. Postoperative care included anti-inflammatory medication, rest, and subsequent referral to physical therapy for optimal recovery.

7. Intraoperative report: Patient presented with severe inflammation on the affected joint secondary to calcific tendinitis. Arthroscopic intervention performed under general anesthesia. Arthroscope inserted through small incisions, confirming the presence of calcific deposits and inflamed tissues. Mechanical debridement of inflamed tissues and removal of calcific material performed. Joint irrigation with anti-inflammatory solution carried out. Postoperative care included anti-inflammatory medication, immobilization, and subsequent referral to physical therapy for optimal recovery.

8. Patient with moderate inflammation associated with calcific tendinitis underwent ultrasound-guided percutaneous needle aspiration, lavage

with anti-inflammatory solution, and corticosteroid injection under local anesthesia. Needle inserted into the calcific deposit, aspirating the material, followed by lavage with anti-inflammatory solution and corticosteroid injection for inflammation control. The procedure was well-tolerated without complications. Postoperative care included pain management, rest, and subsequent physical therapy for optimal recovery.

9. Operative note: Patient presented with mild inflammation on the affected joint due to calcific tendinitis. Arthroscopic intervention performed under general anesthesia. Arthroscope inserted through small incisions, confirming the presence of calcific deposits and inflamed tissues. Mechanical debridement of inflamed tissues and removal of calcific material performed. Joint irrigation with anti-inflammatory solution carried out. Postoperative care included anti-inflammatory medication, rest, and subsequent referral to physical therapy for optimal recovery.

10. Intraoperative report: Patient presented with severe inflammation on the affected joint secondary to calcific tendinitis. Ultrasound-guided percutaneous needle aspiration performed under local anesthesia, followed by lavage with anti-inflammatory solution and corticosteroid injection. Needle inserted into the calcific deposit, aspirating the material and lavaging with anti-inflammatory solution for inflammation control. Corticosteroid injection administered for additional anti-inflammatory effect. The procedure was well-tolerated without complications. Postoperative care included pain management, rest, and subsequent physical therapy for optimal recovery.

1. Patient diagnosed with mild calcific tendinitis underwent minimally invasive intervention, ultrasound-guided needle aspiration of the calcific deposit, and corticosteroid injection under local anesthesia. The procedure was well-tolerated without complications. Postoperative instructions included pain management and a scheduled follow-up appointment in two weeks for re-evaluation and consideration of physical therapy.

2. Operative note: Patient diagnosed with moderate calcific tendinitis underwent arthroscopic intervention, mechanical debridement of the calcific deposits, and corticosteroid injection under general anesthesia. The procedure was successful, with complete removal of the calcific material. Postoperative instructions included pain management, immobilization, and a scheduled follow-up appointment in four weeks for assessment of progress and initiation of physical therapy if deemed appropriate.

3. Patient diagnosed with severe calcific tendinitis and associated bone erosion underwent open surgical intervention, extensive debridement of the calcific deposits and eroded bone, and tendon repair under general anesthesia. The procedure was successful in restoring tendon integrity. Postoperative instructions included pain management, immobilization, and a scheduled follow-up appointment in six weeks for assessment of healing progress, imaging studies, and consideration of rehabilitation.

4. Intraoperative report: Patient diagnosed with mild calcific tendinitis underwent ultrasound-guided percutaneous needle aspiration and lavage of the calcific deposit under local anesthesia. The procedure was uneventful, with effective removal of the calcific material. Postoperative instructions included pain management and a scheduled follow-up appointment in four weeks for re-evaluation and discussion of conservative management options.

5. Patient diagnosed with moderate calcific tendinitis and associated joint inflammation underwent arthroscopic intervention, debridement of the calcific deposits, joint lavage with anti-inflammatory solution, and corticosteroid injection under general anesthesia. The procedure was successful in alleviating inflammation and removing the calcific material. Postoperative instructions included pain management, immobilization, and a scheduled follow-up appointment in four weeks for assessment of response to treatment and consideration of further interventions if necessary.

6. Operative note: Patient diagnosed with severe calcific tendinitis and significant functional impairment underwent open surgical intervention, extensive debridement of the calcific deposits and eroded bone, and augmentation with allograft under general anesthesia. The procedure successfully restored tendon integrity and addressed the bone erosion. Postoperative instructions included pain management, immobilization, and a scheduled follow-up appointment in six weeks for evaluation of healing progress and rehabilitation planning.

7. Intraoperative report: Patient diagnosed with mild calcific tendinitis underwent ultrasound-guided percutaneous needle aspiration of the calcific deposit and corticosteroid injection under local anesthesia. The procedure was well-tolerated, with successful removal of the calcific material. Postoperative instructions included pain management and a scheduled follow-up appointment in two weeks for re-evaluation and consideration of conservative management options.

8. Patient diagnosed with moderate calcific tendinitis and persistent symptoms underwent arthroscopic intervention, debridement of the calcific deposits, and corticosteroid injection under general anesthesia. The procedure effectively addressed the calcific deposits and improved symptoms. Postoperative instructions included pain management, immobilization, and a scheduled follow-up appointment in six weeks for assessment of treatment response and potential further interventions.

9. Operative note: Patient diagnosed with severe calcific tendinitis, tendon rupture, and associated joint inflammation underwent open surgical intervention, thorough debridement of the calcific deposits, tendon repair with synthetic graft, and joint lavage with anti-inflammatory solution under general anesthesia. The procedure successfully restored tendon integrity and reduced inflammation. Postoperative instructions included pain management, immobilization, and a scheduled follow-up appointment in eight weeks for evaluation of healing progress and consideration of rehabilitation.

10. Intraoperative report: Patient diagnosed with mild calcific tendinitis underwent ultrasound-guided percutaneous needle aspiration and lavage of the calcific deposit, followed by corticosteroid injection under local anesthesia. The procedure was successful in removing the calcific material and alleviating symptoms. Postoperative instructions included pain management and a scheduled follow-up appointment in four weeks for re-evaluation and discussion of conservative management options.

## M65.3 Trigger finger

Operative Note 1: Patient presented with trigger finger of the right index finger. Under local anesthesia, a 2 cm longitudinal incision was made over the A1 pulley. The pulley was released using a no. 15 blade, and the flexor tendon was visualized. No adhesions or other abnormalities were noted. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient tolerated the procedure well, and postoperative instructions were provided.

Operative Note 2: Patient underwent trigger finger release surgery for the left middle finger. A transverse incision was made at the MCP joint. The A1 pulley was identified and released using a blunt hemostat. The flexor tendon glided smoothly after release. The wound was irrigated and closed using interrupted sutures. The patient was given postoperative instructions and discharged in stable condition.

Operative Note 3: Trigger finger release was performed on the right ring finger. A transverse incision was made over the A1 pulley, and the pulley was released using a knife. No complications were encountered during the procedure. The wound was irrigated and closed with sutures. The patient was advised on postoperative care and discharged.

Operative Note 4: The patient underwent trigger finger release for the left thumb. A longitudinal incision was made, exposing the A1 pulley. The pulley was divided with a scalpel, and the tendon was observed to glide smoothly. Hemostasis was achieved, and the wound was closed with interrupted sutures. The patient was provided with postoperative instructions and discharged without complications.

Operative Note 5: Trigger finger release was performed on the right little finger. A transverse incision was made, and the A1 pulley was identified. A release was achieved using sharp dissection, and the flexor tendon was inspected for any abnormalities. No adhesions or nodules were found. The wound was closed meticulously, and the patient was given postoperative care instructions.

Operative Note 6: The patient presented with trigger finger of the left ring finger. A longitudinal incision was made over the A1 pulley, and the pulley was released using a no. 11 blade. The flexor tendon was explored and found to be intact. Hemostasis was ensured, and the wound was closed with sutures. The patient was discharged with postoperative instructions and scheduled for a follow-up appointment.

Operative Note 7: Trigger finger release surgery was performed on the right thumb. An oblique incision was made, exposing the A1 pulley. The pulley was released using a combination of blunt and sharp dissection. The flexor tendon was assessed for any irregularities and found to be normal. The wound was closed with sutures, and the patient received postoperative instructions before being discharged.

Operative Note 8: Patient underwent trigger finger release surgery for the left index finger. A transverse incision was made, and the A1 pulley was identified. The pulley was released using a no. 15 blade, ensuring complete freedom of the flexor tendon. Hemostasis was achieved, and the wound was closed with sutures. The patient was educated on postoperative care and discharged without complications.

Operative Note 9: Trigger finger release was performed on the right middle finger. A longitudinal incision was made over the A1 pulley, and the pulley was released using sharp dissection. The flexor tendon was inspected and found to be gliding smoothly without any restrictions. The wound was closed with interrupted sutures, and the patient was discharged with postoperative instructions.

Operative Note 10: The patient underwent trigger finger release surgery for the left little finger. A transverse incision was made, and the A1 pulley was exposed. The pulley was divided using a scalpel, allowing unrestricted gliding of the flexor tendon. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

Operative Note 11: Trigger finger release was performed on the right thumb. A longitudinal incision was made, and the A1 pulley was identified. The pulley was released using a combination of blunt and sharp dissection. The flexor tendon was examined and found to be free of adhesions or nodules. The wound was thoroughly irrigated and closed with interrupted sutures. The patient tolerated the procedure well and was discharged with appropriate postoperative instructions.

Operative Note 12: Patient underwent trigger finger release surgery for the left ring finger. A transverse incision was made over the A1 pulley, which was subsequently released using a no. 11 blade. The flexor tendon was carefully evaluated for any abnormalities and found to be normal. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient was provided with postoperative care instructions and scheduled for a follow-up visit.

Operative Note 13: Trigger finger release was performed on the right middle finger. An oblique incision was made, exposing the A1 pulley. The pulley was released using sharp dissection, ensuring complete freedom of the flexor tendon. No complications were encountered during the procedure. The wound was closed with sutures, and the patient was discharged with appropriate postoperative care guidelines.

Operative Note 14: The patient presented with trigger finger of the left little finger. A longitudinal incision was made over the A1 pulley, and the pulley was released using a no. 15 blade. The flexor tendon was assessed and found to glide smoothly. Hemostasis was achieved, and the wound was closed meticulously with sutures. The patient received postoperative instructions and was discharged in a stable condition.

Operative Note 15: Trigger finger release surgery was performed on the right index finger. A transverse incision was made, and the A1 pulley was identified and released using a knife. The flexor tendon was carefully inspected for any abnormalities, but none were found. The wound was thoroughly irrigated and closed with sutures. The patient was counseled on postoperative care and discharged with follow-up instructions.

Operative Note 16: Patient underwent trigger finger release for the left thumb. A longitudinal incision was made, and the A1 pulley was released using a no. 11 blade. The flexor tendon glided smoothly after release. The wound was irrigated and closed with interrupted sutures. The patient tolerated the procedure well, and postoperative instructions were provided, emphasizing early motion and hand exercises.

Operative Note 17: Trigger finger release was performed on the right little finger. A transverse incision was made, and the A1 pulley was identified and released using a scalpel. The flexor tendon was examined and found to be intact with no signs of abnormality. Hemostasis was achieved, and the wound was closed with sutures. The patient was educated on postoperative care and discharged without complications.

Operative Note 18: The patient presented with trigger finger of the left index finger. A longitudinal incision was made over the A1 pulley, which was released using a no. 15 blade. The flexor tendon was evaluated and found to be moving freely. Hemostasis was ensured, and the wound was closed with sutures. The patient was discharged with postoperative instructions and scheduled for a follow-up appointment.

Operative Note 19: Trigger finger release was performed on the right ring finger. A transverse incision was made, and the A1 pulley was released using sharp dissection. The flexor tendon was assessed and found to be uninhibited in its gliding motion. The wound was closed meticulously with sutures, and the patient was provided with postoperative care guidelines.

Operative Note 20: The patient underwent trigger finger release surgery for the left middle finger. A longitudinal incision was made, exposing the A1 pulley. The pulley was divided using a knife, allowing for unobstructed movement of the flexor tendon. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient received postoperative instructions and was discharged in stable condition.

Operative Note 21: Patient presented with trigger finger of the right thumb. Under local anesthesia with 5 mL of lidocaine, a 2 cm longitudinal incision was made over the A1 pulley. The pulley was released using a no. 15 blade, and the flexor tendon was visualized. No adhesions or other abnormalities were noted. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient tolerated the procedure well, and postoperative instructions were provided.

Operative Note 22: Trigger finger release was performed on the left index finger. The patient received regional anesthesia with an ulnar nerve block using 10 mL of 0.5% bupivacaine. A transverse incision was made at the MCP joint. The A1 pulley was identified and released using a blunt hemostat. The flexor tendon glided smoothly after release. The wound was irrigated and closed using interrupted sutures. The patient was given postoperative instructions and discharged in stable condition.

Operative Note 23: The patient underwent trigger finger release surgery for the right ring finger. General anesthesia was administered with 100 mg of propofol and 50 mcg of fentanyl. A transverse incision was made over the A1 pulley, and the pulley was released using a no. 15 blade. No complications were encountered during the procedure. The wound was irrigated and closed with sutures. The patient received appropriate postoperative care instructions and was monitored before being discharged.

Operative Note 24: Trigger finger release was performed on the left little finger. The patient received sedation anesthesia with 2 mg of midazolam and 50 mcg of dexmedetomidine. A transverse incision was made, and the A1 pulley was identified. A release was achieved using sharp dissection, and the flexor tendon was inspected for any abnormalities. No adhesions or nodules were found. The wound was closed meticulously with sutures, and the patient was discharged with postoperative instructions.

Operative Note 25: The patient underwent trigger finger release surgery for the right middle finger. Local anesthesia was administered with 10 mL of lidocaine with epinephrine. A longitudinal incision was made over the A1 pulley, and the pulley was released using a no. 11 blade. The flexor tendon was explored and found to be intact. Hemostasis was ensured, and the wound was closed with sutures. The patient was discharged with postoperative instructions and scheduled for a follow-up appointment.

Operative Note 26: Trigger finger release was performed on the left thumb. The patient received regional anesthesia with a digital nerve block using 5 mL of 1% lidocaine. A longitudinal incision was made, and the A1 pulley was exposed. The pulley was released using a combination of blunt and sharp dissection. The flexor tendon was assessed for any irregularities and found to be normal. The wound was closed with sutures, and the patient received postoperative instructions before being discharged.

Operative Note 27: The patient presented with trigger finger of the right index finger. General anesthesia was induced with 200 mg of propofol and maintained with sevoflurane. A longitudinal incision was made over the A1 pulley, and the pulley was released using a no. 15 blade. The flexor tendon was carefully examined and found to glide smoothly. Hemostasis was achieved, and the wound was closed meticulously with sutures. The patient was provided with postoperative care instructions and monitored in the recovery room.

Operative Note 28:Trigger finger release surgery was performed on the left ring finger. The patient received monitored anesthesia care (MAC) with intravenous sedation using 2 mg of midazolam and 50 mcg of fentanyl. An oblique incision was made, exposing the A1 pulley. The pulley was released using sharp dissection, ensuring complete freedom of the flexor tendon. No complications were encountered during the procedure. The wound was closed with sutures, and the patient was discharged with appropriate postoperative care guidelines.

Operative Note 29: Patient underwent trigger finger release for the right little finger. Local anesthesia was administered with 10 mL of lidocaine with epinephrine. A transverse incision was made, and the A1 pulley was identified and released using a scalpel. The flexor tendon was examined and found to be gliding smoothly without any restrictions. The wound was closed with interrupted sutures, and the patient was educated on postoperative care and discharged without complications.

Operative Note 30: The patient presented with trigger finger of the left index finger. Regional anesthesia was achieved with a brachial plexus block using 20 mL of 0.5% bupivacaine. A longitudinal incision was made over the A1 pulley, which was released using a no. 15 blade. The flexor tendon was evaluated and found to be moving freely. Hemostasis was ensured, and the wound was closed with sutures. The patient was discharged with postoperative instructions and scheduled for a follow-up appointment.

Operative Note 31: Trigger finger release was performed on the right thumb. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Significant bone erosion was noted at the proximal phalanx. The pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, emphasizing the need for close follow-up due to the bone erosion.

Operative Note 32: Patient underwent trigger finger release surgery for the left middle finger. Regional anesthesia was achieved with a digital nerve block. During the procedure, bone erosion was observed at the metacarpophalangeal (MCP) joint. The A1 pulley was released, and thorough debridement of the eroded bone was performed. The flexor tendon glided smoothly post-debridement. The wound was irrigated and closed with sutures. The patient was provided with postoperative care instructions, including the need for radiographic follow-up to assess the extent of bone erosion.

Operative Note 33: Trigger finger release was performed on the right ring finger. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Bone erosion was noted at the base of the proximal phalanx. The pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon was inspected and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. The patient was educated on postoperative care, with emphasis on hand immobilization to promote bone healing.

Operative Note 34: The patient presented with trigger finger of the left little finger. Regional anesthesia was administered with an ulnar nerve block. During the procedure, significant bone erosion was identified at the distal phalanx. The A1 pulley was released, and meticulous debridement of the eroded bone was carried out. The flexor tendon glided smoothly after debridement. The wound was closed with interrupted sutures, and the patient received postoperative instructions, including the need for radiographic evaluation to assess the extent of bone erosion.

Operative Note 35: Trigger finger release surgery was performed on the right index finger. The patient received monitored anesthesia care (MAC). Intraoperatively, bone erosion was observed at the metacarpal head. The A1 pulley was released, and thorough debridement of the eroded bone was performed. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. The patient was discharged with postoperative care instructions, emphasizing the importance of protecting the affected finger to prevent further bone erosion.

Operative Note 36: Patient underwent trigger finger release for the left thumb. General anesthesia was induced and maintained throughout the procedure. Intraoperative examination revealed bone erosion at the base of the proximal phalanx. The A1 pulley was released, and meticulous debridement of the eroded bone was carried out. The flexor tendon glided smoothly post-debridement. The wound was thoroughly irrigated and closed with sutures. The patient was provided with postoperative instructions, including the need for radiographic follow-up to assess the progression of bone erosion.

Operative Note 37: Trigger finger release was performed on the right little finger. The patient received local anesthesia with 10 mL of lidocaine. Bone erosion was observed at the distal phalanx intraoperatively. The A1 pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon was examined and found to be free of adhesions. Hemostasis was achieved, and the wound was closed meticulously. The patient was discharged with postoperative care instructions, including the need for regular follow-up to monitor the progression of bone erosion.

Operative Note 38: The patient presented with trigger finger of the left ring finger. Regional anesthesia was achieved with a digital nerve block. Intraoperatively, bone erosion was noted at the proximal phalanx. The A1 pulley was released, and thorough debridement of the eroded bone was performed. The flexor tendon glided smoothly after debridement. The wound was irrigated and closed with sutures. The patient received postoperative instructions, with emphasis on hand immobilization to promote healing of the eroded bone.

Operative Note 39: Trigger finger release was performed on the right index finger. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion was observed at the metacarpophalangeal (MCP) joint. The pulley was released, and meticulous debridement of the eroded bone was performed. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, with special attention to protecting the finger and monitoring the progression of bone erosion.

Operative Note 40: The patient underwent trigger finger release surgery for the left middle finger. The procedure was performed under general anesthesia. Intraoperatively, bone erosion was noted at the distal phalanx. The A1 pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon glided smoothly after debridement. The wound was closed meticulously with sutures, and the patient was provided with postoperative care instructions, including the need for radiographic evaluation to assess the extent of bone erosion and appropriate follow-up.

Operative Note 41: Trigger finger release was performed on the right thumb. The patient reported severe bone pain. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Significant bone erosion was observed at the proximal phalanx, causing the patient's discomfort. The pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up to monitor bone pain progression.

Operative Note 42: Patient underwent trigger finger release surgery for the left index finger. The patient experienced severe bone pain. Regional anesthesia was administered, providing temporary relief. Intraoperatively, significant bone erosion was identified at the metacarpophalangeal (MCP) joint, correlating with the pain. The A1 pulley was released, and meticulous debridement of the eroded bone was performed. The flexor tendon glided smoothly post-debridement. The wound was irrigated and closed with sutures. The patient received postoperative instructions, including pain management strategies and the need for close monitoring of bone pain.

Operative Note 43: Trigger finger release was performed on the right ring finger. The patient presented with severe bone pain. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Extensive bone erosion was noted at the base of the proximal phalanx, correlating with the patient's pain. The pulley was released, and meticulous debridement of the eroded bone was performed. The flexor tendon was examined and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. The patient was provided with postoperative care instructions, emphasizing pain management and the need for close follow-up.

Operative Note 44: The patient presented with severe bone pain associated with trigger finger of the left little finger. Regional anesthesia was administered to alleviate pain during the procedure. Intraoperatively, significant bone erosion was identified at the distal phalanx, corresponding to the patient's symptoms. The A1 pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon glided smoothly after debridement. The wound was closed with interrupted sutures. The patient received postoperative instructions, including pain management strategies and the importance of monitoring bone pain progression.

Operative Note 45: Trigger finger release surgery was performed on the right middle finger. The patient reported severe bone pain. General anesthesia was induced and maintained throughout the procedure to alleviate discomfort. Intraoperatively, extensive bone erosion was observed, contributing to the patient's pain. The A1 pulley was released, and meticulous debridement of the eroded bone was performed. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. Postoperatively, the patient was provided with pain management strategies and scheduled for regular follow-up to monitor bone pain severity.

Operative Note 46: Patient underwent trigger finger release for the left thumb. The patient experienced severe bone pain. Local anesthesia was administered, providing temporary relief. During the procedure, significant bone erosion was observed at the proximal phalanx, corresponding to the patient's pain. The A1 pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon glided smoothly after debridement. The wound was closed with sutures, and the patient received postoperative instructions, including pain management strategies and the need for close monitoring of bone pain intensity.

Operative Note 47: Trigger finger release was performed on the right index finger. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Severe bone pain was reported by the patient. Extensive bone erosion was noted at the distal phalanx, causing the patient's discomfort. The pulley was released, and thorough debridement of the eroded bone was performed. The flexor tendon was evaluated and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up to assess bone pain relief.

Operative Note 48: The patient presented with severe bone pain associated with trigger finger of the left ring finger. Regional anesthesia was administered to alleviate pain during the procedure. Intraoperatively, significant bone erosion was identified at the metacarpophalangeal (MCP) joint, corresponding to the patient's pain. The A1 pulley was released, and meticulous debridement of the eroded bone was performed. The flexor tendon glided smoothly post-debridement. The wound was irrigated and closed with sutures. The patient received postoperative instructions, emphasizing pain management and the need for regular monitoring of bone pain progression.

Operative Note 49: Trigger finger release was performed on the right little finger. The patient reported severe bone pain. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion was observed at the base of the proximal phalanx, correlating with the patient's pain. The pulley was released, and careful debridement of the eroded bone was performed. The flexor tendon was examined and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. The patient was provided with postoperative care instructions, including pain management strategies and the need for close follow-up.

Operative Note 50: The patient underwent trigger finger release surgery for the left middle finger. The patient reported severe bone pain. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, extensive bone erosion was noted at the distal phalanx, contributing to the patient's pain. The A1 pulley was released, and meticulous debridement of the eroded bone was performed. The flexor tendon glided smoothly after debridement. The wound was closed meticulously with sutures, and the patient was provided with postoperative care instructions, emphasizing pain management strategies and the need for close monitoring of bone pain intensity.

Operative Note 51: Surgical intervention was performed for trigger finger release on the right thumb. The patient experienced severe bone pain. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion was noted at the proximal phalanx, contributing to the patient's discomfort. In addition to pulley release, bone grafting was performed to address the erosion. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up to monitor bone healing and pain relief.

Operative Note 52: Surgical intervention was performed for trigger finger release on the left index finger. The patient presented with severe bone pain. Regional anesthesia was administered to alleviate discomfort during the procedure. Intraoperatively, significant bone erosion was identified at the metacarpophalangeal (MCP) joint, corresponding to the patient's pain. In addition to pulley release, bone resurfacing was performed to address the erosion. The flexor tendon glided smoothly after the intervention. The wound was irrigated and closed meticulously. Postoperatively, the patient received pain management strategies and was scheduled for regular follow-up to monitor bone healing and pain resolution.

Operative Note 53: Surgical intervention was performed for trigger finger release on the right ring finger. The patient reported severe bone pain. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion was observed at the base of the proximal phalanx, causing the patient's discomfort. Along with pulley release, bone augmentation was performed to address the erosion. The flexor tendon was examined and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing pain management and the need for close follow-up to assess bone healing and pain relief.

Operative Note 54: Surgical intervention was performed for trigger finger release on the left little finger. The patient presented with severe bone pain. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, significant bone erosion was noted at the distal phalanx, correlating with the patient's pain. In addition to pulley release, bone resection was performed to address the erosion. The flexor tendon glided smoothly post-intervention. The wound was closed with interrupted sutures. The patient received postoperative instructions, including pain management strategies and the need for regular monitoring of bone healing and pain resolution.

Operative Note 55: Surgical intervention was performed for trigger finger release on the right middle finger. The patient reported severe bone pain. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion was observed, contributing to the patient's pain. Along with pulley release, bone grafting was performed to address the erosion. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. Postoperatively, the patient received pain management strategies and was scheduled for regular follow-up to monitor bone healing and pain relief.

Operative Note 56: Surgical intervention was performed for trigger finger release on the left thumb. The patient experienced severe bone pain. Local anesthesia was administered, providing temporary relief. During the procedure, significant bone erosion was observed at the proximal phalanx, corresponding to the patient's pain. Along with pulley release, bone resurfacing was performed to address the erosion. The flexor tendon glided smoothly after the intervention. The wound was closed with sutures, and the patient received postoperative instructions, including pain management strategies and the need for close monitoring of bone healing and pain resolution

Operative Note 57: Surgical intervention was performed for trigger finger release on the right index finger. The patient reported severe bone pain. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion was noted at the distal phalanx, causing the patient's discomfort. In addition to pulley release, bone augmentation was performed to address the erosion. The flexor tendon was evaluated and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up to assess bone healing and pain relief.

Operative Note 58: Surgical intervention was performed for trigger finger release on the left ring finger. The patient presented with severe bone pain. Regional anesthesia was administered to alleviate discomfort during the procedure. Intraoperatively, significant bone erosion was identified at the metacarpophalangeal (MCP) joint, corresponding to the patient's pain. In addition to pulley release, bone resection was performed to address the erosion. The flexor tendon glided smoothly post-intervention. The wound was irrigated and closed with sutures. The patient received postoperative instructions, emphasizing pain management and the need for regular follow-up to monitor bone healing and pain resolution.

Operative Note 59: Surgical intervention was performed for trigger finger release on the right little finger. The patient reported severe bone pain. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion was observed at the base of the proximal phalanx, causing the patient's discomfort. Along with pulley release, bone grafting was performed to address the erosion. The flexor tendon was examined and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. The patient received postoperative instructions, emphasizing pain management and the need for close follow-up to assess bone healing and pain relief.

Operative Note 60: Surgical intervention was performed for trigger finger release on the left middle finger. The patient presented with severe bone pain. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion was noted, contributing to the patient's pain. Along with pulley release, bone resection was performed to address the erosion. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. Postoperatively, the patient received pain management strategies and was scheduled for regular follow-up to monitor bone healing and pain relief.

Operative Note 61: Surgical intervention was performed for trigger finger release on the right thumb. The patient experienced severe bone pain. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion was noted at the proximal phalanx, contributing to the patient's discomfort. In addition to pulley release, bone recontouring was performed to address the erosion. The flexor tendon was evaluated and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up to monitor bone healing and pain resolution.

Operative Note 62: Surgical intervention was performed for trigger finger release on the left index finger. The patient reported severe bone pain. Regional anesthesia was administered to alleviate discomfort during the procedure. Intraoperatively, significant bone erosion was identified at the metacarpophalangeal (MCP) joint, corresponding to the patient's pain. In addition to pulley release, bone grafting and fixation were performed to address the erosion. The flexor tendon glided smoothly post-intervention. The wound was irrigated and closed meticulously. The patient received postoperative instructions, emphasizing pain management and the need for regular follow-up to monitor bone healing and pain relief.

Operative Note 63: Surgical intervention was performed for trigger finger release on the right ring finger. The patient presented with severe bone pain. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion was observed at the base of the proximal phalanx, causing the patient's discomfort. Along with pulley release, bone resurfacing and arthroplasty were performed to address the erosion. The flexor tendon was examined and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing pain management and the need for close follow-up to assess bone healing and pain resolution.

Operative Note 64: Surgical intervention was performed for trigger finger release on the left little finger. The patient reported severe bone pain. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, significant bone erosion was noted at the distal phalanx, correlating with the patient's pain. In addition to pulley release, bone realignment and fixation were performed to address the erosion. The flexor tendon glided smoothly after the intervention. The wound was closed with interrupted sutures. The patient received postoperative instructions, including pain management strategies and the need for regular monitoring of bone healing and pain resolution.

Operative Note 65: Surgical intervention was performed for trigger finger release on the right middle finger. The patient reported severe bone pain. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion was observed, contributing to the patient's pain. Along with pulley release, bone grafting and stabilization were performed to address the erosion. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. Postoperatively, the patient received pain management strategies and was scheduled for regular follow-up to monitor bone healing and pain relief.

Operative Note 66: Surgical intervention was performed for trigger finger release on the left thumb. The patient experienced severe bone pain. Local anesthesia was administered, providing temporary relief. During the procedure, significant bone erosion was observed at the proximal phalanx, corresponding to the patient's pain. In addition to pulley release, bone fusion was performed to address the erosion. The flexor tendon glided smoothly after the intervention. The wound was closed with sutures, and the patient received postoperative instructions, including pain management strategies and the need for close monitoring of bone healing and pain resolution.

Operative Note 67: Surgical intervention was performed for trigger finger release on the right index finger. The patient reported severe bone pain. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion was noted at the distal phalanx, causing the patient's discomfort. In addition to pulley release, bone grafting and fixation with a plate were performed to address the erosion. The flexor tendon was evaluated and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up to assess bone healing and pain relief.

Operative Note 68: Surgical intervention was performed for trigger finger release on the left ring finger. The patient presented with severe bone pain. Regional anesthesia was administered to alleviate discomfort during the procedure. Intraoperatively, significant bone erosion was identified at the metacarpophalangeal (MCP) joint, corresponding to the patient's pain. In addition to pulley release, bone resection and joint reconstruction were performed to address the erosion. The flexor tendon glided smoothly post-intervention. The wound was irrigated and closed with sutures. The patient received postoperative instructions, emphasizing pain management and the need for regular follow-up to monitor bone healing and pain relief.

Operative Note 69: Surgical intervention was performed for trigger finger release on the right little finger. The patient reported severe bone pain. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion was observed at the base of the proximal phalanx, causing the patient's discomfort. Along with pulley release, bone grafting and joint resurfacing were performed to address the erosion. The flexor tendon was examined and found to be intact. Hemostasis was achieved, and the wound was closed with sutures. The patient received postoperative instructions, emphasizing pain management and the need for close follow-up to assess bone healing and pain resolution.

Operative Note 70: Surgical intervention was performed for trigger finger release on the left middle finger. The patient presented with severe bone pain. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion was noted, contributing to the patient's pain. Along with pulley release, bone realignment and joint fusion were performed to address the erosion. The flexor tendon was assessed and found to be intact. Hemostasis was achieved, and the wound was closed meticulously. Postoperatively, the patient received pain management strategies and was scheduled for regular follow-up to monitor bone healing and pain relief.

Operative Note 71: Surgical intervention was performed for trigger finger release on the right thumb. The patient presented with severe bone pain and signs of a severe infection at the metacarpophalangeal (MCP) joint. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion and joint inflammation were observed, necessitating aggressive debridement and irrigation. After thorough cleaning, pulley release and joint stabilization were performed. The flexor tendon was assessed and found to be intact. Intravenous antibiotics were initiated, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for close monitoring of bone healing and infection resolution.

Operative Note 72: Surgical intervention was performed for trigger finger release on the left index finger. The patient reported severe bone pain with signs of a deep joint infection. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, extensive bone erosion and joint involvement were identified, indicating a severe infection. Along with pulley release, aggressive debridement and irrigation of the joint were performed. The flexor tendon glided smoothly post-intervention. Intravenous antibiotics were initiated, and the wound was closed with sutures. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for regular follow-up to assess bone healing and infection resolution.

Operative Note 73: Surgical intervention was performed for trigger finger release on the right ring finger. The patient presented with severe bone pain and a deep joint infection. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion and joint inflammation were noted, warranting thorough debridement and irrigation. In addition to pulley release, joint stabilization and bone grafting were performed. The flexor tendon was examined and found to be intact. Intravenous antibiotics were initiated, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for close follow-up to monitor bone healing and infection resolution.

Operative Note 74: Surgical intervention was performed for trigger finger release on the left little finger. The patient reported severe bone pain with signs of a deep joint infection. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, significant bone erosion and joint involvement were noted, indicating a severe infection. In addition to pulley release, aggressive debridement and irrigation of the joint were performed. The flexor tendon glided smoothly post-intervention. Intravenous antibiotics were initiated, and the wound was closed with interrupted sutures. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for regular monitoring of bone healing and infection resolution.

Operative Note 75: Surgical intervention was performed for trigger finger release on the right middle finger. The patient presented with severe bone pain and a deep joint infection. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion and joint inflammation were observed, necessitating aggressive debridement and irrigation. Along with pulley release, joint fusion and bone grafting were performed. The flexor tendon was assessed and found to be intact. Intravenous antibiotics were initiated, and the wound was closed meticulously. Postoperatively, the patient received antibiotic therapy, wound care instructions, and was scheduled for regular follow-up to monitor bone healing and infection resolution.

Operative Note 76: Surgical intervention was performed for trigger finger release on the left thumb. The patient experienced severe bone pain and presented with a deep joint infection. Local anesthesia was administered, providing temporary relief. During the procedure, significant bone erosion and joint involvement were observed, indicating a severe infection. In addition to pulley release, aggressive debridement and joint irrigation were performed. The flexor tendon glided smoothly after the intervention. Intravenous antibiotics were initiated, and the wound was closed with sutures. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for regular monitoring of bone healing and infection resolution.

Operative Note 77: Surgical intervention was performed for trigger finger release on the right index finger. The patient reported severe bone pain with signs of a deep joint infection. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion and joint inflammation were noted, warranting aggressive debridement and joint irrigation. Along with pulley release, joint stabilization and bone resection were performed. The flexor tendon was evaluated and found to be intact. Intravenous antibiotics were initiated, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for close follow-up to monitor bone healing and infection resolution.

Operative Note 78: Surgical intervention was performed for trigger finger release on the left ring finger. The patient presented with severe bone pain and a deep joint infection. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, significant bone erosion and joint involvement were identified, indicating a severe infection. In addition to pulley release, aggressive debridement and joint reconstruction were performed. The flexor tendon glided smoothly post-intervention. Intravenous antibiotics were initiated, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for regular follow-up to assess bone healing and infection resolution.

Operative Note 79: Surgical intervention was performed for trigger finger release on the right little finger. The patient reported severe bone pain with signs of a deep joint infection. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion and joint inflammation were observed, warranting aggressive debridement and irrigation. Along with pulley release, joint fusion and bone grafting were performed. The flexor tendon was examined and found to be intact. Intravenous antibiotics were initiated, and the wound was closed with sutures. The patient received postoperative instructions, emphasizing antibiotic therapy, wound care, and the need for close follow-up to monitor bone healing and infection resolution.

Operative Note 80: Surgical intervention was performed for trigger finger release on the left middle finger. The patient presented with severe bone pain and a deep joint infection. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion and joint inflammation were noted, necessitating aggressive debridement and irrigation. Along with pulley release, joint stabilization and bone grafting were performed. The flexor tendon was assessed and found to be intact. Intravenous antibiotics were initiated, and the wound was closed meticulously. Postoperatively, the patient received antibiotic therapy, wound care instructions, and was scheduled for regular follow-up to monitor bone healing and infection resolution.

Operative Note 81: Surgical intervention was performed for trigger finger release on the right thumb. The patient presented with severe bone pain and marked inflammation at the metacarpophalangeal (MCP) joint. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion and joint inflammation were observed, warranting meticulous debridement and irrigation. After thorough cleaning, pulley release and joint stabilization were performed. The flexor tendon was evaluated and found to be intact. Postoperatively, the patient received anti-inflammatory medications and was advised to monitor for signs of persistent inflammation or infection.

Operative Note 82: Surgical intervention was performed for trigger finger release on the left index finger. The patient reported severe bone pain and significant inflammation at the affected joint. Regional anesthesia was administered for pain management. Intraoperatively, noticeable bone erosion and joint inflammation were identified. Along with pulley release, aggressive debridement and joint irrigation were performed to address the inflammation. The flexor tendon glided smoothly post-intervention. Postoperatively, the patient received anti-inflammatory medications and was instructed to monitor for signs of persistent inflammation or infection.

Operative Note 83: Surgical intervention was performed for trigger finger release on the right ring finger. The patient presented with severe bone pain and marked inflammation at the joint. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion and joint inflammation were noted, warranting meticulous debridement and irrigation. In addition to pulley release, joint stabilization and bone grafting were performed to address the inflammation. The flexor tendon was examined and found to be intact. Postoperatively, the patient received anti-inflammatory medications and was advised to monitor for signs of persistent inflammation or infection.

Operative Note 84: Surgical intervention was performed for trigger finger release on the left little finger. The patient reported severe bone pain and noticeable inflammation at the joint. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, significant bone erosion and joint involvement were observed, indicating a high degree of inflammation. In addition to pulley release, aggressive debridement and joint irrigation were performed. The flexor tendon glided smoothly post-intervention. Postoperatively, the patient received anti-inflammatory medications and was instructed to monitor for signs of persistent inflammation or infection.

Operative Note 85: Surgical intervention was performed for trigger finger release on the right middle finger. The patient presented with severe bone pain and marked inflammation at the joint. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion and joint inflammation were observed, necessitating meticulous debridement and irrigation. Along with pulley release, joint fusion and bone grafting were performed to address the inflammation. The flexor tendon was assessed and found to be intact. Postoperatively, the patient received anti-inflammatory medications and was advised to monitor for signs of persistent inflammation or infection.

Operative Note 86: Surgical intervention was performed for trigger finger release on the left thumb. The patient experienced severe bone pain and noticeable inflammation at the affected joint. Local anesthesia was administered, providing temporary relief. During the procedure, significant bone erosion and joint inflammation were observed. In addition to pulley release, aggressive debridement and joint irrigation were performed to address the inflammation. The flexor tendon glided smoothly after the intervention. Postoperatively, the patient received anti-inflammatory medications and was instructed to monitor for signs of persistent inflammation or infection.

Operative Note 87: Surgical intervention was performed for trigger finger release on the right index finger. The patient reported severe bone pain and marked inflammation at the joint. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Extensive bone erosion and joint inflammation were noted, warranting meticulous debridement and irrigation. Along with pulley release, joint stabilization and bone resection were performed to address the inflammation. The flexor tendon was evaluated and found to be intact. Postoperatively, the patient received anti-inflammatory medications and was advised to monitor for signs of persistent inflammation or infection.

Operative Note 88: Surgical intervention was performed for trigger finger release on the left ring finger. The patient presented with severe bone pain and noticeable inflammation at the joint. Regional anesthesia was administered to alleviate discomfort. Intraoperatively, significant bone erosion and joint inflammation were identified, indicating a high degree of inflammation. In addition to pulley release, aggressive debridement and joint reconstruction were performed. The flexor tendon glided smoothly post-intervention. Postoperatively, the patient received anti-inflammatory medications and was instructed to monitor for signs of persistent inflammation or infection.

Operative Note 89: Surgical intervention was performed for trigger finger release on the right little finger. The patient reported severe bone pain and marked inflammation at the joint. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Significant bone erosion and joint inflammation were observed, warranting meticulous debridement and irrigation. Along with pulley release, joint fusion and bone grafting were performed to address the inflammation. The flexor tendon was examined and found to be intact. Postoperatively, the patient received anti-inflammatory medications and was advised to monitor for signs of persistent inflammation or infection.

Operative Note 90: Surgical intervention was performed for trigger finger release on the left middle finger. The patient presented with severe bone pain and noticeable inflammation at the joint. General anesthesia was induced and maintained throughout the procedure. Intraoperatively, extensive bone erosion and joint inflammation were noted, necessitating meticulous debridement and irrigation. Along with pulley release, joint stabilization and bone grafting were performed to address the inflammation. The flexor tendon was assessed and found to be intact. Postoperatively, the patient received anti-inflammatory medications and was advised to monitor for signs of persistent inflammation or infection.

Operative Note 91: Surgical intervention was performed for trigger finger release on the right thumb. The patient presented with severe bone pain and limited range of motion due to advanced stage trigger finger. Under regional anesthesia, a longitudinal incision was made over the A1 pulley. Extensive pulley thickening and nodule formation were observed, indicating a severe case. The A1 pulley was released, and the flexor tendon glided smoothly. Postoperatively, the patient will require close follow-up to assess the response to surgery and determine the need for additional therapies such as hand therapy or corticosteroid injections.

Operative Note 92: Surgical intervention was performed for trigger finger release on the left index finger. The patient reported severe bone pain and significant functional impairment. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Intraoperatively, marked thickening and adhesion of the pulley were noted. The pulley release was performed, and the flexor tendon demonstrated improved gliding. Postoperatively, the patient will be scheduled for a follow-up appointment in two weeks to assess the hand's functional recovery and determine the need for further interventions.

Operative Note 93: Surgical intervention was performed for trigger finger release on the right ring finger. The patient presented with severe bone pain and difficulty in finger extension. Regional anesthesia was administered for the procedure. Intraoperatively, the A1 pulley was found to be thickened and constricted, causing impingement of the flexor tendon. The pulley release was performed successfully, and the tendon glided smoothly. Postoperatively, the patient will be assessed in one week to evaluate the response to surgery and consider the need for further treatment, such as physical therapy or additional interventions.

Operative Note 94: Surgical intervention was performed for trigger finger release on the left little finger. The patient reported severe bone pain and a noticeable catching sensation during finger flexion. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Intraoperatively, the pulley was found to be significantly thickened, causing tendon constriction. The release of the pulley was performed, resulting in improved tendon gliding. Postoperatively, the patient will be scheduled for a follow-up appointment in three weeks to assess hand function and determine the need for additional therapies.

Operative Note 95: Surgical intervention was performed for trigger finger release on the right middle finger. The patient presented with severe bone pain and a visible triggering of the finger during movement. Under regional anesthesia, a transverse incision was made, exposing the A1 pulley. Intraoperatively, the pulley was found to be thickened and causing tendon constriction. The release of the pulley was performed successfully, resulting in improved finger movement. Postoperatively, the patient will be evaluated in two weeks to assess hand function and determine the need for further interventions.

Operative Note 96: Surgical intervention was performed for trigger finger release on the left thumb. The patient reported severe bone pain and persistent triggering of the thumb. Under general anesthesia, a longitudinal incision was made over the A1 pulley. Intraoperatively, extensive pulley thickening and nodule formation were observed, indicating an advanced stage of trigger finger. The A1 pulley was released, and the flexor tendon demonstrated improved gliding. Postoperatively, the patient will require close monitoring and a follow-up appointment in one week to assess hand function and determine the need for further interventions.

Operative Note 97: Surgical intervention was performed for trigger finger release on the right index finger. The patient presented with severe bone pain and limited finger extension. Regional anesthesia was administered for the procedure. Intraoperatively, the A1 pulley was found to be significantly thickened, causing impingement of the flexor tendon. The pulley release was performed successfully, resulting in improved finger movement. Postoperatively, the patient will be assessed in two weeks to evaluate the response to surgery and consider the need for further treatment, such as hand therapy or additional interventions.

Operative Note 98: Surgical intervention was performed for trigger finger release on the left ring finger. The patient reported severe bone pain and a noticeable catching sensation during finger flexion. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Intraoperatively, the pulley was found to be thickened, causing tendon constriction. The release of the pulley was performed successfully, resulting in improved tendon gliding. Postoperatively, the patient will be scheduled for a follow-up appointment in three weeks to assess hand function and determine the need for additional therapies.

Operative Note 99: Surgical intervention was performed for trigger finger release on the right little finger. The patient presented with severe bone pain and difficulty in finger flexion. Under regional anesthesia, a longitudinal incision was made over the A1 pulley. Intraoperatively, the pulley was found to be significantly thickened, causing impingement of the flexor tendon. The release of the pulley was performed successfully, resulting in improved finger movement. Postoperatively, the patient will be evaluated in two weeks to assess hand function and determine the need for further interventions.

Operative Note 100: Surgical intervention was performed for trigger finger release on the left middle finger. The patient reported severe bone pain and a visible triggering of the finger during movement. Under general anesthesia, a transverse incision was made, exposing the A1 pulley. Intraoperatively, the pulley was found to be thickened and causing tendon constriction. The release of the pulley was performed successfully, resulting in improved finger movement. Postoperatively, the patient will be scheduled for a follow-up appointment in three weeks to assess hand function and determine the need for additional therapies.