## M65.4 Radial styloid tenosynovitis [de Quervain]

1. Operative Note: Radial Styloid Tenosynovitis Release

Procedure: A radial styloid tenosynovitis release was performed through a dorsal approach. The extensor retinaculum was incised, and the tendons were identified. Careful dissection was done to release the constricting sheath around the affected tendons. Hemostasis was achieved, and the incision was closed using absorbable sutures. The patient tolerated the procedure well, and postoperative instructions were given.

2. Operative Note: Radial Styloid Tenosynovitis Debridement

Procedure: A radial styloid tenosynovitis debridement was performed via a dorsal approach. The extensor retinaculum was incised, and the diseased synovium was excised meticulously. Any adhesions or thickened tissue were removed, ensuring the smooth gliding of the tendons. Hemostasis was achieved, and the wound was closed using sutures. The patient was advised on postoperative care and follow-up.

3. Operative Note: Radial Styloid Tenosynovitis Bursectomy

Procedure: A radial styloid tenosynovitis bursectomy was performed through a dorsal incision. The affected bursa was identified and excised meticulously to alleviate inflammation and pain. The surrounding tissues were inspected for any abnormalities. The wound was closed using sutures, and the patient was given instructions for wound care and follow-up.

4. Operative Note: Radial Styloid Tenosynovitis Synovectomy

Procedure: A radial styloid tenosynovitis synovectomy was performed via a dorsal approach. The extensor retinaculum was incised, and the diseased synovium was carefully excised from the tendon sheath. Adhesions and thickened tissue were removed to restore smooth tendon movement. The wound was closed using sutures, and postoperative care instructions were provided to the patient.

5. Operative Note: Radial Styloid Tenosynovitis Tenolysis

Procedure: A radial styloid tenosynovitis tenolysis was performed through a dorsal approach. The extensor retinaculum was incised, and the affected tendons were carefully dissected and freed from any adhesions or constrictions. The surrounding tissues were inspected for any abnormalities. Hemostasis was achieved, and the incision was closed. The patient was advised on postoperative care and follow-up.

6. Operative Note: Radial Styloid Tenosynovitis Tendon Repair

Procedure: A radial styloid tenosynovitis tendon repair was performed via a dorsal incision. The extensor retinaculum was incised, and the torn or damaged tendon was identified. The ends of the tendon were debrided and sutured together using an appropriate technique. The repaired tendon was tested for proper gliding and stability. The wound was closed, and postoperative instructions were provided.

7. Operative Note: Radial Styloid Tenosynovitis Capsulotomy

Procedure: A radial styloid tenosynovitis capsulotomy was performed through a dorsal approach. The joint capsule was incised, allowing access to the affected tendon sheath. The constricting tissue was carefully released to relieve compression. The joint capsule was repaired, and the wound was closed using sutures. Postoperative care instructions were given to the patient.

8. Operative Note: Radial Styloid Tenosynovitis Arthroscopy

Procedure: A radial styloid tenosynovitis arthroscopy was performed using a dorsal approach. An arthroscope was inserted into the joint to visualize the affected tendon sheath. The

diseased tissue was debrided and removed. Any constrictions or adhesions were released to restore normal tendon function. The joint was thoroughly irrigated, and the incisions were closed. Postoperative instructions were provided.

9. Operative Note: Radial Styloid Tenosynovitis Osteotomy

Procedure: A radial styloid tenosynovitis osteotomy was performed through a dorsal incision. The radial styloid process was accessed and carefully resected to alleviate pressure on the tendon sheath. The surrounding tissues were inspected, and any abnormalities were addressed. Hemostasis was achieved, and the wound was closed. The patient received postoperative care instructions and scheduled follow-up appointments.

10. Operative Note: Radial Styloid Tenosynovitis Ligament Reconstruction

Procedure: A radial styloid tenosynovitis ligament reconstruction was performed via a dorsal approach. The affected ligament was identified and reconstructed using appropriate graft material. The graft was secured in place using sutures or anchors. The tendon sheath was examined for any additional abnormalities, and the wound was closed. Postoperative care instructions were given to the patient, emphasizing the importance of rehabilitation.

Sure! Here are 10 more synthetic operative notes pertaining to Radial Styloid Tenosynovitis, each within 70 words:

1. Operative Note: Radial Styloid Tenosynovitis Fasciotomy

Procedure: A radial styloid tenosynovitis fasciotomy was performed through a dorsal approach. The constricting fascia was released to relieve pressure on the affected tendons. Careful dissection was done to ensure proper decompression. Hemostasis was achieved, and the wound was closed using sutures. The patient was educated about postoperative care and advised on follow-up appointments.

2. Operative Note: Radial Styloid Tenosynovitis Corticosteroid Injection

Procedure: A radial styloid tenosynovitis corticosteroid injection was administered under ultrasound guidance. The affected tendon sheath was identified, and a corticosteroid solution was injected to reduce inflammation and pain. The patient tolerated the procedure well, and post-injection instructions were provided. Follow-up was scheduled to assess the response and determine further management.

3. Operative Note: Radial Styloid Tenosynovitis Platelet-Rich Plasma (PRP) Injection

Procedure: A radial styloid tenosynovitis platelet-rich plasma (PRP) injection was performed under ultrasound guidance. Autologous PRP was prepared and injected into the affected tendon sheath to promote healing and tissue regeneration. The patient experienced minimal discomfort during the procedure. Post-injection care instructions were given, and a follow-up appointment was scheduled for evaluation.

4. Operative Note: Radial Styloid Tenosynovitis Endoscopic Release

Procedure: A radial styloid tenosynovitis endoscopic release was performed using a minimally invasive approach. A small incision was made, and an endoscope was inserted to visualize the affected tendon sheath. The constricting tissue was released using specialized instruments. Hemostasis was achieved, and the incision was closed. The patient was instructed on postoperative care and provided with follow-up details.

5. Operative Note: Radial Styloid Tenosynovitis Tendon Transfer

Procedure: A radial styloid tenosynovitis tendon transfer was performed to address tendon dysfunction. The diseased tendon was released, and an appropriate donor tendon was harvested and transferred to restore proper function. The donor tendon was secured using sutures or anchors. The wound was closed, and the patient was given postoperative instructions and scheduled for follow-up assessments.

6. Operative Note: Radial Styloid Tenosynovitis Wrist Arthrodesis

Procedure: A radial styloid tenosynovitis wrist arthrodesis was performed to address severe joint instability. The affected joint surfaces were prepared and fused using screws or plates. Additional procedures, such as tenosynovectomy or ligament repair, were performed as needed. The wound was closed, and the patient received instructions on immobilization and rehabilitation protocols.

7. Operative Note: Radial Styloid Tenosynovitis Soft Tissue Augmentation

Procedure: A radial styloid tenosynovitis soft tissue augmentation was performed to reinforce the affected tendon sheath. An appropriate graft or synthetic material was used to augment the weak or damaged tissue. The graft was secured in place using sutures or anchors. The wound was closed, and postoperative care instructions were provided to the patient.

8. Operative Note: Radial Styloid Tenosynovitis Arthroplasty

Procedure: A radial styloid tenosynovitis arthroplasty was performed to address joint degeneration and pain. The affected joint surfaces were reshaped and replaced with an artificial implant. Any constricting tissues were released,

and tendon gliding was ensured. The joint stability and range of motion were assessed before closing the wound. The patient was educated on postoperative care and follow-up appointments.

9. Operative Note: Radial Styloid Tenosynovitis Nerve Decompression

Procedure: A radial styloid tenosynovitis nerve decompression was performed to alleviate symptoms of nerve compression. The affected nerve was identified and carefully released from any constricting tissues or adhesions. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided, and the patient was advised on potential nerve recovery and follow-up evaluations.

10. Operative Note: Radial Styloid Tenosynovitis Arthroscopic Resection

Procedure: A radial styloid tenosynovitis arthroscopic resection was performed using a minimally invasive approach. An arthroscope was inserted, allowing visualization of the affected tendon sheath. The diseased or abnormal tissue was excised using specialized instruments. The joint was thoroughly irrigated, and the incisions were closed. Postoperative care instructions were given, emphasizing the importance of early mobilization and rehabilitation.

Certainly! Here are 10 synthetic operative notes pertaining to Radial Styloid Tenosynovitis, incorporating variations in anesthesia dosage, each within 70 words:

1. Operative Note: Radial Styloid Tenosynovitis Release with Local Anesthesia

Procedure: A radial styloid tenosynovitis release was performed under local anesthesia with the administration of lidocaine. The extensor retinaculum was incised, and the affected tendons were released from the constricting sheath. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient remained comfortable throughout the procedure, and postoperative instructions were provided.

2. Operative Note: Radial Styloid Tenosynovitis Debridement with Moderate Sedation

Procedure: A radial styloid tenosynovitis debridement was performed under moderate sedation. The extensor retinaculum was incised, and the diseased synovium was meticulously excised. Adhesions and thickened tissue were removed to restore normal tendon gliding. Hemostasis was achieved, and the wound was closed. The patient remained sedated and comfortable during the procedure, and postoperative care instructions were given.

3. Operative Note: Radial Styloid Tenosynovitis Bursectomy with General Anesthesia

Procedure: A radial styloid tenosynovitis bursectomy was performed under general anesthesia. The affected bursa was identified and excised meticulously. Surrounding tissues were inspected for abnormalities. Hemostasis was achieved, and the wound was closed. The patient was carefully monitored throughout the procedure, and postoperative care instructions were provided following their recovery from anesthesia.

4. Operative Note: Radial Styloid Tenosynovitis Synovectomy with Regional Anesthesia

Procedure: A radial styloid tenosynovitis synovectomy was performed under regional anesthesia using a nerve block. The diseased synovium was excised meticulously, and any adhesions were released. Hemostasis was achieved, and the wound was closed. The patient experienced numbness in the surgical area and remained comfortable throughout the procedure. Postoperative instructions were given before the regional anesthesia wore off.

5. Operative Note: Radial Styloid Tenosynovitis Tenolysis with Local Anesthesia and Sedation

Procedure: A radial styloid tenosynovitis tenolysis was performed under local anesthesia with the administration of lidocaine, combined with sedation. The constricting tissue around the affected tendons was carefully released. Hemostasis was achieved, and the wound was closed. The patient remained relaxed and pain-free throughout the procedure. Postoperative instructions were provided following their recovery from sedation.

6. Operative Note: Radial Styloid Tenosynovitis Tendon Repair with General Anesthesia

Procedure: A radial styloid tenosynovitis tendon repair was performed under general anesthesia. The torn or damaged tendon was meticulously repaired using sutures. Hemostasis was achieved, and the repaired tendon was tested for stability. The wound was closed, and the patient was carefully monitored throughout the procedure. Postoperative care instructions were given following their recovery from anesthesia.

7. Operative Note: Radial Styloid Tenosynovitis Capsulotomy with Local Anesthesia and Sedation

Procedure: A radial styloid tenosynovitis capsulotomy was performed under local anesthesia with the administration of lidocaine, along with sedation. The joint capsule was incised to access the affected tendon sheath. Constricting tissues were released, and the joint capsule was repaired. The patient remained comfortable and sedated throughout the procedure, and postoperative instructions were provided.

8. Operative Note:

Radial Styloid Tenosynovitis Arthroscopy with Regional Anesthesia

Procedure: A radial styloid tenosynovitis arthroscopy was performed under regional anesthesia using a nerve block. An arthroscope was inserted to visualize the affected tendon sheath. Diseased tissue was debrided and removed, and any constrictions were released. The joint was thoroughly irrigated, and the incisions were closed. The patient experienced numbness in the surgical area and remained comfortable throughout the procedure.

9. Operative Note: Radial Styloid Tenosynovitis Osteotomy with General Anesthesia and Epidural Block

Procedure: A radial styloid tenosynovitis osteotomy was performed under general anesthesia combined with an epidural block. The radial styloid process was carefully resected to alleviate pressure on the tendon sheath. Hemostasis was achieved, and the wound was closed. The patient remained comfortable and pain-free throughout the procedure. Postoperative instructions were given following their recovery from anesthesia.

10. Operative Note: Radial Styloid Tenosynovitis Ligament Reconstruction with Local Anesthesia and Intravenous Sedation

Procedure: A radial styloid tenosynovitis ligament reconstruction was performed under local anesthesia with the administration of lidocaine, accompanied by intravenous sedation. The affected ligament was reconstructed using an appropriate graft. The graft was secured, and the wound was closed. The patient remained relaxed and pain-free throughout the procedure. Postoperative instructions were provided before their recovery from sedation.

Certainly! Here are 10 synthetic operative notes pertaining to Radial Styloid Tenosynovitis, incorporating bone erosion, each within 70 words:

1. Operative Note: Radial Styloid Tenosynovitis Debridement with Bone Erosion Management

Procedure: A radial styloid tenosynovitis debridement was performed to address tendon pathology and bone erosion. The diseased synovium was meticulously excised, and bone erosions were carefully managed using bone grafts or synthetic bone substitutes. Adhesions were released, and hemostasis was achieved. The wound was closed, and postoperative care instructions were given to promote healing and rehabilitation.

2. Operative Note: Radial Styloid Tenosynovitis Arthroscopic Synovectomy with Bone Erosion Evaluation

Procedure: A radial styloid tenosynovitis arthroscopic synovectomy was performed to address synovial inflammation and bone erosions. The affected tendon sheath was visualized using an arthroscope, and diseased synovium was excised. Bone erosions were evaluated for severity and managed accordingly using bone grafts or bone substitutes. The joint was irrigated, and the incisions were closed. Postoperative instructions were provided.

3. Operative Note: Radial Styloid Tenosynovitis Osteotomy with Bone Erosion Reconstruction

Procedure: A radial styloid tenosynovitis osteotomy was performed to address bone erosion and alleviate pressure on the tendon sheath. The eroded bone was meticulously resected, and the defect was reconstructed using bone grafts or synthetic bone substitutes. The tendon sheath was examined for abnormalities, and any constrictions were released. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided.

4. Operative Note: Radial Styloid Tenosynovitis Tendon Repair with Bone Erosion Management

Procedure: A radial styloid tenosynovitis tendon repair was performed to address tendon pathology and bone erosion. The torn or damaged tendon was meticulously repaired using sutures, and bone erosions were managed using bone grafts or substitutes. The repaired tendon was tested for stability, and the joint was irrigated. The wound was closed, and postoperative care instructions were provided.

5. Operative Note: Radial Styloid Tenosynovitis Arthrodesis with Bone Erosion Stabilization

Procedure: A radial styloid tenosynovitis arthrodesis was performed to address severe joint instability and bone erosion. The affected joint surfaces were prepared, and bone erosions were stabilized using plates, screws, or other fixation methods. Additional procedures, such as tenosynovectomy, were performed. The joint was irrigated, and the wound was closed. Postoperative care instructions were given to promote healing and rehabilitation.

6. Operative Note: Radial Styloid Tenosynovitis Soft Tissue Augmentation with Bone Erosion Reconstruction

Procedure: A radial styloid tenosynovitis soft tissue augmentation was performed to reinforce the affected tendon sheath and address bone erosion. An appropriate graft or synthetic material was used to augment the weak or damaged tissue, and bone erosions were reconstructed using bone grafts or substitutes. The graft was secured, and the wound was closed. Postoperative care instructions were provided.

7. Operative Note: Radial Styloid Tenosynovitis Arthroplasty with Bone Erosion Management

Procedure: A radial styloid tenosynovitis arthroplasty was performed to address joint degeneration, tendon pathology, and bone erosion. The affected joint surfaces were reshaped, and bone erosions were managed using bone grafts or substitutes. The joint

stability and range of motion were assessed before closing the wound. Postoperative care instructions were given to promote healing and rehabilitation.

8. Operative Note: Radial Styloid Tenosynovitis Tendon Transfer with Bone Erosion Reconstruction

Procedure: A radial styloid tenosynovitis tendon transfer was performed to address tendon dysfunction and bone erosion. The diseased tendon was released, and an appropriate donor tendon was harvested and transferred. Bone erosions were reconstructed using bone grafts or substitutes. The donor tendon was secured, and the wound was closed. Postoperative care instructions were provided to promote healing and rehabilitation.

9. Operative Note: Radial Styloid Tenosynovitis Excision with Bone Erosion Curettage

Procedure: A radial styloid tenosynovitis excision was performed to address tendon pathology and bone erosion. The affected tendons were meticulously excised, and bone erosions were carefully curetted. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given to promote healing and rehabilitation, with emphasis on bone erosion management.

10. Operative Note: Radial Styloid Tenosynovitis Ligament Reconstruction with Bone Erosion Evaluation

Procedure: A radial styloid tenosynovitis ligament reconstruction was performed to address tendon pathology, ligament instability, and bone erosion. The affected ligament was reconstructed using an appropriate graft, and bone erosions were evaluated for severity. Bone grafts or substitutes were utilized for erosion management. The graft was secured, and the wound was closed. Postoperative care instructions were provided to promote healing and rehabilitation.

Certainly! Here are 10 synthetic operative notes pertaining to Radial Styloid Tenosynovitis, incorporating severe bone pain, each within 70 words:

1. Operative Note: Radial Styloid Tenosynovitis Release with Severe Bone Pain Management

Procedure: A radial styloid tenosynovitis release was performed to alleviate severe bone pain and tendon pathology. The affected tendons were meticulously released from the constricting sheath. Intensive pain management measures, including local anesthesia and postoperative pain medications, were administered. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided, emphasizing pain control and follow-up evaluations.

2. Operative Note: Radial Styloid Tenosynovitis Debridement with Severe Bone Pain Assessment

Procedure: A radial styloid tenosynovitis debridement was performed to address severe bone pain and tendon pathology. The diseased synovium was meticulously excised, and the affected area was carefully assessed for bone erosions or abnormalities contributing to the pain. Pain management strategies, including regional anesthesia and analgesics, were employed. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given.

3. Operative Note: Radial Styloid Tenosynovitis Arthroscopic Synovectomy with Severe Bone Pain Evaluation

Procedure: A radial styloid tenosynovitis arthroscopic synovectomy was performed to alleviate severe bone pain and synovial inflammation. The affected tendon sheath was visualized using an arthroscope, and diseased synovium was excised. Severe bone pain was evaluated through careful inspection of erosions or fractures. Pain management, including nerve blocks and analgesics, was administered. The wound was closed, and postoperative instructions were provided.

4. Operative Note: Radial Styloid Tenosynovitis Osteotomy with Severe Bone Pain Alleviation

Procedure: A radial styloid tenosynovitis osteotomy was performed to address severe bone pain and tendon pathology. The affected bone was meticulously resected to alleviate pressure on the tendon sheath. Intensive pain management measures, including nerve blocks and postoperative pain medications, were employed. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing pain control and rehabilitation.

5. Operative Note: Radial Styloid Tenosynovitis Tendon Repair with Severe Bone Pain Management

Procedure: A radial styloid tenosynovitis tendon repair was performed to address severe bone pain and tendon pathology. The torn or damaged tendon was meticulously repaired using sutures. Intensive pain management strategies, including local anesthesia and postoperative analgesics, were employed. The repaired tendon was tested for stability, and the wound was closed. Postoperative care instructions were provided, focusing on pain control and rehabilitation.

6. Operative Note: Radial Styloid Tenosynovitis Arthrodesis with Severe Bone Pain Alleviation

Procedure: A radial styloid tenosynovitis arthrodesis was performed to address severe joint instability, tendon pathology, and bone pain. The affected joint surfaces were prepared, and bone erosions or fractures contributing to the severe bone pain were addressed. Intensive pain management measures, including regional anesthesia and postoperative pain medications, were employed. The joint was stabilized, and the wound was closed. Postoperative care instructions were given.

7. Operative Note: Radial Styloid Tenosynovitis Soft Tissue Augmentation with Severe Bone Pain Relief

Procedure: A radial styloid tenosynovitis soft tissue augmentation was performed to address severe bone pain and reinforce the affected tendon sheath. An appropriate graft

or synthetic material was used to augment the weak or damaged tissue. Intensive pain management measures, including local anesthesia and analgesics, were administered. The graft was secured, and the wound was closed. Postoperative instructions emphasized pain control and follow-up evaluations.

8. Operative Note: Radial Styloid Tenosynovitis Arthroplasty with Severe Bone Pain Management

Procedure: A radial styloid tenosynovitis arthroplasty was performed to address severe joint degeneration, tendon pathology, and bone pain. The affected joint surfaces were reshaped, and measures were taken to alleviate severe bone pain, such as addressing erosions or fractures. Intensive pain management strategies, including nerve blocks and postoperative analgesics, were employed. The joint stability and range of motion were assessed before closing the wound. Postoperative instructions focused on pain control and rehabilitation.

9. Operative Note: Radial Styloid Tenosynovitis Tendon Transfer with Severe Bone Pain Relief

Procedure: A radial styloid tenosynovitis tendon transfer was performed to address severe bone pain and tendon dysfunction. The diseased tendon was released, and an appropriate donor tendon was harvested and transferred. Intensive pain management measures, including local anesthesia and postoperative analgesics, were employed. The donor tendon was secured, and the wound was closed. Postoperative care instructions emphasized pain control and rehabilitation.

10. Operative Note: Radial Styloid Tenosynovitis Excision with Severe Bone Pain Alleviation

Procedure: A radial styloid tenosynovitis excision was performed to address severe bone pain and tendon pathology. The affected tendons were meticulously excised, and measures were taken to alleviate severe bone pain, such as addressing erosions or fractures. Intensive pain management strategies, including nerve blocks and postoperative analgesics, were employed. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, emphasizing pain control and follow-up evaluations.

Certainly! Here are 10 synthetic operative notes pertaining to Radial Styloid Tenosynovitis, mentioning a surgical intervention, each within 70 words:

1. Operative Note: Radial Styloid Tenosynovitis Release with Surgical Intervention

Procedure: A radial styloid tenosynovitis release was performed to address tendon pathology and restore normal tendon movement. Surgical intervention involved meticulously releasing the affected tendons from the constricting sheath. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, emphasizing proper hand and wrist exercises to facilitate rehabilitation and prevent recurrence.

2. Operative Note: Radial Styloid Tenosynovitis Excision with Surgical Intervention

Procedure: A radial styloid tenosynovitis excision was performed to address severe tendon inflammation and pain. Surgical intervention involved excising the diseased tendon sheath and any adhesions present. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, focusing on pain management and hand rehabilitation exercises to optimize functional recovery.

3. Operative Note: Radial Styloid Tenosynovitis Debridement with Surgical Intervention

Procedure: A radial styloid tenosynovitis debridement was performed to remove diseased tissue and promote healing. Surgical intervention involved meticulously excising the diseased synovium and removing any constrictions or adhesions affecting tendon movement. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing hand and wrist immobilization to facilitate recovery.

4. Operative Note: Radial Styloid Tenosynovitis Arthroscopy with Surgical Intervention

Procedure: A radial styloid tenosynovitis arthroscopy was performed to visualize and treat the affected tendon sheath. Surgical intervention involved inserting an arthroscope to assess the pathology, followed by debridement, release of constrictions, and removal of adhesions. The joint was irrigated, and the incisions were closed. Postoperative care instructions were provided, including hand therapy and follow-up evaluations.

5. Operative Note: Radial Styloid Tenosynovitis Osteotomy with Surgical Intervention

Procedure: A radial styloid tenosynovitis osteotomy was performed to address tendon pathology and alleviate pressure on the tendon sheath. Surgical intervention involved carefully resecting the radial styloid process. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing immobilization of the hand and wrist to promote proper healing.

6. Operative Note: Radial Styloid Tenosynovitis Ligament Reconstruction with Surgical Intervention

Procedure: A radial styloid tenosynovitis ligament reconstruction was performed to restore stability and function to the affected joint. Surgical intervention involved reconstructing the damaged ligament using an appropriate graft. The graft was secured, and the wound was closed. Postoperative care instructions were provided, including hand and wrist immobilization and a gradual return to functional activities.

7. Operative Note: Radial Styloid Tenosynovitis Tendon Repair with Surgical Intervention

Procedure: A radial styloid tenosynovitis tendon repair was performed to address tendon tears or ruptures. Surgical intervention involved meticulously repairing the torn or damaged tendon using sutures. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing hand and wrist immobilization and a structured rehabilitation program to optimize tendon healing.

8. Operative Note: Radial Styloid Tenosynovitis Arthrodesis with Surgical Intervention

Procedure: A radial styloid tenosynovitis arthrodesis was performed to address severe joint instability and restore joint function. Surgical intervention involved fusing

the affected joint surfaces using plates, screws, or other fixation methods. Additional procedures, such as tenosynovectomy, were performed. The joint was irrigated, and the wound was closed. Postoperative care instructions were provided, including immobilization and hand therapy.

9. Operative Note: Radial Styloid Tenosynovitis Soft Tissue Augmentation with Surgical Intervention

Procedure: A radial styloid tenosynovitis soft tissue augmentation was performed to reinforce the affected tendon sheath and promote healing. Surgical intervention involved using an appropriate graft or synthetic material to augment the weakened or damaged tissue. The graft was secured, and the wound was closed. Postoperative care instructions were given, emphasizing hand immobilization and adherence to the rehabilitation program.

10. Operative Note: Radial Styloid Tenosynovitis Synovectomy with Surgical Intervention

Procedure: A radial styloid tenosynovitis synovectomy was performed to address inflamed synovium and improve tendon function. Surgical intervention involved meticulously excising the diseased synovium, releasing any constrictions, and removing adhesions affecting tendon movement. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, including hand therapy and follow-up evaluations.

Certainly! Here are 10 more synthetic operative notes pertaining to Radial Styloid Tenosynovitis, each within 70 words:

1. Operative Note: Radial Styloid Tenosynovitis Denervation with Surgical Intervention

Procedure: A radial styloid tenosynovitis denervation was performed to address chronic pain and tendon pathology. Surgical intervention involved selectively disabling the sensory nerves responsible for transmitting pain signals. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, focusing on pain management and hand rehabilitation exercises to optimize functional recovery.

2. Operative Note: Radial Styloid Tenosynovitis Arthroplasty with Surgical Intervention

Procedure: A radial styloid tenosynovitis arthroplasty was performed to address severe joint degeneration and tendon pathology. Surgical intervention involved reshaping the affected joint surfaces and addressing any bone erosions or deformities contributing to the condition. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing hand immobilization and a gradual return to functional activities.

3. Operative Note: Radial Styloid Tenosynovitis Tendon Transfer with Surgical Intervention

Procedure: A radial styloid tenosynovitis tendon transfer was performed to address tendon dysfunction and restore normal hand function. Surgical intervention involved harvesting a donor tendon and transferring it to replace the diseased tendon. The donor tendon was secured, and the wound was closed. Postoperative care instructions were provided, including hand immobilization and a structured rehabilitation program.

4. Operative Note: Radial Styloid Tenosynovitis Excision with Surgical Intervention and Joint Exploration

Procedure: A radial styloid tenosynovitis excision was performed to address tendon pathology and alleviate pain. Surgical intervention involved meticulously excising the diseased tendon sheath and exploring the joint for any additional abnormalities. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing hand immobilization and regular follow-up evaluations to monitor the joint's condition.

5. Operative Note: Radial Styloid Tenosynovitis Osteotomy with Surgical Intervention and Bone Grafting

Procedure: A radial styloid tenosynovitis osteotomy was performed to address severe bone deformities and tendon pathology. Surgical intervention involved carefully resecting the affected bone and stabilizing it with bone grafts. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, including hand immobilization and adherence to the rehabilitation program to facilitate bone healing and functional recovery.

6. Operative Note: Radial Styloid Tenosynovitis Synovectomy with Surgical Intervention and Capsular Release

Procedure: A radial styloid tenosynovitis synovectomy was performed to address synovial inflammation and tendon dysfunction. Surgical intervention involved meticulously excising the diseased synovium and releasing any constrictions in the joint capsule. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing hand immobilization and hand therapy to optimize tendon healing and joint mobility.

7. Operative Note: Radial Styloid Tenosynovitis Arthroscopic Debridement with Surgical Intervention

Procedure: A radial styloid tenosynovitis arthroscopic debridement was performed to address tendon pathology and promote healing. Surgical intervention involved using an arthroscope to visualize and meticulously remove diseased tissue, adhesions, and synovial inflammation. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, including hand immobilization and a structured rehabilitation program.

8. Operative Note: Radial Styloid Tenosynovitis Tendon Reconstruction with Surgical Intervention

Procedure:

A radial styloid tenosynovitis tendon reconstruction was performed to address severe tendon damage and dysfunction. Surgical intervention involved using autograft or allograft tendons to reconstruct the affected tendon. The graft was secured, and the wound was closed. Postoperative care instructions were given, emphasizing hand immobilization, adherence to the rehabilitation program, and regular follow-up evaluations.

9. Operative Note: Radial Styloid Tenosynovitis Joint Resurfacing with Surgical Intervention

Procedure: A radial styloid tenosynovitis joint resurfacing was performed to address joint degeneration and restore joint function. Surgical intervention involved resurfacing the affected joint surfaces with biocompatible materials or joint implants. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided, including hand immobilization and a gradual return to functional activities.

10. Operative Note: Radial Styloid Tenosynovitis Tenolysis with Surgical Intervention

Procedure: A radial styloid tenosynovitis tenolysis was performed to address tendon adhesions and restore normal tendon gliding. Surgical intervention involved meticulously releasing the adhesions and ensuring smooth movement of the affected tendons. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were given, emphasizing hand immobilization, hand therapy, and regular follow-up evaluations to monitor tendon recovery.

1. Operative Note: Radial Styloid Tenosynovitis Drainage with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis drainage was performed to address a severe infection affecting the extreme moving joint. Surgical intervention involved meticulously draining the infected area, irrigating with antimicrobial solutions, and ensuring proper wound care. Postoperative care instructions were provided, emphasizing systemic antibiotics, immobilization, and close monitoring for signs of infection recurrence.

2. Operative Note: Radial Styloid Tenosynovitis Debridement with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis debridement was performed to address a severe infection on the extreme moving joint. Surgical intervention involved meticulously removing necrotic tissue, flushing the area with antimicrobial solutions, and ensuring appropriate wound closure. Postoperative care instructions were given, emphasizing systemic antibiotics, hand immobilization, and frequent wound assessments for infection control.

3. Operative Note: Radial Styloid Tenosynovitis Washout with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis washout was performed to address a severe infection affecting the extreme moving joint. Surgical intervention involved thorough irrigation and debridement of the infected joint, followed by closure and appropriate wound management. Postoperative care instructions were provided, including systemic antibiotics, hand immobilization, and close monitoring for signs of infection resolution.

4. Operative Note: Radial Styloid Tenosynovitis Joint Exploration with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis joint exploration was performed to assess and address a severe infection on the extreme moving joint. Surgical intervention involved meticulous exploration of the joint, removal of infected tissue, and irrigation with antimicrobial solutions. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included systemic antibiotics, hand immobilization, and regular follow-up evaluations.

5. Operative Note: Radial Styloid Tenosynovitis Synovectomy with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis synovectomy was performed to address a severe infection affecting the extreme moving joint. Surgical intervention involved meticulous excision of the infected synovium, followed by irrigation and appropriate wound closure. Postoperative care instructions were given, including systemic antibiotics, hand immobilization, and close monitoring for infection eradication.

6. Operative Note: Radial Styloid Tenosynovitis Incision and Drainage with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis incision and drainage were performed to address a severe infection on the extreme moving joint. Surgical intervention involved making an incision, evacuating the purulent material, irrigating the wound, and ensuring adequate drainage. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included systemic antibiotics, hand immobilization, and frequent wound assessments for infection control.

7. Operative Note: Radial Styloid Tenosynovitis Arthroscopic Debridement with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis arthroscopic debridement was performed to address a severe infection on the extreme moving joint. Surgical intervention involved using an arthroscope to visualize and meticulously remove infected tissue, followed by irrigation and appropriate wound closure. Postoperative care instructions included systemic antibiotics, hand immobilization, and regular follow-up evaluations.

8. Operative Note: Radial Styloid Tenosynovitis Joint Resection with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis joint resection was performed to address a severe infection affecting the extreme moving joint. Surgical intervention involved resecting the infected joint surfaces, followed by irrigation, placement of antimicrobial agents, and appropriate wound closure. Postoperative care instructions included systemic antibiotics, hand immobilization, and close monitoring for infection resolution.

9. Operative Note: Radial Styloid Tenosynovitis Joint Fusion with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis joint fusion was performed to address a severe infection on the extreme moving joint. Surgical intervention involved fusing the affected joint surfaces using plates, screws, or other fixation methods, followed by irrigation and wound closure. Postoperative care instructions included systemic antibiotics, hand immobilization, and regular follow-up evaluations.

10. Operative Note: Radial Styloid Tenosynovitis Amputation with Surgical Intervention for Severe Joint Infection

Procedure: A radial styloid tenosynovitis amputation was performed to address a severe infection on the extreme moving joint that was unresponsive to conservative measures. Surgical intervention involved removing the affected joint and surrounding tissues, followed by appropriate wound closure. Postoperative care instructions included systemic antibiotics, hand rehabilitation, and psychosocial support for the patient's adjustment.

1. Operative Note: Radial Styloid Tenosynovitis Synovectomy with Surgical Intervention for Severe Inflammatory Response

Procedure: A radial styloid tenosynovitis synovectomy was performed to address severe inflammation affecting the tendon sheath. Surgical intervention involved meticulous excision of the inflamed synovium, followed by irrigation and appropriate wound closure. Postoperative care instructions were given, including hand immobilization, anti-inflammatory medications, and regular follow-up evaluations to monitor inflammation resolution.

2. Operative Note: Radial Styloid Tenosynovitis Debridement with Surgical Intervention for Chronic Inflammation

Procedure: A radial styloid tenosynovitis debridement was performed to address chronic inflammation of the tendon sheath. Surgical intervention involved meticulous removal of inflamed tissue, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, anti-inflammatory medications, and a structured rehabilitation program to promote tendon healing and reduce inflammation.

3. Operative Note: Radial Styloid Tenosynovitis Corticosteroid Injection with Surgical Intervention for Acute Inflammation

Procedure: A radial styloid tenosynovitis corticosteroid injection was performed to address acute inflammation of the tendon sheath. Surgical intervention involved delivering a corticosteroid solution into the affected area, followed by appropriate wound closure. Postoperative care instructions were given, including hand immobilization, anti-inflammatory medications, and close monitoring of the patient's response to the injection.

4. Operative Note: Radial Styloid Tenosynovitis Bursectomy with Surgical Intervention for Inflammation and Bursitis

Procedure: A radial styloid tenosynovitis bursectomy was performed to address inflammation and bursitis associated with the tendon sheath. Surgical intervention involved meticulous excision of the inflamed bursa, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, anti-inflammatory medications, and regular follow-up evaluations to monitor bursitis resolution.

5. Operative Note: Radial Styloid Tenosynovitis Anti-inflammatory Medication Administration with Surgical Intervention for Moderate Inflammation

Procedure: A radial styloid tenosynovitis surgical intervention was performed along with the administration of anti-inflammatory medications to address moderate inflammation of the tendon sheath. Surgical intervention involved appropriate treatment based on the underlying pathology, followed by wound closure. Postoperative care instructions included hand immobilization, continuation of anti-inflammatory medications, and regular follow-up evaluations to assess the patient's response to treatment.

6. Operative Note: Radial Styloid Tenosynovitis Excision with Surgical Intervention for Chronic Inflammation and Fibrosis

Procedure: A radial styloid tenosynovitis excision was performed to address chronic inflammation and fibrosis affecting the tendon sheath. Surgical intervention involved meticulous excision of the inflamed and fibrotic tissue, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, anti-inflammatory medications, and a structured rehabilitation program to promote tendon healing and reduce inflammation.

7. Operative Note: Radial Styloid Tenosynovitis Tenolysis with Surgical Intervention for Recurrent Inflammation and Adhesions

Procedure: A radial styloid tenosynovitis tenolysis was performed to address recurrent inflammation and adhesions affecting the tendon sheath. Surgical intervention involved meticulous release of adhesions, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, anti-inflammatory medications, and regular follow-up evaluations to monitor inflammation and adhesion recurrence.

8.

Operative Note: Radial Styloid Tenosynovitis Arthroscopic Debridement with Surgical Intervention for Inflammation and Joint Pathology

Procedure: A radial styloid tenosynovitis arthroscopic debridement was performed to address inflammation and associated joint pathology. Surgical intervention involved using an arthroscope to visualize and meticulously remove inflamed tissue and any joint abnormalities, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, anti-inflammatory medications, and a structured rehabilitation program.

9. Operative Note: Radial Styloid Tenosynovitis Resection with Surgical Intervention for Severe Inflammation and Tendon Degeneration

Procedure: A radial styloid tenosynovitis resection was performed to address severe inflammation and tendon degeneration. Surgical intervention involved resecting the affected portion of the tendon, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, anti-inflammatory medications, and regular follow-up evaluations to monitor inflammation resolution and tendon healing.

10. Operative Note: Radial Styloid Tenosynovitis Anti-inflammatory Injection with Surgical Intervention for Persistent Inflammation

Procedure: A radial styloid tenosynovitis surgical intervention was performed along with the administration of an anti-inflammatory injection to address persistent inflammation of the tendon sheath. Surgical intervention involved appropriate treatment based on the underlying pathology, followed by wound closure. Postoperative care instructions included hand immobilization, continuation of anti-inflammatory medications, and regular follow-up evaluations to assess the patient's response to treatment.

1. Operative Note: Radial Styloid Tenosynovitis Release with Surgical Intervention for Mild Diagnosis

Procedure: A radial styloid tenosynovitis release was performed to address a mild case of tendon inflammation. Surgical intervention involved releasing the tight tendon sheath, followed by appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in two weeks to assess the patient's response to treatment.

2. Operative Note: Radial Styloid Tenosynovitis Debridement with Surgical Intervention for Moderate Diagnosis

Procedure: A radial styloid tenosynovitis debridement was performed to address moderate tendon inflammation and adhesions. Surgical intervention involved meticulous removal of inflamed tissue and adhesions, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in four weeks to monitor the patient's recovery and response to treatment.

3. Operative Note: Radial Styloid Tenosynovitis Tenolysis with Surgical Intervention for Severe Diagnosis

Procedure: A radial styloid tenosynovitis tenolysis was performed to address severe tendon inflammation and extensive adhesions. Surgical intervention involved meticulous release of adhesions, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in six weeks to assess the patient's response to treatment and determine the need for further intervention.

4. Operative Note: Radial Styloid Tenosynovitis Joint Resurfacing with Surgical Intervention for Recurrent Diagnosis

Procedure: A radial styloid tenosynovitis joint resurfacing was performed to address recurrent inflammation and joint degeneration. Surgical intervention involved resurfacing the affected joint surfaces, followed by appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in eight weeks to assess the success of the procedure and monitor the patient's recovery.

5. Operative Note: Radial Styloid Tenosynovitis Synovectomy with Surgical Intervention for Chronic Diagnosis

Procedure: A radial styloid tenosynovitis synovectomy was performed to address chronic inflammation and synovial hypertrophy. Surgical intervention involved meticulous excision of the inflamed synovium, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in three months to evaluate the effectiveness of the procedure and determine the need for further intervention.

6. Operative Note: Radial Styloid Tenosynovitis Joint Fusion with Surgical Intervention for Degenerative Diagnosis

Procedure: A radial styloid tenosynovitis joint fusion was performed to address degenerative joint disease and chronic inflammation. Surgical intervention involved fusing the affected joint surfaces using plates, screws, or other fixation methods, followed by irrigation and wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in six months to assess joint fusion success and the patient's overall recovery.

7. Operative Note: Radial Styloid Tenosynovitis Tendon Reconstruction with Surgical Intervention for Severe and Chronic Diagnosis

Procedure: A radial styloid tenosynovitis tendon reconstruction was performed to address severe and chronic tendon damage. Surgical intervention involved using autograft or allograft tendons to reconstruct the affected tendon, followed by appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in three months to assess tendon healing and functional recovery.

8. Operative Note: Radial Styloid Tenosynovitis Arthroscopic Debridement with Surgical Intervention for Failed Conservative Management

Procedure: A radial styloid tenosynovitis arthroscopic debridement was performed to address persistent inflammation and failed conservative management. Surgical intervention involved using an arthroscope to visualize and meticulously remove inflamed tissue, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a follow-up evaluation in four weeks to assess the success of the procedure and determine further treatment options.

9. Operative Note: Radial Styloid Tenosynovitis Amputation with Surgical Intervention for Irreversible Diagnosis

Procedure: A radial styloid tenosynovitis amputation was performed to address irreversible tendon damage and severe inflammation. Surgical intervention involved removing the affected joint and surrounding tissues, followed by appropriate wound closure. Postoperative care instructions included pain management, hand rehabilitation, and a follow-up evaluation in one week to monitor wound healing and provide psychosocial support for the patient's adjustment.

10. Operative Note: Radial Styloid Tenosynovitis Bursectomy with Surgical Intervention for Complicated Diagnosis

Procedure: A radial styloid tenosynovitis bursectomy was performed to address complicated tendon inflammation and associated bursitis. Surgical intervention involved meticulous excision of the inflamed bursa, followed by irrigation and appropriate wound closure. Postoperative care instructions included hand immobilization, pain management, and a customized follow-up plan based on the patient's specific needs and the complexity of the diagnosis.

## M65.8 Other synovitis and tenosynovitis

1. Patient presented with symptoms of other synovitis and tenosynovitis in the left wrist. A thorough examination revealed swelling, tenderness, and limited range of motion. The diagnosis was confirmed through imaging studies. Treatment included non-steroidal anti-inflammatory drugs (NSAIDs) and splinting. Patient was advised to follow up in two weeks for reassessment.

2. Operative note: Procedure performed was synovectomy and tenosynovectomy for other synovitis and tenosynovitis in the right ankle. The affected synovial and tenosynovial tissues were excised meticulously. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions included elevation, rest, and gradual mobilization.

3. Operative note: Patient underwent arthroscopic debridement and synovial biopsy for other synovitis and tenosynovitis in the left knee. The joint was accessed through two portals, and the synovium was inspected for inflammation. Debridement was performed, and multiple synovial samples were obtained for analysis. Postoperatively, the patient was advised to initiate physical therapy.

4. Operative note: The procedure involved incision and drainage for other synovitis and tenosynovitis in the right thumb. An aseptic technique was used, and a longitudinal incision was made over the affected tendon sheath. Purulent fluid was drained, and the wound was irrigated thoroughly. The wound was left open for secondary intention healing.

5. Operative note: Open tenosynovectomy was performed for other synovitis and tenosynovitis in the right elbow. A longitudinal incision was made over the extensor tendon sheath, and the diseased synovium was excised completely. Hemostasis was ensured, and the wound was closed layer by layer. Patient was placed in a splint for immobilization.

6. Operative note: Patient underwent ultrasound-guided corticosteroid injection for other synovitis and tenosynovitis in the left shoulder. The joint was sterilized, and a needle was inserted under ultrasound guidance. Triamcinolone was injected into the affected synovial and tenosynovial spaces. The patient tolerated the procedure well and was advised to monitor for any adverse effects.

7. Operative note: Surgical release was performed for other synovitis and tenosynovitis in the right index finger. A transverse incision was made over the flexor tendon sheath, and careful dissection was carried out to release the constricted tendons. The incision was closed with sutures, and a dressing was applied. Patient was instructed to perform hand exercises.

8. Operative note: Patient underwent minimally invasive tenosynovectomy for other synovitis and tenosynovitis in the left hip. Two small incisions were made, and a specialized instrument was used to remove the inflamed tenosynovial tissue. Hemostasis was achieved, and the incisions were closed with adhesive strips. Patient was advised to gradually increase weight-bearing activities.

9. Operative note: The procedure performed was arthroscopic synovectomy for other synovitis and tenosynovitis in the right shoulder. The joint was accessed using multiple portals, and the inflamed synovium was visualized. Careful excision of the synovium was performed, and the joint was irrigated thoroughly. Patient was advised to initiate a rehabilitation program.

10. Operative note: Patient underwent ultrasound-guided aspiration and lavage for other synovitis and tenosynovitis in the left ankle. Under sterile conditions, a needle was inserted into the affected joint space, and fluid was aspirated. Saline solution was then infused into the joint, followed by gentle manipulation to remove debris. The patient reported immediate relief post-procedure.

1. Operative note: The patient underwent open synovectomy and tenosynovectomy for other synovitis and tenosynovitis in the left knee. A midline incision was made, and the inflamed synovium and tenosynovium were excised meticulously. Hemostasis was achieved, and the wound was closed in layers. Postoperative instructions included physical therapy and weight-bearing as tolerated.

2. Operative note: Patient presented with chronic other synovitis and tenosynovitis in the right wrist. Arthroscopic synovectomy and tenosynovectomy were performed. Multiple portals were created, allowing visualization and excision of the diseased tissues. The joint was irrigated thoroughly, and the portals were closed with sutures. Patient was advised to wear a wrist splint for support.

3. Operative note: The procedure performed was percutaneous needle aspiration for other synovitis and tenosynovitis in the left ankle. Under sterile conditions, a needle was inserted into the affected joint space, and fluid was aspirated. The patient reported immediate relief, and the joint was immobilized with a splint for a few days.

4. Operative note: Patient underwent ultrasound-guided corticosteroid injection for other synovitis and tenosynovitis in the right elbow. The joint was prepared and visualized under ultrasound guidance. A mixture of corticosteroid and local anesthetic was injected into the inflamed synovium and tenosynovium. Patient tolerated the procedure well with no complications reported.

5. Operative note: The patient underwent arthroscopic debridement and synovectomy for other synovitis and tenosynovitis in the left hip. Multiple portals were created, and the joint was thoroughly inspected. Debridement of inflamed tissues was performed, followed by meticulous hemostasis and closure of the portals. Postoperatively, the patient was prescribed pain medication and instructed to avoid weight-bearing activities.

6. Operative note: Open tenosynovectomy was performed for other synovitis and tenosynovitis in the right thumb. A longitudinal incision was made, and the diseased tenosynovial tissue was excised completely. Hemostasis was ensured, and the wound was closed using absorbable sutures. Patient was advised to avoid activities that strain the thumb during the healing process.

7. Operative note: Patient underwent arthroscopic synovectomy and tenosynovectomy for other synovitis and tenosynovitis in the left shoulder. The joint was accessed using multiple portals, and the inflamed synovium and tenosynovium were excised meticulously. The joint was irrigated thoroughly, and the portals were closed. Patient was instructed to start gentle range-of-motion exercises.

8. Operative note: Surgical release was performed for other synovitis and tenosynovitis in the right ankle. A longitudinal incision was made over the affected tendon sheath, and careful dissection was carried out to release the constricted tendons. The wound was closed with sutures, and a compression bandage was applied. Patient was advised to elevate and rest the foot.

9. Operative note: Patient presented with recalcitrant other synovitis and tenosynovitis in the left index finger. A decision was made to perform a tendon sheath irrigation. The sheath was accessed, and a sterile solution was infused to flush out inflammatory debris. The procedure was well-tolerated, and the finger was splinted for protection.

10. Operative note: Patient underwent ultrasound-guided aspiration and corticosteroid injection for other synovitis and tenosynovitis in the right knee. Under aseptic conditions, the joint was accessed with a needle, and synovial fluid was aspirated. Corticosteroid medication was then injected into the joint space. The patient reported significant pain relief and was advised to monitor for any adverse reactions.

1. Operative note: Patient underwent open synovectomy and tenosynovectomy for other synovitis and tenosynovitis in the left knee under general anesthesia. A midline incision was made, and the inflamed synovium and tenosynovium were excised meticulously. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and postoperative pain was managed with intravenous analgesics.

2. Operative note: The patient presented with chronic other synovitis and tenosynovitis in the right wrist. Arthroscopic synovectomy and tenosynovectomy were performed under local anesthesia with sedation. Multiple portals were created, allowing visualization and excision of the diseased tissues. The patient remained comfortable throughout the procedure, and postoperative pain was managed with oral analgesics.

3. Operative note: The procedure performed was percutaneous needle aspiration for other synovitis and tenosynovitis in the left ankle under local anesthesia. Under sterile conditions, a needle was inserted into the affected joint space, and fluid was aspirated. The patient reported minimal discomfort during the procedure, and postoperative pain was managed with a combination of oral and topical analgesics.

4. Operative note: Patient underwent ultrasound-guided corticosteroid injection for other synovitis and tenosynovitis in the right elbow under regional anesthesia. The joint was prepared and visualized under ultrasound guidance. A mixture of corticosteroid and local anesthetic was injected into the inflamed synovium and tenosynovium. The patient remained comfortable throughout the procedure, and postoperative pain was minimal.

5. Operative note: The patient underwent arthroscopic debridement and synovectomy for other synovitis and tenosynovitis in the left hip under spinal anesthesia. Multiple portals were created, and the joint was thoroughly inspected. Debridement of inflamed tissues was performed, followed by meticulous hemostasis and closure of the portals. The patient remained stable during the procedure, and postoperative pain was managed with intravenous and oral analgesics.

6. Operative note: Open tenosynovectomy was performed for other synovitis and tenosynovitis in the right thumb under local anesthesia with sedation. A longitudinal incision was made, and the diseased tenosynovial tissue was excised completely. Hemostasis was ensured, and the wound was closed using absorbable sutures. The patient remained comfortable throughout the procedure, and postoperative pain was managed with oral analgesics.

7. Operative note: Patient underwent arthroscopic synovectomy and tenosynovectomy for other synovitis and tenosynovitis in the left shoulder under general anesthesia. The joint was accessed using multiple portals, and the inflamed synovium and tenosynovium were excised meticulously. The joint was irrigated thoroughly, and the portals were closed. The patient tolerated the procedure well, and postoperative pain was managed with a patient-controlled analgesia pump.

8. Operative note: Surgical release was performed for other synovitis and tenosynovitis in the right ankle under regional anesthesia. A longitudinal incision was made over the affected tendon sheath, and careful dissection was carried out to release the constricted tendons. The wound was closed with sutures, and a compression bandage was applied. The patient remained comfortable throughout the procedure, and postoperative pain was managed with oral and topical analgesics.

9. Operative note: Patient presented with recalcitrant other synovitis and tenosynovitis in the left index finger. A decision was made to

perform a tendon sheath irrigation under local anesthesia. The sheath was accessed, and a sterile solution was infused to flush out inflammatory debris. The procedure was well-tolerated by the patient, and postoperative pain was minimal.

10. Operative note: Patient underwent ultrasound-guided aspiration and corticosteroid injection for other synovitis and tenosynovitis in the right knee under local anesthesia with intravenous sedation. Under aseptic conditions, the joint was accessed with a needle, and synovial fluid was aspirated. Corticosteroid medication was then injected into the joint space. The patient remained comfortable throughout the procedure, and postoperative pain was managed with a combination of oral and intravenous analgesics.

1. Operative note: Patient presented with severe other synovitis and tenosynovitis in the left wrist, accompanied by bone erosion. Open synovectomy, tenosynovectomy, and bone debridement were performed. The inflamed synovium and tenosynovium were excised, and eroded bone fragments were meticulously removed. Hemostasis was achieved, and the wound was closed in layers. Postoperative imaging confirmed successful removal of the diseased tissues and bone fragments.

2. Operative note: The procedure performed was arthroscopic synovectomy, tenosynovectomy, and bone curettage for other synovitis and tenosynovitis with bone erosion in the right knee. Multiple portals were created, allowing visualization and excision of the inflamed tissues. Bone erosions were carefully curetted, and loose fragments were removed. The joint was irrigated thoroughly, and the portals were closed. Postoperative imaging confirmed resolution of bone erosion.

3. Operative note: Patient underwent joint reconstruction for other synovitis and tenosynovitis with significant bone erosion in the left ankle. Open surgery was performed to address the damaged joint. Synovectomy, tenosynovectomy, and bone grafting were carried out to restore the joint integrity. The joint was stabilized using internal fixation. Postoperative imaging showed improved joint alignment and reduced bone erosion.

4. Operative note: The patient presented with advanced other synovitis and tenosynovitis in the right elbow, causing extensive bone erosion. A comprehensive procedure was performed, including synovectomy, tenosynovectomy, bone debridement, and joint reconstruction. The eroded bone was carefully removed, and the joint was stabilized with hardware. Postoperative imaging confirmed successful restoration of joint architecture and resolution of bone erosion.

5. Operative note: Patient underwent arthroscopic debridement, bone grafting, and joint stabilization for other synovitis and tenosynovitis with bone erosion in the left hip. Arthroscopic techniques were employed to remove inflamed tissues and perform bone grafting. The joint was then stabilized using internal fixation. Postoperative imaging showed improved joint congruity and restoration of bone integrity.

6. Operative note: Open surgery was performed for other synovitis and tenosynovitis with bone erosion in the right thumb. Synovectomy, tenosynovectomy, and bone reconstruction were carried out. The eroded bone was meticulously excised, and bone grafting was performed to restore structural support. The joint was stabilized using a combination of internal fixation and external splinting. Postoperative imaging showed successful bone reconstruction.

7. Operative note: Patient presented with severe other synovitis and tenosynovitis in the left shoulder, leading to extensive bone erosion. Open synovectomy, tenosynovectomy, and bone augmentation were performed. The eroded bone surfaces were carefully debrided, and bone grafts were placed to enhance bone regeneration. The joint was stabilized using specialized hardware. Postoperative imaging confirmed improved joint stability and reduced bone erosion.

8. Operative note: The procedure performed was joint arthrodesis for other synovitis and tenosynovitis with advanced bone erosion in the right ankle. Arthrodesis involved the fusion of affected joint surfaces, eliminating joint motion and relieving pain. The eroded bone was prepared, and internal fixation was used to achieve rigid fusion. Postoperative imaging demonstrated successful joint fusion and resolution of bone erosion.

9. Operative note: Patient underwent arthroscopic synovectomy, tenosynovectomy, and bone grafting for other synovitis and tenosynovitis with bone erosion in the left knee. Arthroscopic

techniques were utilized to remove diseased tissues and perform bone grafting to fill the eroded areas. The joint was stabilized with internal fixation. Postoperative imaging showed improved joint congruity and restoration of bone structure.

10. Operative note: Open surgery was performed for other synovitis and tenosynovitis with significant bone erosion in the right wrist. Synovectomy, tenosynovectomy, and bone reconstruction were carried out. The eroded bone was meticulously excised, and bone grafts were placed to facilitate bone healing. The joint was stabilized using a combination of internal fixation and external bracing. Postoperative imaging demonstrated successful bone reconstruction and reduced bone erosion.

1. Operative note: The patient presented with severe other synovitis and tenosynovitis in the left knee, accompanied by debilitating bone pain. Open synovectomy, tenosynovectomy, and bone debridement were performed to alleviate the pain. The inflamed tissues were excised meticulously, and bone fragments causing pain were removed. Hemostasis was achieved, and the wound was closed. Postoperatively, the patient reported significant relief from bone pain.

2. Operative note: Patient underwent arthroscopic synovectomy, tenosynovectomy, and bone curettage for other synovitis and tenosynovitis with severe bone pain in the right ankle. The procedure aimed to alleviate pain by removing inflamed tissues and addressing the underlying bone pathology. Bone erosions were carefully curetted, and loose fragments causing pain were excised. Postoperatively, the patient experienced a reduction in bone pain.

3. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right elbow, causing excruciating bone pain. A comprehensive procedure was performed, including synovectomy, tenosynovectomy, bone debridement, and joint reconstruction. The procedure aimed to alleviate the severe bone pain and restore joint function. Postoperatively, the patient reported a significant reduction in bone pain and improved overall comfort.

4. Operative note: Patient underwent arthroscopic debridement, bone grafting, and joint stabilization for other synovitis and tenosynovitis with severe bone pain in the left hip. The procedure targeted the relief of severe bone pain by removing inflamed tissues, addressing bone pathology, and stabilizing the joint. Postoperatively, the patient experienced substantial relief from bone pain and improved mobility.

5. Operative note: Open surgery was performed for other synovitis and tenosynovitis with severe bone pain in the right thumb. Synovectomy, tenosynovectomy, and bone reconstruction were carried out to address the underlying cause of bone pain. The inflamed tissues were meticulously excised, and bone grafting was performed to alleviate bone pain and promote healing. Postoperatively, the patient reported a significant reduction in severe bone pain.

6. Operative note: Patient presented with severe other synovitis and tenosynovitis in the left shoulder, causing intense bone pain. Open synovectomy, tenosynovectomy, and bone augmentation were performed to relieve bone pain and improve joint function. The procedure involved meticulous removal of inflamed tissues and addressing the underlying bone pathology. Postoperatively, the patient reported relief from severe bone pain.

7. Operative note: The procedure performed was joint arthrodesis for other synovitis and tenosynovitis with severe bone pain in the right ankle. Arthrodesis aimed to alleviate the severe bone pain by fusing the affected joint surfaces, eliminating joint motion. Postoperatively, the patient reported a significant reduction in bone pain and improved functionality.

8. Operative note: Patient underwent arthroscopic synovectomy, tenosynovectomy, and bone grafting for other synovitis and tenosynovitis with severe bone pain in the left knee. The procedure aimed to alleviate severe bone pain by removing inflamed tissues and addressing the underlying bone pathology. Bone grafts were placed to promote bone healing and reduce pain. Postoperatively, the patient experienced relief from severe bone pain.

9. Operative note: Open surgery was performed for other synovitis and tenosynovitis with severe bone pain in the right wrist. Synovectomy, tenosynovectomy, and bone reconstruction were carried out to address the source of severe bone pain. The procedure involved meticulous excision of inflamed tissues and bone reconstruction to alleviate pain. Postoperatively, the patient reported a significant reduction in severe bone pain.

10. Operative note: Patient underwent joint replacement surgery for other synovitis and tenosynovitis with severe bone pain in the left hip. The procedure aimed to relieve severe bone pain by replacing the affected joint surfaces with a prosthetic implant. Postoperatively, the patient experienced substantial relief from severe bone pain and improved joint function.

1. Operative note: The patient presented with severe other synovitis and tenosynovitis in the left knee, refractory to conservative management. Surgical intervention was deemed necessary, and an arthroscopic synovectomy and tenosynovectomy were performed. The inflamed tissues were meticulously excised, and hemostasis was achieved. The joint was irrigated thoroughly, and the portals were closed. Postoperatively, the patient was instructed to follow a rehabilitation program for optimal recovery.

2. Operative note: Patient underwent open surgical intervention for other synovitis and tenosynovitis with bone erosion in the right wrist. A dorsal incision was made, and extensive synovectomy, tenosynovectomy, and bone debridement were performed. The inflamed tissues and eroded bone fragments were meticulously removed. The wound was closed, and postoperative immobilization was initiated to facilitate healing and recovery.

3. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right ankle, necessitating surgical intervention. Open synovectomy, tenosynovectomy, and joint debridement were performed. The inflamed tissues were excised, and loose fragments were removed. The joint was thoroughly irrigated, and the wound was closed. Postoperatively, the patient was placed on a weight-bearing restriction and referred to physical therapy for rehabilitation.

4. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with bone erosion in the left elbow. An open procedure was performed, including synovectomy, tenosynovectomy, bone debridement, and joint stabilization. The inflamed tissues were meticulously excised, and eroded bone fragments were removed. The joint was stabilized with internal fixation. Postoperatively, the patient was placed in a splint and initiated on a range of motion exercises.

5. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right thumb, unresponsive to conservative measures. Surgical intervention was performed, including open synovectomy, tenosynovectomy, and joint reconstruction. The inflamed tissues were excised, and the joint was reconstructed using tendon grafts. The wound was closed, and a thumb spica splint was applied postoperatively for immobilization.

6. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with severe bone pain in the left shoulder. Open synovectomy, tenosynovectomy, bone debridement, and joint stabilization were performed. The inflamed tissues were meticulously excised, and the eroded bone was addressed. The joint was stabilized using specialized hardware. Postoperatively, the patient was placed in a sling and initiated on gentle range of motion exercises.

7. Operative note: The procedure performed was surgical intervention for other synovitis and tenosynovitis with bone erosion in the right ankle. Open synovectomy, tenosynovectomy, bone grafting, and joint fusion were carried out. The inflamed tissues were excised, and bone grafts were placed to facilitate bone healing. The joint was fused to alleviate pain and stabilize the ankle. Postoperatively, the patient was instructed to avoid weight-bearing and referred to physical therapy for rehabilitation.

8. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with bone erosion in the left knee. An arthroscopic procedure was performed, including synovectomy, tenosynovectomy, bone debridement, and microfracture. The inflamed tissues were meticulously excised, and the eroded bone was addressed. Microfracture was performed to stimulate cartilage

healing. Postoperatively, the patient was placed on crutches and initiated on a rehabilitation program.

9. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right wrist, necessitating surgical intervention. Open synovectomy, tenosynovectomy, and bone reconstruction were performed. The inflamed tissues were excised, and bone grafts were placed to facilitate bone healing and alleviate symptoms. The joint was stabilized using internal fixation. Postoperatively, the patient was placed in a wrist splint and initiated on a controlled range of motion exercises.

10. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with severe bone pain in the left hip. A total hip replacement was performed, including the removal of the diseased joint surfaces and implantation of a prosthetic joint. The joint was meticulously prepared, and the implant was placed. Postoperatively, the patient was placed on weight-bearing restrictions and referred to physical therapy for postoperative rehabilitation.

1. Operative note: The patient presented with persistent other synovitis and tenosynovitis in the left knee, requiring surgical intervention. An arthroscopic procedure was performed, including synovectomy, tenosynovectomy, and chondroplasty. The inflamed tissues were excised, and cartilage defects were addressed. Postoperatively, the patient was advised to undergo a comprehensive rehabilitation program for optimal recovery.

2. Operative note: Patient underwent open surgical intervention for other synovitis and tenosynovitis with bone erosion in the right wrist. A volar incision was made, and extensive synovectomy, tenosynovectomy, and bone grafting were performed. The inflamed tissues and eroded bone fragments were meticulously removed, and bone grafts were placed to promote bone healing. The wound was closed, and postoperative immobilization was initiated.

3. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right ankle, necessitating surgical intervention. Arthroscopic synovectomy, tenosynovectomy, and microfracture were performed. The inflamed tissues were excised, and microfracture was performed to stimulate cartilage repair. Postoperatively, the patient was instructed to follow a rehabilitation program to optimize outcomes.

4. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with bone erosion in the left elbow. An open procedure was performed, including synovectomy, tenosynovectomy, bone debridement, and joint reconstruction. The inflamed tissues were meticulously excised, and eroded bone fragments were removed. The joint was reconstructed using a combination of autografts and allografts. Postoperatively, the patient was immobilized and initiated on a progressive rehabilitation program.

5. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right thumb, unresponsive to conservative measures. Surgical intervention was performed, including arthroscopic synovectomy, tenosynovectomy, and joint debridement. The inflamed tissues were meticulously excised, and loose fragments were removed. Postoperatively, the patient was placed in a thumb spica splint and referred to hand therapy for rehabilitation.

6. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with severe bone pain in the left shoulder. Open synovectomy, tenosynovectomy, bone debridement, and joint resurfacing were performed. The inflamed tissues were excised, and the joint surfaces were resurfaced with articular cartilage grafts. Postoperatively, the patient was placed in a sling and initiated on a structured rehabilitation program.

7. Operative note: The procedure performed was surgical intervention for other synovitis and tenosynovitis with bone erosion in the right ankle. Arthroscopic synovectomy, tenosynovectomy, bone debridement, and ligament repair were carried out. The inflamed tissues were meticulously excised, eroded bone was addressed, and the damaged ligaments were reconstructed. Postoperatively, the patient was placed in a supportive brace and referred to physical therapy for rehabilitation.

8. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with bone erosion in the left knee. An open synovectomy, tenosynovectomy, bone debridement, and osteotomy were performed. The inflamed tissues were meticulously excised, eroded bone was addressed, and an osteotomy was performed to realign the joint. Postoperatively, the patient was placed in a knee immobilizer and initiated on a progressive rehabilitation program.

9. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right wrist, necessitating surgical intervention. Arthroscopic synovectomy, tenosynovectomy, and joint fusion were performed. The inflamed tissues were excised, and the joint surfaces were fused to alleviate symptoms and improve stability. Postoperatively, the patient was placed in a wrist splint and initiated on a controlled range of motion exercises.

10. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with severe bone pain in the left hip. A hip arthroscopy was performed, including synovectomy, tenosynovectomy, and labral repair. The inflamed tissues were meticulously excised, and the torn labrum was repaired. Postoperatively, the patient was placed on weight-bearing restrictions and referred to physical therapy for rehabilitation.

1. Operative note: The patient presented with severe other synovitis and tenosynovitis with a superimposed infection in the right knee joint. Surgical intervention was urgently performed to address the infection. An open arthrotomy was carried out, and extensive debridement of infected tissues was performed. Intraoperative cultures were obtained, and appropriate antibiotics were administered. The joint was thoroughly irrigated, and a drain was placed. Postoperatively, the patient was started on intravenous antibiotics and closely monitored for signs of improvement.

2. Operative note: Patient underwent surgical intervention for severe other synovitis and tenosynovitis with an infected joint in the left ankle. An arthroscopic procedure was performed to address the infection. The joint was thoroughly irrigated with antibiotic solution, and infected tissues were meticulously debrided. Intra-articular antibiotics were administered, and the joint was flushed. Postoperatively, the patient was placed on a course of oral antibiotics and advised to follow up for close monitoring.

3. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right wrist, complicated by an infected joint. Urgent surgical intervention was performed to address the infection. An open procedure was carried out, involving synovectomy, tenosynovectomy, and extensive debridement of infected tissues. Intraoperative cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, the patient was started on intravenous antibiotics and closely monitored for resolution of infection.

4. Operative note: Patient underwent surgical intervention for severe other synovitis and tenosynovitis with an infected joint in the left elbow. An open synovectomy, tenosynovectomy, and joint debridement were performed. Infected tissues were meticulously excised, and the joint was thoroughly irrigated with antibiotic solution. Postoperatively, the patient was placed on a course of intravenous antibiotics and closely monitored for signs of infection resolution.

5. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right thumb, complicated by a deep joint infection. Surgical intervention was urgently performed to address the infection. An open synovectomy, tenosynovectomy, and joint irrigation were performed. The infected tissues were meticulously debrided, and the joint was thoroughly flushed with antibiotic solution. Postoperatively, the patient was started on intravenous antibiotics and closely monitored for response to treatment.

6. Operative note: Patient underwent surgical intervention for severe other synovitis and tenosynovitis with an infected joint in the left shoulder. An arthroscopic procedure was performed to address the infection. The joint was extensively irrigated with antibiotic solution, and infected synovial tissues were meticulously excised. Postoperatively, the patient was started on oral antibiotics and advised to follow up for evaluation of infection control.

7. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right ankle, complicated by an infected joint. Urgent surgical intervention was performed to address the infection. An open procedure was carried out, involving synovectomy, tenosynovectomy, and thorough debridement of infected tissues. The joint was extensively irrigated, and a drain was placed. Postoperatively, the patient was started on intravenous antibiotics and closely monitored for signs of infection resolution.

8. Operative note: Patient underwent surgical intervention for severe other synovitis and tenosynovitis with an infected joint in the left knee. An arthroscopic procedure was performed to address the infection. The joint was irrigated with antibiotic solution, and infected tissues were meticulously debrided. Postoperatively, the patient was started on

a course of oral antibiotics and instructed to follow up for close monitoring.

9. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right wrist, complicated by a deep joint infection. Urgent surgical intervention was performed to address the infection. An open synovectomy, tenosynovectomy, and joint debridement were performed. Infected tissues were meticulously excised, and the joint was thoroughly irrigated with antibiotic solution. Postoperatively, the patient was started on intravenous antibiotics and closely monitored for resolution of infection.

10. Operative note: Patient underwent surgical intervention for severe other synovitis and tenosynovitis with an infected joint in the left elbow. An arthroscopic procedure was performed to address the infection. The joint was extensively irrigated with antibiotic solution, and infected synovial tissues were meticulously excised. Postoperatively, the patient was started on oral antibiotics and advised to follow up for evaluation of infection control.

1. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right knee, characterized by marked inflammation. Arthroscopic intervention was performed, including synovectomy, tenosynovectomy, and intra-articular corticosteroid injection. The inflamed tissues were meticulously excised, and corticosteroids were administered to reduce inflammation. Postoperatively, the patient was advised to undergo physical therapy for comprehensive rehabilitation.

2. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with moderate inflammation in the left wrist. An open synovectomy and tenosynovectomy were performed to alleviate symptoms. The inflamed tissues were excised, and meticulous hemostasis was achieved. Postoperatively, the patient was placed on a splint and prescribed anti-inflammatory medication to manage residual inflammation.

3. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right ankle, accompanied by significant joint inflammation. Open synovectomy, tenosynovectomy, and joint irrigation were performed. The inflamed tissues were excised, and the joint was thoroughly irrigated to reduce inflammation. Postoperatively, the patient was prescribed nonsteroidal anti-inflammatory drugs (NSAIDs) for symptomatic relief.

4. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with mild inflammation in the left elbow. An arthroscopic procedure was performed, including synovectomy, tenosynovectomy, and irrigation. The inflamed tissues were meticulously excised, and the joint was irrigated to minimize inflammation. Postoperatively, the patient was instructed to apply ice and elevate the elbow to further reduce inflammation.

5. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right thumb, exhibiting significant inflammation. Surgical intervention was performed, including arthroscopic synovectomy, tenosynovectomy, and corticosteroid injection. The inflamed tissues were meticulously excised, and corticosteroids were administered to address inflammation. Postoperatively, the patient was prescribed a short course of oral corticosteroids to manage residual inflammation.

6. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with moderate inflammation in the left shoulder. Open synovectomy, tenosynovectomy, and joint debridement were performed. The inflamed tissues were excised, and the joint was thoroughly irrigated to alleviate inflammation. Postoperatively, the patient was prescribed NSAIDs and advised to apply cold compresses for further reduction of inflammation.

7. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right ankle, exhibiting extensive inflammation. Urgent surgical intervention was performed, including open synovectomy, tenosynovectomy, and intra-articular injection of anti-inflammatory medication. The inflamed tissues were excised, and anti-inflammatory medication was administered to address the inflammation. Postoperatively, the patient was prescribed a course of oral corticosteroids to manage residual inflammation.

8. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with mild inflammation in the left knee. An arthroscopic procedure was performed, including synovectomy, tenosynovectomy, and joint irrigation. The inflamed tissues were meticulously excised, and the joint was irrigated to reduce inflammation. Postoperatively, the patient was instructed to take NSAIDs and apply topical anti-inflammatory gels for symptomatic relief.

9. Operative note: The patient presented with severe other synovitis and tenosynovitis in the right

wrist, accompanied by marked joint inflammation. Open synovectomy, tenosynovectomy, and joint lavage were performed. The inflamed tissues were excised, and the joint was thoroughly irrigated to address inflammation. Postoperatively, the patient was placed on a short course of oral corticosteroids and advised to rest and elevate the wrist to minimize inflammation.

10. Operative note: Patient underwent surgical intervention for other synovitis and tenosynovitis with moderate inflammation in the left elbow. An arthroscopic procedure was performed, including synovectomy, tenosynovectomy, and intra-articular injection of anti-inflammatory medication. The inflamed tissues were meticulously excised, and anti-inflammatory medication was administered to alleviate inflammation. Postoperatively, the patient was prescribed NSAIDs and instructed to apply ice packs for further reduction of inflammation.

## M65.9 Synovitis and tenosynovitis, unspecified

1. Operative Note: Patient presented with synovitis in the left knee. Arthroscopic debridement and synovectomy were performed. Intraoperative findings revealed inflamed synovial tissue with no evidence of cartilage damage. Hemostasis was achieved, and the incisions were closed. Patient tolerated the procedure well and was transferred to the recovery room in stable condition.

2. Operative Note: Tenosynovitis was noted in the right wrist extensor tendons. A dorsal incision was made, and the extensor retinaculum was released. The affected tendons were visualized and found to be thickened and inflamed. Tenosynovectomy was performed, and the tendon sheaths were irrigated with saline. Closure was done in layers. The patient had an uneventful postoperative course.

3. Operative Note: Synovitis of the left ankle was diagnosed. Arthroscopic examination revealed hypertrophic synovial tissue with signs of inflammation. A thorough synovectomy was performed, targeting all affected areas. The joint was flushed with sterile saline. Hemostasis was achieved, and the wounds were closed. The patient was discharged with instructions for rehabilitation and follow-up.

4. Operative Note: Tenosynovitis involving the flexor tendons of the right hand was observed. A volar incision was made, and the flexor sheath was exposed. The sheath was opened longitudinally, and the inflamed synovium was excised. The tendons were inspected for any adhesions and released accordingly. Closure was performed meticulously. The patient experienced immediate relief of symptoms postoperatively.

5. Operative Note: Bilateral knee synovitis was evident in the patient. Bilateral arthroscopic synovectomy was performed sequentially. Intraoperative findings revealed inflamed synovial tissue with areas of hyperemia and hypertrophy. Complete synovial removal was achieved, and thorough irrigation was performed. The patient was provided with postoperative care instructions and scheduled for follow-up evaluation.

6. Operative Note: Tenosynovitis involving the right thumb extensor tendon was confirmed. A radial dorsal incision was made, exposing the affected tendon. The tendon sheath was opened, revealing inflamed synovium. Tenosynovectomy was performed meticulously, ensuring complete removal of the inflamed tissue. The extensor retinaculum was repaired, and the wound was closed. The patient's symptoms improved significantly after the procedure.

7. Operative Note: Synovitis was noted in the right hip joint during arthroscopic examination. The synovium appeared hypertrophic and inflamed. A thorough synovectomy was performed using a combination of shaving and thermal ablation techniques. The joint was thoroughly irrigated with saline. The patient tolerated the procedure well and was advised on postoperative rehabilitation exercises.

8. Operative Note: Tenosynovitis involving the left index finger flexor tendons was confirmed intraoperatively. A volar zigzag incision was made, exposing the affected tendon sheath. The sheath was opened, and the inflamed synovium was excised meticulously. Adhesions were released, and the wound was closed in layers. The patient reported immediate improvement in finger mobility and pain relief.

9. Operative Note: Synovitis of the right elbow joint was diagnosed. Arthroscopic examination revealed synovial hypertrophy and inflammatory changes. A complete synovectomy was performed, addressing all affected areas. The joint was lavaged with saline, and hemostasis was achieved. The patient was placed in a splint and provided with instructions for gentle range-of-motion exercises.

10. Operative Note: Tenosynovitis involving the left ankle tendons was confirmed intraoperatively. A medial incision was made, and the tendon sheaths were exposed. The sheaths were opened, and the inflamed synovium was meticulously excised. Adhesions were released, and the incision was closed. The patient experienced resolution of pain and improved ankle function in the postoperative period.

1. Operative Note: Synovitis of the right shoulder joint was identified intraoperatively. Arthroscopic synovectomy was performed, removing hypertrophic synovial tissue. The joint was irrigated and examined for any additional pathology, with none noted. The incisions were closed, and the patient was started on a rehabilitation program. Follow-up appointment scheduled in two weeks.

2. Operative Note: Tenosynovitis involving the left thumb flexor tendons was confirmed. A volar approach was used, and the tendon sheath was exposed. The sheath was opened longitudinally, revealing inflamed synovium. Tenosynovectomy was performed, excising the synovial tissue and releasing any adhesions. Wound closure was done meticulously, and the patient reported decreased pain postoperatively.

3. Operative Note: Synovitis was observed in the left temporomandibular joint. An arthrocentesis procedure was performed, followed by injection of corticosteroids into the joint space. The patient was instructed to avoid excessive jaw movements and maintain a soft diet. Postoperative instructions included pain management and follow-up evaluation in four weeks.

4. Operative Note: Tenosynovitis involving the right wrist flexor tendons was diagnosed. A volar incision was made, exposing the affected tendon sheath. The sheath was opened, revealing inflamed synovium. Tenosynovectomy was performed, ensuring complete removal of the synovial tissue. The tendons were inspected and released if necessary. Closure was performed meticulously, and the patient had improved range of motion immediately after the procedure.

5. Operative Note: Synovitis of the left hip joint was identified during arthroscopic examination. Hypertrophic and inflamed synovial tissue was visualized and thoroughly excised. The joint was lavaged and inspected for any additional pathology. Hemostasis was achieved, and the incisions were closed. The patient was advised on postoperative weight-bearing restrictions and referred for physical therapy.

6. Operative Note: Tenosynovitis involving the right ankle extensor tendons was confirmed. A dorsal incision was made, exposing the affected tendon sheath. The sheath was opened, and inflamed synovium was excised meticulously. Adhesions were released, and the wound was closed in layers. The patient experienced improved ankle mobility and decreased pain after the procedure.

7. Operative Note: Synovitis was noted in the right temporomandibular joint. Arthroscopic synovectomy was performed, removing hypertrophic synovial tissue. The joint was irrigated with saline, and the incisions were closed. The patient was advised to continue with conservative management and follow-up evaluation was scheduled in six weeks.

8. Operative Note: Tenosynovitis involving the left elbow flexor tendons was confirmed. A medial incision was made, exposing the affected tendon sheath. The sheath was opened, and inflamed synovium was meticulously excised. Any adhesions were released, and the wound was closed in layers. The patient reported decreased pain and improved elbow function postoperatively.

9. Operative Note: Synovitis was observed in the bilateral knee joints. Bilateral arthroscopic synovectomy was performed. The hypertrophic synovial tissue was meticulously excised, and the joints were lavaged with saline. Hemostasis was achieved, and the incisions were closed. The patient was started on a rehabilitation program to regain knee strength and mobility.

10. Operative Note: Tenosynovitis involving the right shoulder extensor tend

ons was diagnosed. A posterior approach was used, exposing the affected tendon sheath. The sheath was opened, revealing inflamed synovium. Tenosynovectomy was performed, excising the synovial tissue and releasing any adhesions. The wound was closed meticulously, and the patient had improved shoulder function and decreased pain postoperatively.

1. Operative Note: Patient presented with synovitis in the left knee. Under general anesthesia, arthroscopic debridement and synovectomy were performed. Intraoperative findings revealed inflamed synovial tissue with no evidence of cartilage damage. Hemostasis was achieved, and the incisions were closed. The patient tolerated the procedure well with a moderate dosage of anesthesia.

2. Operative Note: Tenosynovitis was noted in the right wrist extensor tendons. The patient received regional anesthesia with a peripheral nerve block. A dorsal incision was made, and the extensor retinaculum was released. The affected tendons were visualized and found to be thickened and inflamed. Tenosynovectomy was performed, and the tendon sheaths were irrigated with saline. Closure was done in layers, and the patient had an uneventful postoperative course.

3. Operative Note: Synovitis of the left ankle was diagnosed. The patient underwent local anesthesia with conscious sedation. Arthroscopic examination revealed hypertrophic synovial tissue with signs of inflammation. A thorough synovectomy was performed, targeting all affected areas. The joint was flushed with sterile saline. Hemostasis was achieved, and the wounds were closed. The patient was discharged with instructions for rehabilitation and follow-up.

4. Operative Note: Tenosynovitis involving the flexor tendons of the right hand was observed. The patient received a combination of local anesthesia and intravenous sedation. A volar incision was made, and the flexor sheath was exposed. The sheath was opened longitudinally, and the inflamed synovium was excised. The tendons were inspected for any adhesions and released accordingly. Closure was performed meticulously, and the patient experienced immediate relief of symptoms postoperatively.

5. Operative Note: Bilateral knee synovitis was evident in the patient. Under general anesthesia, bilateral arthroscopic synovectomy was performed sequentially. Intraoperative findings revealed inflamed synovial tissue with areas of hyperemia and hypertrophy. Complete synovial removal was achieved, and thorough irrigation was performed. The patient was provided with postoperative care instructions and scheduled for follow-up evaluation.

6. Operative Note: Tenosynovitis involving the left thumb flexor tendons was confirmed. The patient received regional anesthesia with a digital nerve block. A volar approach was used, and the tendon sheath was exposed. The sheath was opened, revealing inflamed synovium. Tenosynovectomy was performed, excising the synovial tissue and releasing any adhesions. Wound closure was done meticulously, and the patient reported decreased pain postoperatively.

7. Operative Note: Synovitis was noted in the right hip joint during arthroscopic examination. The patient underwent general anesthesia with a laryngeal mask airway. The synovium appeared hypertrophic and inflamed. A complete synovectomy was performed, using a combination of shaving and thermal ablation techniques. The joint was thoroughly irrigated with saline. The patient tolerated the procedure well and was advised on postoperative rehabilitation exercises.

8. Operative Note: Tenosynovitis involving the left index finger flexor tendons was confirmed intraoperatively. The patient received local anesthesia with monitored anesthesia care. A volar zigzag incision was made, exposing the affected tendon sheath. The sheath was opened, and the inflamed synovium was excised meticulously. Adhesions were released, and the wound was closed in layers. The patient reported immediate

improvement in finger mobility and pain relief.

9. Operative Note: Synovitis of the right elbow joint was diagnosed. Under regional anesthesia with an axillary nerve block, arthroscopic examination revealed synovial hypertrophy and inflammatory changes. A complete synovectomy was performed, addressing all affected areas. The joint was lavaged with saline, and hemostasis was achieved. The patient was placed in a splint and provided with instructions for gentle range-of-motion exercises.

10. Operative Note: Tenosynovitis involving the left ankle tendons was confirmed. The patient received general anesthesia with endotracheal intubation. A medial incision was made, exposing the affected tendon sheath. The sheath was opened, and inflamed synovium was meticulously excised. Adhesions were released, and the wound was closed in layers. The patient experienced resolution of pain and improved ankle function postoperatively.

1. Operative Note: Patient presented with synovitis in the right knee with evidence of bone erosion. Under general anesthesia, arthroscopic debridement, synovectomy, and bone microfracture were performed. Intraoperative findings revealed inflamed synovial tissue and localized areas of bone erosion. Hemostasis was achieved, and the incisions were closed. The patient tolerated the procedure well, and postoperative imaging confirmed successful bone healing.

2. Operative Note: Tenosynovitis was noted in the left wrist extensor tendons with associated bone erosion. The patient received regional anesthesia with a brachial plexus block. A dorsal incision was made, and the extensor retinaculum was released. The affected tendons were visualized, and tenosynovectomy was performed. Careful debridement of the eroded bone was carried out. Closure was done in layers, and the patient had an uneventful postoperative course.

3. Operative Note: Synovitis of the right ankle with evidence of bone erosion was diagnosed. The patient underwent general anesthesia with endotracheal intubation. Arthroscopic examination revealed hypertrophic synovial tissue, diffuse joint inflammation, and localized bone erosion. A comprehensive synovectomy was performed, addressing all affected areas. The joint was lavaged, and bone debridement was carried out. The patient was discharged with instructions for rehabilitation and scheduled for follow-up evaluation.

4. Operative Note: Tenosynovitis involving the flexor tendons of the right hand with associated bone erosion was observed. The patient received local anesthesia with intravenous sedation. A volar incision was made, and the flexor sheath was exposed. The sheath was opened, and inflamed synovium and eroded bone were meticulously excised. Tendon adhesions were released, and the wound was closed. The patient experienced significant improvement in hand function postoperatively.

5. Operative Note: Bilateral knee synovitis with evidence of bone erosion was evident in the patient. Under general anesthesia, bilateral arthroscopic synovectomy and bone grafting were performed sequentially. Intraoperative findings revealed inflamed synovial tissue, diffuse joint inflammation, and areas of bone erosion. Complete synovial removal and bone grafting were achieved. The patient was provided with postoperative care instructions and scheduled for follow-up evaluation.

6. Operative Note: Tenosynovitis involving the left thumb flexor tendons with bone erosion was confirmed. The patient received regional anesthesia with a digital nerve block. A volar approach was used, and the tendon sheath was exposed. The sheath was opened, revealing inflamed synovium and eroded bone. Tenosynovectomy, bone debridement, and repair were performed. Wound closure was done meticulously, and the patient reported decreased pain and improved thumb function postoperatively.

7. Operative Note: Synovitis was noted in the right hip joint with evidence of bone erosion. The patient underwent general anesthesia with a laryngeal mask airway. The synovium appeared hypertrophic and inflamed, with localized bone erosion. A complete synovectomy, bone debridement, and microfracture were performed. The joint was thoroughly irrigated, and the patient tolerated the procedure well. Postoperative imaging revealed satisfactory bone healing.

8. Operative Note: Tenosynovitis involving the left index finger flexor tendons with associated bone erosion was confirmed intraoperatively. The patient received local anesthesia with monitored anesthesia care. A volar

zigzag incision was made, exposing the affected tendon sheath. The sheath was opened, and the inflamed synovium, along with eroded bone, was excised meticulously. Adhesions were released, and the wound was closed in layers. The patient reported immediate improvement in finger mobility and pain relief.

9. Operative Note: Synovitis of the right elbow joint with evidence of bone erosion was diagnosed. Under regional anesthesia with an axillary nerve block, arthroscopic examination revealed synovial hypertrophy, diffuse inflammation, and localized bone erosion. A complete synovectomy, bone debridement, and osteochondral grafting were performed. The joint was lavaged, and the patient tolerated the procedure well. Postoperative rehabilitation was initiated for optimal joint function.

10. Operative Note: Tenosynovitis involving the left ankle tendons with associated bone erosion was confirmed. The patient received general anesthesia with endotracheal intubation. A medial incision was made, exposing the affected tendon sheath. The sheath was opened, and inflamed synovium, along with eroded bone, was meticulously excised. Adhesions were released, and the wound was closed in layers. The patient experienced resolution of pain, improved ankle function, and postoperative imaging showed signs of bone regeneration.

1. Operative Note: Patient presented with severe bone pain due to synovitis in the right knee. Under general anesthesia, open synovectomy was performed. Intraoperative findings revealed extensive synovial hypertrophy, joint inflammation, and severe bone erosion. Complete synovial removal was achieved, and bone grafting was performed to address the affected areas. The patient tolerated the procedure well, and postoperative pain management was initiated.

2. Operative Note: Tenosynovitis was noted in the left wrist extensor tendons with severe bone pain. The patient received regional anesthesia with an upper extremity nerve block. A dorsal incision was made, and the extensor retinaculum was released. The affected tendons were visualized, and tenosynovectomy was performed. Careful debridement of the eroded bone was carried out. Closure was done meticulously, and the patient had an uneventful postoperative course with improved pain control.

3. Operative Note: Severe bone pain was observed in the right ankle joint with synovitis. The patient underwent general anesthesia with endotracheal intubation. Arthroscopic examination revealed extensive synovial hypertrophy, diffuse inflammation, and severe bone erosion. A comprehensive synovectomy was performed, addressing all affected areas. Bone debridement and stabilization were carried out to alleviate pain and improve joint function. The patient was discharged with postoperative pain management instructions.

4. Operative Note: Tenosynovitis involving the flexor tendons of the right hand was confirmed with severe bone pain. The patient received local anesthesia with intravenous sedation. A volar incision was made, and the flexor sheath was exposed. The sheath was opened, and inflamed synovium and eroded bone were meticulously excised. Tendon adhesions were released, and the wound was closed. The patient reported significant reduction in bone pain and improved hand function postoperatively.

5. Operative Note: Severe bone pain due to bilateral knee synovitis was evident in the patient. Under general anesthesia, bilateral arthroscopic synovectomy and bone microfracture were performed sequentially. Intraoperative findings revealed extensive synovial hypertrophy, diffuse joint inflammation, and severe bone erosion. Complete synovial removal and bone microfracture were achieved. The patient was provided with postoperative pain management and scheduled for follow-up evaluation.

6. Operative Note: Tenosynovitis involving the left thumb flexor tendons with severe bone pain was confirmed. The patient received regional anesthesia with a digital nerve block. A volar approach was used, and the tendon sheath was exposed. The sheath was opened, revealing inflamed synovium and eroded bone. Tenosynovectomy, bone debridement, and repair were performed. Wound closure was done meticulously, and the patient reported significant relief from severe bone pain postoperatively.

7. Operative Note: Severe bone pain was noted in the right hip joint during arthroscopic examination, indicating advanced synovitis. The patient underwent general anesthesia with a laryngeal mask airway. The synovium appeared hypertrophic and inflamed, with extensive bone erosion. A complete synovectomy, bone debridement, and joint stabilization were performed. The patient tolerated the procedure well, and postoperative pain control was optimized.

8. Operative Note: Tenosynovitis involving the left index finger flexor tendons was confirmed intraoperatively, causing severe bone pain. The patient received local anesthesia with monitored anesthesia care. A volar zigzag

incision was made, exposing the affected tendon sheath. The sheath was opened, and the inflamed synovium, along with eroded bone, was meticulously excised. Adhesions were released, and the wound was closed in layers. The patient experienced immediate relief from severe bone pain and improved finger mobility.

9. Operative Note: Severe bone pain due to synovitis was diagnosed in the right elbow joint. Under regional anesthesia with an axillary nerve block, arthroscopic examination revealed synovial hypertrophy, diffuse inflammation, and severe bone erosion. A complete synovectomy, bone debridement, and osteochondral grafting were performed to alleviate pain and restore joint integrity. The patient tolerated the procedure well, and postoperative pain management was initiated.

10. Operative Note: Tenosynovitis involving the left ankle tendons with severe bone pain was confirmed. The patient received general anesthesia with endotracheal intubation. A medial incision was made, exposing the affected tendon sheath. The sheath was opened, and inflamed synovium, along with eroded bone, was meticulously excised. Adhesions were released, and the wound was closed in layers. The patient experienced significant relief from severe bone pain and improved ankle function postoperatively.

1. Operative Note: Patient presented with synovitis in the right knee requiring surgical intervention. Under general anesthesia, open synovectomy was performed. Intraoperative findings revealed inflamed synovial tissue and evidence of synovial hypertrophy. Complete synovial removal was achieved, and thorough irrigation was performed. The patient tolerated the procedure well and was advised on postoperative care and follow-up evaluation.

2. Operative Note: Surgical intervention was necessary for tenosynovitis involving the left wrist extensor tendons. The patient received regional anesthesia with a brachial plexus block. A dorsal incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, excising the inflamed synovial tissue and addressing any tendon adhesions. Closure was done meticulously, and the patient was provided with postoperative instructions and scheduled for a follow-up visit.

3. Operative Note: Synovitis of the right ankle required surgical intervention. The patient underwent general anesthesia with endotracheal intubation. Arthroscopic examination revealed hypertrophic synovial tissue and signs of inflammation. A thorough synovectomy was performed, targeting all affected areas. The joint was lavaged, and any loose bodies were removed. The patient tolerated the procedure well and was started on a rehabilitation program.

4. Operative Note: Surgical intervention was indicated for tenosynovitis involving the flexor tendons of the right hand. The patient received local anesthesia with intravenous sedation. A volar incision was made, and the flexor sheath was exposed. The sheath was opened, and the inflamed synovium was meticulously excised. Adhesions were released, and the wound was closed in layers. The patient reported improved hand function and decreased pain postoperatively.

5. Operative Note: Bilateral knee synovitis necessitated surgical intervention. Under general anesthesia, bilateral arthroscopic synovectomy was performed sequentially. Intraoperative findings revealed inflamed synovial tissue with areas of hypertrophy. Complete synovial removal was achieved, and the joints were thoroughly irrigated. The patient was provided with postoperative care instructions and scheduled for a follow-up evaluation.

6. Operative Note: Surgical intervention was required for tenosynovitis involving the left thumb flexor tendons. The patient received regional anesthesia with a digital nerve block. A volar approach was used, and the tendon sheath was exposed. The sheath was opened, revealing inflamed synovium. Tenosynovectomy was performed, excising the synovial tissue and releasing any adhesions. The wound was closed meticulously, and the patient reported improved thumb function postoperatively.

7. Operative Note: Synovitis was diagnosed in the right hip joint necessitating surgical intervention. The patient underwent general anesthesia with a laryngeal mask airway. A surgical approach was made, exposing the joint capsule. The hypertrophic synovium was excised thoroughly, and the joint was lavaged. Any loose bodies were removed. The patient tolerated the procedure well and was provided with postoperative instructions and pain management.

8. Operative Note: Surgical intervention was necessary for tenosynovitis involving the left index finger flexor tendons. The patient received local anesthesia with monitored anesthesia care. A volar zigzag incision was made, exposing the affected tendon sheath. The sheath was opened, and the inflamed synovium was excised meticulously. Adhesions were released, and the wound was closed in layers. The patient reported improved finger mobility and decreased pain postoperatively.

9. Operative Note: Synovitis of the right elbow joint required surgical intervention. Under regional anesthesia with an axillary nerve block, arthroscopic examination revealed hypertrophic synovial tissue. A comprehensive synovectomy was performed, addressing all affected areas. The joint was thoroughly irrigated, and any loose bodies were removed. The patient tolerated the procedure well and was instructed on postoperative care and follow-up evaluation.

10. Operative Note: Surgical intervention was indicated for tenosynovitis involving the left ankle tendons. The patient received general anesthesia with endotracheal intubation. A surgical incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, excising the inflamed synovial tissue. Adhesions were released, and the wound was closed meticulously. The patient experienced resolution of pain and improved ankle function postoperatively.

1. Operative Note: Surgical intervention was performed for synovitis in the right knee joint. Under general anesthesia, an arthroscopic synovectomy was carried out. Intraoperative findings revealed extensive synovial hypertrophy and inflammation. Complete synovial removal was achieved, and the joint was irrigated thoroughly. The patient tolerated the procedure well and was prescribed postoperative rehabilitation for optimal recovery.

2. Operative Note: Tenosynovitis involving the left wrist extensor tendons necessitated surgical intervention. The patient received regional anesthesia with a peripheral nerve block. A dorsal incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, excising the inflamed synovium and addressing any adhesions. The wound was closed meticulously, and the patient was advised on postoperative care and scheduled for follow-up evaluation.

3. Operative Note: Surgical intervention was required for synovitis in the right ankle joint. The patient underwent general anesthesia with endotracheal intubation. An open synovectomy was performed, removing the hypertrophic synovial tissue. The joint was thoroughly irrigated, and any loose bodies were excised. The patient tolerated the procedure well and was started on a rehabilitation program for optimal recovery.

4. Operative Note: Tenosynovitis involving the flexor tendons of the right hand necessitated surgical intervention. The patient received local anesthesia with intravenous sedation. A volar incision was made, exposing the flexor sheath. Tenosynovectomy was performed, excising the inflamed synovium and releasing adhesions. The wound was closed meticulously, and the patient reported improved hand function and decreased pain postoperatively.

5. Operative Note: Surgical intervention was performed for bilateral knee synovitis. Under general anesthesia, bilateral arthroscopic synovectomy was carried out sequentially. Intraoperative examination revealed synovial hypertrophy and inflammation. Complete synovial removal was achieved, and the joints were thoroughly irrigated. The patient received postoperative instructions and was scheduled for a follow-up visit.

6. Operative Note: Tenosynovitis involving the left thumb flexor tendons necessitated surgical intervention. The patient received regional anesthesia with a digital nerve block. A volar approach was used, exposing the affected tendon sheath. Tenosynovectomy was performed, excising the inflamed synovium and addressing adhesions. The wound was closed meticulously, and the patient reported improved thumb function postoperatively.

7. Operative Note: Surgical intervention was required for synovitis in the right hip joint. The patient underwent general anesthesia with a laryngeal mask airway. A surgical approach was made, exposing the joint capsule. The hypertrophic synovium was excised thoroughly, and the joint was irrigated. Any loose bodies were removed. The patient tolerated the procedure well and was provided with postoperative instructions and pain management.

8. Operative Note: Tenosynovitis involving the left index finger flexor tendons necessitated surgical intervention. The patient received local anesthesia with monitored anesthesia care. A volar zigzag incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, excising the inflamed synovium and releasing adhesions. The wound was closed in layers, and the patient reported improved finger mobility and decreased pain postoperatively.

9. Operative Note: Surgical intervention was indicated for synovitis in the right elbow joint. Under regional anesthesia with an axillary nerve block, arthroscopic examination revealed synovial hypertrophy and

inflammation. A comprehensive synovectomy was performed, addressing all affected areas. The joint was thoroughly irrigated, and any loose bodies were removed. The patient tolerated the procedure well and was instructed on postoperative care and follow-up evaluation.

10. Operative Note: Tenosynovitis involving the left ankle tendons required surgical intervention. The patient received general anesthesia with endotracheal intubation. A surgical incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, excising the inflamed synovium and addressing adhesions. The wound was closed meticulously, and the patient experienced resolution of pain and improved ankle function postoperatively.

1. Operative Note: Severe infection with synovitis was observed in the right knee joint. The patient underwent urgent surgical intervention under general anesthesia. An open synovectomy was performed, and extensive debridement of infected tissues was carried out. The joint was thoroughly irrigated with antibiotic solution. Closure was done meticulously, and the patient was initiated on intravenous antibiotics postoperatively.

2. Operative Note: Surgical intervention was necessary for tenosynovitis with severe infection involving the flexor tendons of the right hand. The patient received regional anesthesia with a brachial plexus block. A volar incision was made, and the infected tendon sheath was exposed. Tenosynovectomy and extensive debridement were performed, followed by thorough irrigation with antibiotic solution. The wound was closed meticulously, and intravenous antibiotics were initiated postoperatively.

3. Operative Note: Severe infection and synovitis were noted in the right ankle joint requiring urgent surgical intervention. The patient underwent general anesthesia with endotracheal intubation. An open synovectomy and thorough debridement were performed, addressing the infected tissues and removing any necrotic material. The joint was lavaged with antibiotic solution, and wound closure was done meticulously. Intravenous antibiotics were started immediately postoperatively.

4. Operative Note: Surgical intervention was necessary for tenosynovitis with severe infection involving the left wrist extensor tendons. The patient received regional anesthesia with a peripheral nerve block. A dorsal incision was made, and the infected tendon sheath was exposed. Tenosynovectomy and extensive debridement were performed, followed by thorough irrigation with antibiotic solution. The wound was closed meticulously, and intravenous antibiotics were initiated postoperatively.

5. Operative Note: Severe infection with synovitis was observed in the right hip joint requiring urgent surgical intervention. The patient underwent general anesthesia with a laryngeal mask airway. An open synovectomy and thorough debridement were performed, addressing the infected synovial tissue and eradicating any necrotic material. The joint was lavaged with antibiotic solution, and wound closure was done meticulously. Intravenous antibiotics were started immediately postoperatively.

6. Operative Note: Surgical intervention was necessary for tenosynovitis with severe infection involving the left thumb flexor tendons. The patient received regional anesthesia with a digital nerve block. A volar approach was used, and the infected tendon sheath was exposed. Tenosynovectomy and extensive debridement were performed, followed by thorough irrigation with antibiotic solution. The wound was closed meticulously, and intravenous antibiotics were initiated postoperatively.

7. Operative Note: Severe infection with synovitis was observed in the right elbow joint requiring urgent surgical intervention. The patient underwent general anesthesia with a laryngeal mask airway. An open synovectomy and thorough debridement were performed, addressing the infected synovium and removing any necrotic tissue. The joint was lavaged with antibiotic solution, and wound closure was done meticulously. Intravenous antibiotics were started immediately postoperatively.

8. Operative Note: Surgical intervention was necessary for tenosynovitis with severe infection involving the left index finger flexor tendons. The patient received local anesthesia with monitored anesthesia care. A volar zigzag incision was made, and the infected tendon sheath was exposed. Tenosynovectomy and extensive debridement were performed, followed by thorough irrigation with antibiotic solution. The wound was closed in layers, and intravenous antibiotics were initiated postoperatively

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9. Operative Note: Severe infection with synovitis was observed in the right knee joint necessitating urgent surgical intervention. The patient underwent general anesthesia, and an arthroscopic approach was utilized. Arthroscopic synovectomy and extensive debridement were performed, addressing the infected synovial tissue and removing any necrotic material. The joint was irrigated with antibiotic solution, and postoperatively, intravenous antibiotics were initiated.

10. Operative Note: Surgical intervention was necessary for tenosynovitis with severe infection involving the left ankle tendons. The patient received regional anesthesia with a nerve block. A surgical incision was made, and the infected tendon sheath was exposed. Tenosynovectomy and extensive debridement were performed, followed by thorough irrigation with antibiotic solution. The wound was closed meticulously, and intravenous antibiotics were initiated postoperatively.

1. Operative Note: Surgical intervention was performed for severe synovitis in the right knee joint. Under general anesthesia, an arthroscopic synovectomy was carried out. Intraoperative findings revealed marked synovial hypertrophy and intense inflammation. Complete synovial removal was achieved, and the joint was thoroughly irrigated. The patient tolerated the procedure well and was advised on postoperative care and follow-up evaluation.

2. Operative Note: Tenosynovitis involving the left wrist extensor tendons necessitated surgical intervention. The patient received regional anesthesia with a peripheral nerve block. A dorsal incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and associated adhesions. The wound was closed meticulously, and the patient was provided with postoperative care instructions and scheduled for follow-up evaluation.

3. Operative Note: Surgical intervention was required for severe synovitis in the right ankle joint. The patient underwent general anesthesia with endotracheal intubation. An open synovectomy was performed, removing the hypertrophic and inflamed synovial tissue. The joint was thoroughly irrigated, and any loose bodies were excised. The patient tolerated the procedure well and was started on a rehabilitation program for optimal recovery.

4. Operative Note: Tenosynovitis involving the flexor tendons of the right hand necessitated surgical intervention. The patient received local anesthesia with intravenous sedation. A volar incision was made, exposing the flexor sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. The wound was closed meticulously, and the patient reported improved hand function and decreased pain postoperatively.

5. Operative Note: Surgical intervention was performed for synovitis in the bilateral knee joints. Under general anesthesia, bilateral arthroscopic synovectomy was carried out sequentially. Intraoperative examination revealed varying degrees of synovial hypertrophy and inflammation. Complete synovial removal was achieved, and the joints were thoroughly irrigated. The patient received postoperative instructions and was scheduled for a follow-up visit.

6. Operative Note: Tenosynovitis involving the left thumb flexor tendons necessitated surgical intervention. The patient received regional anesthesia with a digital nerve block. A volar approach was used, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. The wound was closed meticulously, and the patient reported improved thumb function postoperatively.

7. Operative Note: Surgical intervention was required for severe synovitis in the right hip joint. The patient underwent general anesthesia with a laryngeal mask airway. A surgical approach was made, exposing the joint capsule. The hypertrophic and inflamed synovium was excised thoroughly, and the joint was irrigated. Any loose bodies were removed. The patient tolerated the procedure well and was provided with postoperative instructions and pain management.

8. Operative Note: Tenosynovitis involving the left index finger flexor tendons necessitated surgical intervention. The patient received local anesthesia with monitored anesthesia care. A volar zigzag incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. The wound was closed in layers, and the patient reported improved finger mobility and decreased pain postoperatively.

9. Operative Note: Surgical intervention was indicated for severe synovitis in the right elbow joint. Under regional anesthesia with an ax

illary nerve block, arthroscopic examination revealed varying degrees of synovial hypertrophy and inflammation. A comprehensive synovectomy was performed, addressing all affected areas. The joint was thoroughly irrigated, and any loose bodies were removed. The patient tolerated the procedure well and was instructed on postoperative care and follow-up evaluation.

10. Operative Note: Tenosynovitis involving the left ankle tendons required surgical intervention. The patient received general anesthesia with endotracheal intubation. A surgical incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. The wound was closed meticulously, and the patient experienced resolution of pain and improved ankle function postoperatively.

1. Operative Note: Surgical intervention was performed for severe synovitis in the right knee joint. Under general anesthesia, an arthroscopic synovectomy was carried out. Intraoperative findings revealed extensive synovial hypertrophy and inflammation. Complete synovial removal was achieved, and the joint was thoroughly irrigated. Due to the severity of the diagnosis, the patient was scheduled for frequent postoperative follow-ups to monitor the response to treatment and ensure optimal recovery.

2. Operative Note: Tenosynovitis involving the left wrist extensor tendons necessitated surgical intervention. The patient received regional anesthesia with a peripheral nerve block. A dorsal incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and associated adhesions. Given the moderate severity of the diagnosis, the patient was advised on a structured rehabilitation program and scheduled for regular follow-up visits to assess progress and adjust treatment if needed.

3. Operative Note: Surgical intervention was required for mild synovitis in the right ankle joint. The patient underwent general anesthesia with endotracheal intubation. An open synovectomy was performed, removing the hypertrophic synovial tissue. The joint was thoroughly irrigated, and any loose bodies were excised. Considering the relatively mild severity of the diagnosis, the patient was provided with postoperative instructions and scheduled for a follow-up evaluation in a few weeks to assess the response to treatment.

4. Operative Note: Tenosynovitis involving the flexor tendons of the right hand necessitated surgical intervention. The patient received local anesthesia with intravenous sedation. A volar incision was made, exposing the flexor sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. Given the moderate severity of the diagnosis, the patient was prescribed a tailored hand therapy program and scheduled for periodic follow-up visits to monitor progress and adjust treatment as required.

5. Operative Note: Surgical intervention was performed for severe synovitis in the bilateral knee joints. Under general anesthesia, bilateral arthroscopic synovectomy was carried out sequentially. Intraoperative examination revealed extensive synovial hypertrophy and inflammation. Complete synovial removal was achieved, and the joints were thoroughly irrigated. Due to the severe severity of the diagnosis, the patient was scheduled for frequent postoperative follow-ups to monitor the response to treatment, manage pain, and ensure optimal recovery.

6. Operative Note: Tenosynovitis involving the left thumb flexor tendons necessitated surgical intervention. The patient received regional anesthesia with a digital nerve block. A volar approach was used, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. Based on the mild severity of the diagnosis, the patient was instructed on home care measures and scheduled for a follow-up evaluation in a few weeks to assess the need for further intervention.

7. Operative Note: Surgical intervention was required for moderate synovitis in the right hip joint. The patient underwent general anesthesia with a laryngeal mask airway. An open synovectomy and thorough debridement were performed, addressing the inflamed synovium and removing any necrotic tissue. The joint was lavaged, and wound closure was done meticulously. Considering the moderate severity of the diagnosis, the patient was prescribed a structured rehabilitation program and scheduled for periodic follow-up visits to assess progress and adjust treatment as necessary.

8. Operative Note: Tenosynovitis involving

the left index finger flexor tendons necessitated surgical intervention. The patient received local anesthesia with monitored anesthesia care. A volar zigzag incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. Given the mild severity of the diagnosis, the patient was advised on hand exercises and provided with a hand splint. A follow-up evaluation was scheduled in a few weeks to assess the response to conservative measures.

9. Operative Note: Surgical intervention was indicated for severe synovitis in the right elbow joint. Under regional anesthesia with an axillary nerve block, an arthroscopic synovectomy was performed. Intraoperative examination revealed extensive synovial hypertrophy and inflammation. Complete synovial removal was achieved, and the joint was thoroughly irrigated. Due to the severe severity of the diagnosis, the patient was scheduled for regular postoperative follow-ups to monitor the response to treatment, manage pain, and provide necessary interventions for optimal recovery.

10. Operative Note: Tenosynovitis involving the left ankle tendons required surgical intervention. The patient received general anesthesia with endotracheal intubation. A surgical incision was made, exposing the affected tendon sheath. Tenosynovectomy was performed, addressing the inflamed synovium and releasing adhesions. Considering the mild severity of the diagnosis, the patient was provided with postoperative instructions and scheduled for a follow-up evaluation in a few weeks to assess the response to treatment and determine the need for further intervention.

## M66.0 Rupture of popliteal cyst

1. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision

The patient was positioned supine, and a sterile field was established. A longitudinal incision was made over the posterior aspect of the knee. Dissection was carried down to the ruptured popliteal cyst, which was identified and excised completely. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and postoperative instructions were provided.

2. Operative Note: Rupture of Popliteal Cyst

Procedure: Arthroscopic Cyst Decompression

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Two small arthroscopic portals were established, and a diagnostic arthroscopy was performed. The ruptured popliteal cyst was visualized and decompressed using arthroscopic instruments. The cystic fluid was aspirated, and thorough lavage was performed. The portals were closed, and the patient was discharged with postoperative care instructions.

3. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Marsupialization

Under general anesthesia, the patient was positioned prone, and the knee was flexed at 90 degrees. A longitudinal incision was made over the cyst, and careful dissection was performed to expose the cyst wall. The cyst was marsupialized by creating a communication between the cyst and the joint space. Hemostasis was achieved, and the wound was closed in layers. The patient was provided with postoperative instructions.

4. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Fenestration

With the patient in supine position, a sterile field was prepared. A curvilinear incision was made over the posterior aspect of the knee. The ruptured popliteal cyst was identified, and multiple small fenestrations were created in the cyst wall. The cystic fluid was evacuated, and thorough irrigation was performed. The incision was closed in layers, and the patient was discharged with appropriate postoperative care guidelines.

5. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Sclerotherapy

The patient was positioned supine, and the knee was flexed at 30 degrees. Ultrasound guidance was used to identify the ruptured popliteal cyst. A small needle was inserted into the cyst, and a sclerosing agent was injected to induce cyst sclerosis. The cyst was then aspirated, and the needle was removed. The patient tolerated the procedure well, and postoperative follow-up was scheduled.

6. Operative Note: Rupture of Popliteal Cyst

Procedure: Open Cystectomy

Under general anesthesia, the patient was placed in a supine position. A curvilinear incision was made over the posterior knee, exposing the ruptured popliteal cyst. The cyst wall was carefully dissected and excised in its entirety. Hemostasis was achieved, and the wound was closed in layers. The patient's pain was well managed postoperatively, and appropriate instructions were provided.

7. Operative Note: Rupture of Popliteal Cyst

Procedure: Mini-Open Cyst Excision

The patient was positioned supine, and a sterile field was established. A small curvilinear incision was made over the posterior knee. Dissection was carried down to the ruptured popliteal cyst, which was identified and excised. Hemostasis was achieved, and the incision was closed with sutures. The patient tolerated the procedure well, and postoperative rehabilitation was initiated.

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. Operative Note: Rupture of Popliteal Cyst

Procedure: Endoscopic Cyst Resection

Under general anesthesia, the patient was placed in prone position, and the leg was elevated and exsanguinated. Two small incisions were made, and an endoscope was inserted to visualize the ruptured popliteal cyst. The cyst was resected using endoscopic instruments. Hemostasis was ensured, and the incisions were closed. The patient was given postoperative care instructions and scheduled for follow-up.

9. Operative Note: Rupture of Popliteal Cyst

Procedure: Percutaneous Cyst Aspiration

The patient was positioned supine, and the knee was flexed. Ultrasound guidance was used to locate the ruptured popliteal cyst. A small needle was inserted into the cyst, and the fluid was aspirated. The cyst was decompressed, and the needle was removed. The patient experienced immediate relief, and post-procedure instructions were provided.

10. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Debridement

The patient was positioned supine, and a sterile field was prepared. A longitudinal incision was made over the posterior knee, exposing the ruptured popliteal cyst. Debridement was performed to remove necrotic tissue and debris. Hemostasis was achieved, and the wound was thoroughly irrigated. The incision was closed in layers, and the patient was discharged with appropriate postoperative care guidelines.

1. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Drainage and Capsulorrhaphy

The patient was positioned supine, and the knee was flexed. A curvilinear incision was made over the posterior aspect of the knee, exposing the ruptured popliteal cyst. The cystic fluid was drained, and meticulous debridement was performed. Capsulorrhaphy was carried out to repair the cyst wall. Hemostasis was achieved, and the wound was closed in layers. The patient was given postoperative care instructions.

2. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Resection with Grafting

Under general anesthesia, the patient was positioned supine. A posterior incision was made, and the ruptured popliteal cyst was visualized. The cyst was excised completely, and a graft was placed to reconstruct the resulting defect. Hemostasis was ensured, and the wound was closed in layers. The patient tolerated the procedure well, and appropriate postoperative management was discussed.

3. Operative Note: Rupture of Popliteal Cyst

Procedure: Endovascular Embolization of Ruptured Popliteal Cyst

Under fluoroscopic guidance, a catheter was inserted into the femoral artery. Selective angiography was performed to visualize the ruptured popliteal cyst. Embolic agents were then introduced to occlude the cystic vessels and stop the bleeding. The catheter was removed, and hemostasis was confirmed. The patient was monitored post-procedure, and discharge instructions were provided.

4. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision with Arthroscopic Inspection

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. A longitudinal incision was made over the posterior knee, and the ruptured popliteal cyst was identified. Complete excision of the cyst was performed, followed by arthroscopic inspection of the joint. Any associated intra-articular pathology was addressed. The wounds were closed, and the patient was discharged with postoperative instructions.

5. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Repair with Primary Closure

The patient was positioned supine, and the knee was flexed. A longitudinal incision was made over the posterior knee, exposing the ruptured popliteal cyst. The cystic cavity was thoroughly debrided, and primary closure was achieved with absorbable sutures. Hemostasis was confirmed, and the wound was dressed. The patient was advised on postoperative care, and follow-up was scheduled.

6. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision with Endoscopic-Assisted Technique

Under general anesthesia, the patient was placed in prone position, and the leg was elevated. Two small incisions were made, and an endoscope was used for visualization. The ruptured popliteal cyst was identified and excised with the assistance of endoscopic instruments. Hemostasis was ensured, and the incisions were closed. The patient was provided with postoperative instructions and a follow-up appointment.

7. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision with Adjacent Soft Tissue Repair

The patient was positioned supine, and a sterile field was established. A curvilinear incision was made over the posterior knee, exposing the ruptured popliteal cyst. Complete excision of the cyst was performed, and meticulous repair of adjacent soft

tissues was carried out. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were provided to the patient.

8. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Resection with Tissue Flap Reconstruction

Under general anesthesia, the patient was placed in a supine position. An incision was made over the posterior knee, and the ruptured popliteal cyst was excised. A local tissue flap was harvested and used to reconstruct the resulting defect. Hemostasis was ensured, and the wound was closed meticulously. The patient's recovery was uneventful, and postoperative follow-up was arranged.

9. Operative Note: Rupture of Popliteal Cyst

Procedure: Arthroscopic Popliteal Cyst Decompression and Synovectomy

The patient was placed in the supine position, and the knee was prepared and draped in a sterile manner. Two arthroscopic portals were established, and a diagnostic arthroscopy was performed. The ruptured popliteal cyst was visualized, decompressed, and excised using arthroscopic instruments. Additionally, a synovectomy was performed to address any underlying synovial inflammation. The portals were closed, and postoperative instructions were provided.

10. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision with Reinforcement using Allograft

The patient was positioned supine, and a sterile field was prepared. A longitudinal incision was made over the posterior knee, exposing the ruptured popliteal cyst. The cyst was completely excised, and an allograft was utilized to reinforce the surrounding tissue. Hemostasis was achieved, and the wound was closed meticulously. The patient was instructed on postoperative care and scheduled for follow-up evaluation.

1. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision under Local Anesthesia

The patient was placed in a supine position, and the knee was flexed. Local anesthesia with lidocaine was administered to the operative site. A longitudinal incision was made over the posterior knee, and the ruptured popliteal cyst was identified. Complete excision of the cyst was performed, and hemostasis was achieved. The wound was closed, and postoperative instructions were provided. The patient tolerated the procedure well under local anesthesia.

2. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision under Spinal Anesthesia

The patient was positioned in a sitting position, and a spinal anesthesia block was administered. Once the anesthesia took effect, the patient was placed in a supine position, and the surgical site was prepared. A longitudinal incision was made over the posterior knee, and the ruptured popliteal cyst was identified. The cyst was excised completely, and meticulous hemostasis was achieved. The wound was closed, and postoperative care instructions were given.

3. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Excision under General Anesthesia with Light Sedation

The patient was brought to the operating room and placed under general anesthesia with endotracheal intubation. Anesthesia was supplemented with light sedation throughout the procedure. A longitudinal incision was made over the posterior knee, and the ruptured popliteal cyst was visualized. The cyst was excised, and hemostasis was ensured. The wound was closed, and the patient was awakened and extubated smoothly in the recovery room.

4. Operative Note: Rupture of Popliteal Cyst

Procedure: Arthroscopic Cyst Decompression under Regional Anesthesia

The patient was positioned supine, and regional anesthesia in the form of a femoral nerve block was administered. After confirming adequate sensory and motor blockade, the procedure commenced. Two small arthroscopic portals were established, and the ruptured popliteal cyst was visualized. Arthroscopic decompression of the cyst was performed using specialized instruments. The portals were closed, and the patient recovered well under regional anesthesia.

5. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Marsupialization under Monitored Anesthesia Care (MAC)

The patient was placed in a supine position, and MAC was initiated. The knee was flexed, and a longitudinal incision was made over the posterior knee. The ruptured popliteal cyst was identified, and marsupialization was performed. Throughout the procedure, the patient remained conscious and responsive under the effect of MAC. Hemostasis was achieved, and the wound was closed with sutures.

6. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Fenestration under Local Anesthesia with Sedation

The patient was positioned supine, and local anesthesia with sedation was administered. A curvilinear incision was made over the posterior knee, exposing the ruptured popliteal cyst. Multiple small fenestrations were created in the cyst wall. The cystic fluid was aspirated, and thorough irrigation was performed. The incision was closed, and the patient remained comfortable throughout the procedure.

7. Operative Note: Rupture of Popliteal Cyst

Procedure: Popliteal Cyst Sclerotherapy under General Anesthesia

The patient was placed in a supine position, and general anesthesia was induced. The knee was flexed, and ultrasound guidance was

used to locate the ruptured popliteal cyst. A sclerosing agent was injected into the cyst, followed by aspiration of the cystic fluid. The procedure was carried out successfully under general anesthesia, and the patient's vital signs remained stable throughout.

8. Operative Note: Rupture of Popliteal Cyst

Procedure: Open Cystectomy under Moderate Sedation

The patient was positioned supine, and moderate sedation was administered. A curvilinear incision was made over the posterior knee, exposing the ruptured popliteal cyst. The cyst wall was dissected and excised completely. Hemostasis was achieved, and the wound was closed meticulously. The patient remained sedated but responsive during the procedure, and no complications were encountered.

9. Operative Note: Rupture of Popliteal Cyst

Procedure: Mini-Open Cyst Excision under General Anesthesia

The patient was positioned supine, and general anesthesia was induced. A small curvilinear incision was made over the posterior knee, and the ruptured popliteal cyst was identified. The cyst was excised completely using a mini-open approach. Hemostasis was achieved, and the wound was closed with sutures. The patient was safely extubated and transferred to the recovery area following the procedure.

10. Operative Note: Rupture of Popliteal Cyst

Procedure: Endoscopic Cyst Resection under Deep Sedation

The patient was placed in a prone position, and deep sedation was administered. Two small incisions were made, and an endoscope was inserted for visualization. The ruptured popliteal cyst was identified and resected using endoscopic instruments. Hemostasis was ensured, and the incisions were closed. The patient remained sedated throughout the procedure and had a smooth recovery.

1. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Popliteal Cyst Excision with Bone Debridement

Under general anesthesia, the patient was placed in a supine position. A posterior incision was made, revealing the ruptured popliteal cyst with associated bone erosion. The cyst was excised, and thorough debridement of the eroded bone was performed. Hemostasis was achieved, and the wound was closed in layers. The patient was given postoperative care instructions and scheduled for follow-up evaluation.

2. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Popliteal Cyst Resection with Bone Grafting

The patient was positioned supine, and a sterile field was established. A longitudinal incision was made over the posterior knee, exposing the ruptured popliteal cyst and underlying bone erosion. The cyst was completely excised, and a bone graft was used to address the bone defect. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative instructions for optimal healing.

3. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Popliteal Cyst Decompression with Osteochondral Autograft Transplantation

Under general anesthesia, the patient was placed in a supine position. The ruptured popliteal cyst with associated bone erosion was visualized. The cyst was decompressed, and an osteochondral autograft was harvested and transplanted into the bone defect. Hemostasis was ensured, and the wound was closed. The patient was given postoperative care instructions and scheduled for regular follow-up.

4. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Arthroscopic Cyst Decompression and Microfracture Technique

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopy was performed, revealing the ruptured popliteal cyst and associated bone erosion. The cyst was decompressed, and microfracture technique was employed to stimulate cartilage repair. Hemostasis was achieved, and the portals were closed. Postoperative care instructions were provided to the patient.

5. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Popliteal Cyst Excision with Bone Graft and Fixation

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and accompanying bone erosion. The cyst was excised, and the bone defect was reconstructed using a bone graft. Fixation was achieved using appropriate hardware. Hemostasis was confirmed, and the wound was closed meticulously. The patient received postoperative instructions and was scheduled for follow-up.

6. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Popliteal Cyst Excision with Bone Tunneling and Autograft

The patient was positioned supine, and a sterile field was prepared. A longitudinal incision was made over the posterior knee, exposing the ruptured popliteal cyst and associated bone erosion. The cyst was excised, and bone tunneling was performed to address the erosion. Autograft was harvested and used to fill the bone defect. Hemostasis was achieved, and the wound was closed. Postoperative care instructions were provided.

7. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Arthroscopic Cyst Decompression and Bone Microfracture

The patient was placed in the

supine position, and arthroscopy was performed under general anesthesia. The ruptured popliteal cyst with bone erosion was visualized. Cyst decompression was carried out, and bone microfracture was performed to stimulate cartilage healing. Hemostasis was ensured, and the portals were closed. The patient was given postoperative instructions for optimal recovery.

8. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Popliteal Cyst Excision with Bone Graft and Plate Fixation

Under general anesthesia, the patient was positioned supine. A posterior incision was made, revealing the ruptured popliteal cyst and associated bone erosion. The cyst was excised, and bone grafting was performed to reconstruct the eroded bone. Plate fixation was applied to provide stability. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were provided.

9. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Open Cystectomy with Bone Debridement and Biologic Augmentation

The patient was positioned supine, and a sterile field was prepared. An incision was made over the posterior knee, exposing the ruptured popliteal cyst and bone erosion. Complete cyst excision was performed, followed by thorough debridement of the eroded bone. Biologic augmentation with appropriate materials was carried out to support bone healing. Hemostasis was ensured, and the wound was closed in layers. Postoperative instructions were provided.

10. Operative Note: Rupture of Popliteal Cyst with Bone Erosion

Procedure: Popliteal Cyst Marsupialization with Bone Curettage and Synthetic Graft Placement

Under general anesthesia, the patient was positioned supine. A curvilinear incision was made over the posterior knee, revealing the ruptured popliteal cyst and accompanying bone erosion. Marsupialization of the cyst was performed, and bone curettage was carried out to address the erosion. A synthetic graft was placed to support bone regeneration. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were provided.

1. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Osteotomy

Under general anesthesia, the patient was placed in a supine position. A longitudinal incision was made over the posterior knee, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and an osteotomy was performed to address the underlying bone pathology. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative pain management instructions and was scheduled for follow-up evaluation.

2. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with Subchondral Microfracture

The patient was positioned supine, and arthroscopy was performed under general anesthesia. The ruptured popliteal cyst and severe bone pain were visualized. Cyst decompression was performed, and subchondral microfracture was carried out to alleviate the bone pain. Hemostasis was ensured, and the portals were closed. The patient was provided with postoperative pain management guidelines.

3. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Bone Resection and Nerve Block

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and bone resection was performed to relieve the pain. Additionally, a nerve block was administered for enhanced pain management. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain control measures were discussed with the patient.

4. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Bone Marrow Aspiration

The patient was placed in a supine position, and general anesthesia was induced. A longitudinal incision was made over the posterior knee, revealing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and bone marrow aspiration was performed to alleviate the pain. Hemostasis was ensured, and the wound was closed. The patient was provided with postoperative pain management instructions.

5. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with Corticosteroid Injection

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopy was performed under general anesthesia, visualizing the ruptured popliteal cyst and severe bone pain. Cyst decompression was performed, and a corticosteroid injection was administered into the affected area for pain relief. Hemostasis was achieved, and postoperative pain control measures were discussed.

6. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Nerve Block and Epidural Analgesia

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a nerve block was administered for immediate pain relief. Additionally, epidural analgesia was initiated to provide postoperative pain control. Hemostasis was ensured, and the wound was closed meticulously. The patient's pain management plan was discussed with the anesthesia team.

7. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Resection with Bone Cement

Augmentation

The patient was positioned supine, and a sterile field was established. A longitudinal incision was made over the posterior knee, exposing the ruptured popliteal cyst and severe bone pain. The cyst was resected, and bone cement augmentation was performed to alleviate the pain and provide structural support. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative pain management instructions.

8. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Bone Stimulator Placement

Under general anesthesia, the patient was placed in a supine position. A posterior incision was made, revealing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a bone stimulator device was placed to promote bone healing and alleviate pain. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative pain management guidelines and was scheduled for follow-up evaluation.

9. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with Radiofrequency Ablation

The patient was positioned supine, and arthroscopy was performed under general anesthesia. The ruptured popliteal cyst and severe bone pain were visualized. Cyst decompression was carried out, and radiofrequency ablation was performed to target the pain receptors in the affected bone. Hemostasis was ensured, and the portals were closed. The patient was provided with postoperative pain management instructions.

10. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Percutaneous Bone Cryoablation

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and percutaneous bone cryoablation was performed to provide targeted pain relief. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management strategies were discussed with the patient.

1. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Arthroscopic Lateral Release

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and an arthroscopic lateral release was performed to address any associated joint pathology. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management and rehabilitation protocols were discussed with the patient.

2. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Resection with Medial Meniscus Repair

The patient was placed in the supine position, and general anesthesia was administered. A longitudinal incision was made over the posterior knee, revealing the ruptured popliteal cyst and severe bone pain. The cyst was resected, and a concurrent medial meniscus repair was performed to address any associated pathology. Hemostasis was achieved, and the wound was closed. Postoperative pain management and physical therapy instructions were provided.

3. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Tibial Tubercle Osteotomy

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a tibial tubercle osteotomy was performed to correct any malalignment contributing to the pain. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative pain management and rehabilitation guidelines.

4. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with Cartilage Restoration

The patient was placed in the supine position, and arthroscopy was performed under general anesthesia. The ruptured popliteal cyst and severe bone pain were visualized. Cyst decompression was carried out, and cartilage restoration procedures, such as microfracture or autologous chondrocyte implantation, were performed to address any concurrent cartilage damage. Hemostasis was ensured, and postoperative pain control measures were discussed.

5. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Distal Femoral Osteotomy

Under general anesthesia, the patient was positioned supine. A longitudinal incision was made over the posterior knee, revealing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a distal femoral osteotomy was performed to correct any malalignment and relieve the pain. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management and rehabilitation plans were discussed with the patient.

6. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Resection with Patellar Realignment

The patient was positioned supine, and general anesthesia was induced. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was resected, and patellar realignment procedures, such as a tibial tubercle osteotomy or lateral release, were performed to correct any patellar instability contributing to the pain. Hemostasis was achieved, and the wound was closed. Postoperative pain management and rehabilitation instructions were provided.

7. Operative Note: Rupture of Popliteal Cyst with Se

vere Bone Pain

Procedure: Arthroscopic Cyst Decompression with Meniscectomy

The patient was placed in the supine position, and arthroscopy was performed under general anesthesia. The ruptured popliteal cyst and severe bone pain were visualized. Cyst decompression was performed, and concurrent meniscectomy was carried out to address any meniscal tears contributing to the pain. Hemostasis was ensured, and postoperative pain control measures were discussed.

8. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Tibial Plateau Osteotomy

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a tibial plateau osteotomy was performed to address any deformity or malalignment contributing to the pain. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative pain management and rehabilitation guidelines.

9. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Resection with Anterior Cruciate Ligament (ACL) Reconstruction

The patient was placed in the supine position, and general anesthesia was administered. A longitudinal incision was made over the posterior knee, revealing the ruptured popliteal cyst and severe bone pain. The cyst was resected, and a concurrent ACL reconstruction was performed to address any ligamentous instability and relieve the pain. Hemostasis was achieved, and the wound was closed. Postoperative pain management and rehabilitation instructions were provided.

10. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with Osteochondral Autograft Transplantation (OAT)

Under general anesthesia, the patient was positioned supine. Arthroscopy was performed, visualizing the ruptured popliteal cyst and severe bone pain. Cyst decompression was performed, and osteochondral autograft transplantation (OAT) was carried out to address any cartilage defects contributing to the pain. Hemostasis was ensured, and postoperative pain control measures were discussed.

1. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Tibial Nailing

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a tibial nail was inserted to stabilize any associated fractures and alleviate the pain. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative pain management instructions and was scheduled for follow-up evaluation.

2. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with Lateral Meniscal Repair

The patient was placed in the supine position, and arthroscopy was performed under general anesthesia. The ruptured popliteal cyst and severe bone pain were visualized. Cyst decompression was performed, and a concurrent lateral meniscal repair was carried out to address any associated meniscal tears contributing to the pain. Hemostasis was ensured, and postoperative pain control measures were discussed.

3. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Bone Grafting and Internal Fixation

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and bone grafting was performed to address any bone defects contributing to the pain. Internal fixation with plates and screws was applied for stability. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management instructions were provided.

4. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Resection with Proximal Tibiofibular Joint Fusion

The patient was positioned supine, and general anesthesia was induced. A longitudinal incision was made over the posterior knee, revealing the ruptured popliteal cyst and severe bone pain. The cyst was resected, and a proximal tibiofibular joint fusion was performed to alleviate the pain and stabilize the joint. Hemostasis was achieved, and the wound was closed. Postoperative pain management and rehabilitation instructions were given.

5. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with Subchondroplasty

The patient was placed in the supine position, and arthroscopy was performed under general anesthesia. The ruptured popliteal cyst and severe bone pain were visualized. Cyst decompression was carried out, and subchondroplasty was performed to address any associated subchondral bone defects and relieve the pain. Hemostasis was ensured, and postoperative pain control measures were discussed.

6. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Hemi-Knee Replacement

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a hemi-knee replacement was performed to alleviate the pain and address any significant joint degeneration. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management and rehabilitation plans were discussed with the patient.

7. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Resection with Distal Femoral O

steochondral Allograft Transplantation

The patient was placed in the supine position, and general anesthesia was administered. A longitudinal incision was made over the posterior knee, revealing the ruptured popliteal cyst and severe bone pain. The cyst was resected, and a distal femoral osteochondral allograft transplantation was performed to address any cartilage and bone defects contributing to the pain. Hemostasis was achieved, and the wound was closed. Postoperative pain management and rehabilitation instructions were provided.

8. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Arthroscopic Cyst Decompression with High Tibial Osteotomy

Under general anesthesia, the patient was positioned supine. Arthroscopy was performed, visualizing the ruptured popliteal cyst and severe bone pain. Cyst decompression was performed, and a high tibial osteotomy was carried out to correct any malalignment and relieve the pain. Hemostasis was ensured, and postoperative pain control measures were discussed.

9. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Excision with Patellofemoral Joint Replacement

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe bone pain. The cyst was excised, and a patellofemoral joint replacement was performed to alleviate the pain and address any significant patellofemoral joint degeneration. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management and rehabilitation plans were discussed with the patient.

10. Operative Note: Rupture of Popliteal Cyst with Severe Bone Pain

Procedure: Popliteal Cyst Resection with Bone Morphogenetic Protein (BMP) Application

The patient was positioned supine, and general anesthesia was induced. A longitudinal incision was made over the posterior knee, revealing the ruptured popliteal cyst and severe bone pain. The cyst was resected, and bone morphogenetic protein (BMP) was applied to promote bone healing and alleviate the pain. Hemostasis was achieved, and the wound was closed. Postoperative pain management and rehabilitation instructions were provided.

1. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Knee Joint

Procedure: Popliteal Cyst Excision with Debridement and Irrigation

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe infection on the knee joint. The cyst was excised, and thorough debridement and irrigation were performed to remove infected tissue and promote healing. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and wound care instructions were provided.

2. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Ankle Joint

Procedure: Popliteal Cyst Excision with Ankle Joint Washout and Drain Placement

The patient was positioned supine, and general anesthesia was administered. A posterior incision was made, revealing the ruptured popliteal cyst and severe infection on the ankle joint. The cyst was excised, and an ankle joint washout was performed to remove infected fluid and debris. A drain was placed for ongoing drainage. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and wound care instructions were given.

3. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Hip Joint

Procedure: Popliteal Cyst Excision with Hip Joint Arthrotomy and Pulsed Lavage

Under general anesthesia, the patient was placed in a lateral decubitus position. A posterior incision was made, exposing the ruptured popliteal cyst and severe infection on the hip joint. The cyst was excised, and a hip joint arthrotomy was performed. Pulsed lavage was utilized to thoroughly irrigate the infected joint. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and joint immobilization instructions were provided.

4. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Shoulder Joint

Procedure: Popliteal Cyst Excision with Shoulder Joint Debridement and Antibiotic Spacer Placement

Under general anesthesia, the patient was positioned in a beach chair position. A posterior incision was made, revealing the ruptured popliteal cyst and severe infection on the shoulder joint. The cyst was excised, and extensive debridement of the joint was performed. An antibiotic spacer was placed to provide localized antibiotic therapy. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and shoulder immobilization instructions were given.

5. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Elbow Joint

Procedure: Popliteal Cyst Excision with Elbow Joint Washout and Antibiotic Impregnated Cement Spacer Placement

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst and severe infection on the elbow joint. The cyst was excised, and the elbow joint was thoroughly irrigated and washed out. An antibiotic impregnated cement spacer was placed for targeted antibiotic delivery. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and elbow immobilization instructions were provided.

6. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Wrist Joint

Procedure: Popliteal Cyst Excision with Wrist Joint Arthrotomy and Antibiotic Bead Placement

The patient was positioned supine, and general anesthesia was induced. A posterior incision was made, revealing the ruptured popliteal cyst and severe infection on the wrist joint. The cyst was excised, and

a wrist joint arthrotomy was performed. Antibiotic-impregnated beads were placed in the joint for targeted antibiotic therapy. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and wrist immobilization instructions were given.

7. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Temporomandibular Joint

Procedure: Popliteal Cyst Excision with Temporomandibular Joint Washout and Drain Placement

Under general anesthesia, the patient was positioned supine with the head turned to the contralateral side. A posterior incision was made, exposing the ruptured popliteal cyst and severe infection on the temporomandibular joint. The cyst was excised, and a temporomandibular joint washout was performed. A drain was placed for ongoing drainage. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and jaw immobilization instructions were provided.

8. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Finger Joint

Procedure: Popliteal Cyst Excision with Finger Joint Debridement and Antibiotic Irrigation

Under general anesthesia, the patient's hand was positioned for optimal access. A posterior incision was made, revealing the ruptured popliteal cyst and severe infection on the finger joint. The cyst was excised, and thorough debridement of the joint was performed. The joint was irrigated with antibiotic solution. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and finger immobilization instructions were given.

9. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Spine Joint

Procedure: Popliteal Cyst Excision with Spinal Joint Debridement and Antibiotic Spacer Placement

Under general anesthesia, the patient was placed in the appropriate position for spine surgery. A posterior incision was made, exposing the ruptured popliteal cyst and severe infection on the spine joint. The cyst was excised, and extensive debridement of the joint was performed. An antibiotic spacer was placed to provide localized antibiotic therapy. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and spine immobilization instructions were provided.

10. Operative Note: Rupture of Popliteal Cyst with Severe Infection on the Sacroiliac Joint

Procedure: Popliteal Cyst Excision with Sacroiliac Joint Washout and Antibiotic Bead Placement

The patient was positioned prone, and general anesthesia was induced. A posterior incision was made, revealing the ruptured popliteal cyst and severe infection on the sacroiliac joint. The cyst was excised, and the joint was thoroughly irrigated and washed out. Antibiotic-impregnated beads were placed in the joint for targeted antibiotic therapy. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and sacroiliac joint immobilization instructions were given.

1. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Synovitis

Procedure: Popliteal Cyst Excision with Synovectomy

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and synovitis. The cyst was excised, and a synovectomy was performed to remove inflamed synovial tissue. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and rehabilitation plans were discussed with the patient.

2. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Bursitis

Procedure: Popliteal Cyst Excision with Bursectomy

The patient was placed in the supine position, and general anesthesia was induced. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation and bursitis. The cyst was excised, and a bursectomy was performed to remove the inflamed bursa. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and instructions for activity modification were provided.

3. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Tenosynovitis

Procedure: Popliteal Cyst Excision with Tenosynovectomy

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and tenosynovitis. The cyst was excised, and a tenosynovectomy was performed to remove the inflamed tendon sheath. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and hand therapy were recommended.

4. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Capsulitis

Procedure: Popliteal Cyst Excision with Capsular Release

The patient was placed in the supine position, and general anesthesia was administered. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation and capsulitis. The cyst was excised, and a capsular release was performed to relieve the inflamed joint capsule. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and physical therapy were prescribed.

5. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Fasciitis

Procedure: Popliteal Cyst Excision with Fasciotomy

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and fasciitis. The cyst was excised, and a fasciotomy was performed to release the inflamed fascia. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and instructions for stretching exercises were given.

6. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Tendinitis

Procedure: Popliteal Cyst Excision with Tendon Debridement

The patient was positioned supine, and general anesthesia was induced. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation and tendinitis. The cyst was excised, and thorough debridement of the inflamed tendon was performed. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and physical therapy were recommended.

7. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and

Arthritis

Procedure: Popliteal Cyst Excision with Arthroscopic Joint Debridement

Under general anesthesia, the patient was positioned supine. Arthroscopy was performed, visualizing the ruptured popliteal cyst with severe inflammation and arthritis. The cyst was excised, and arthroscopic joint debridement was performed to remove inflamed synovium and articular debris. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and joint mobilization exercises were advised.

8. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Myositis

Procedure: Popliteal Cyst Excision with Myofascial Release

Under general anesthesia, the patient was placed in the supine position. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and myositis. The cyst was excised, and myofascial release was performed to alleviate tension in the inflamed muscles. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and physical therapy were prescribed.

9. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Chondritis

Procedure: Popliteal Cyst Excision with Chondroplasty

The patient was positioned supine, and general anesthesia was induced. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation and chondritis. The cyst was excised, and chondroplasty was performed to address the inflamed cartilage. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory medications and joint protection measures were discussed.

10. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Osteomyelitis

Procedure: Popliteal Cyst Excision with Bone Debridement and Antibiotic Spacer Placement

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and osteomyelitis. The cyst was excised, and extensive bone debridement was performed. An antibiotic spacer was placed to provide localized antibiotic therapy. Hemostasis was achieved, and the wound was closed meticulously. Postoperative antibiotics and bone immobilization instructions were given.

1. Operative Note: Rupture of Popliteal Cyst with Mild Inflammation and No Complications

Procedure: Popliteal Cyst Excision

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with mild inflammation. The cyst was excised, and meticulous hemostasis was achieved. The wound was closed with sutures. Postoperative follow-up includes pain management and monitoring for any signs of infection or recurrence.

2. Operative Note: Rupture of Popliteal Cyst with Moderate Inflammation and Limited Range of Motion

Procedure: Popliteal Cyst Excision with Synovectomy and Physical Therapy Referral

The patient was positioned supine, and general anesthesia was administered. A posterior incision was made, revealing the ruptured popliteal cyst with moderate inflammation and limited range of motion. The cyst was excised, and a synovectomy was performed. The wound was closed meticulously. Postoperative follow-up includes physical therapy to restore range of motion and reduce inflammation.

3. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Impaired Function

Procedure: Popliteal Cyst Excision with Joint Debridement and Rehabilitation Consultation

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and impaired function. The cyst was excised, and extensive joint debridement was performed. The wound was closed meticulously. Postoperative follow-up includes a consultation with a rehabilitation specialist for personalized therapy and functional recovery.

4. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation, Ligament Damage, and Instability

Procedure: Popliteal Cyst Excision with Ligament Repair and Brace Application

The patient was placed supine, and general anesthesia was induced. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation, ligament damage, and joint instability. The cyst was excised, and ligament repair was performed. A brace was applied for stabilization. Postoperative follow-up includes regular assessments of ligament healing, physical therapy, and gradual return to activity.

5. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation, Cartilage Defects, and Weight-Bearing Limitations

Procedure: Popliteal Cyst Excision with Cartilage Repair and Non-Weight Bearing Instructions

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation, cartilage defects, and weight-bearing limitations. The cyst was excised, and cartilage repair procedures were performed. Non-weight bearing instructions were given. Postoperative follow-up includes cartilage healing assessment, restricted weight-bearing status, and rehabilitation.

6. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Infection

Procedure: Popliteal Cyst Excision with Drain Placement and Intravenous Antibiotic Therapy

Under general anesthesia, the patient was placed in the supine position. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation and infection. The cyst was excised, and a drain was placed for ongoing drainage. Intravenous antibiotic therapy was initiated. Postoperative follow-up includes monitoring infection resolution, wound healing, and adjustment of antibiotic regimen as needed.

7. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation, Joint Dislocation, and Neurovascular Compromise

Procedure: Emergency Popliteal Cyst Excision with Joint Reduction and

Vascular Surgery Consultation

The patient was brought to the operating room urgently. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation, joint dislocation, and neurovascular compromise. The cyst was excised, and joint reduction was performed. A vascular surgery consultation was requested for immediate evaluation and management of the neurovascular status. Postoperative follow-up includes close monitoring of vascular and neurological recovery.

8. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Suspected Malignancy

Procedure: Popliteal Cyst Excision with Tissue Biopsy and Oncology Referral

Under general anesthesia, the patient was positioned supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and suspected malignancy. The cyst was excised, and tissue biopsy samples were obtained for histopathological analysis. An oncology referral was made for further evaluation and management. Postoperative follow-up includes coordination with the oncology team for appropriate treatment.

9. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Concurrent Ligamentous Tears

Procedure: Popliteal Cyst Excision with Ligament Reconstruction and Sports Medicine Consultation

The patient was positioned supine, and general anesthesia was administered. A posterior incision was made, revealing the ruptured popliteal cyst with severe inflammation and concurrent ligamentous tears. The cyst was excised, and ligament reconstruction procedures were performed. A sports medicine consultation was requested for comprehensive management. Postoperative follow-up includes ligament healing assessment, rehabilitation, and sports-specific training.

10. Operative Note: Rupture of Popliteal Cyst with Severe Inflammation and Multiple Fractures

Procedure: Popliteal Cyst Excision with Fracture Fixation and Orthopedic Trauma Consultation

Under general anesthesia, the patient was placed supine. A posterior incision was made, exposing the ruptured popliteal cyst with severe inflammation and multiple fractures. The cyst was excised, and fracture fixation was performed. An orthopedic trauma consultation was requested for further evaluation and management of the complex fractures. Postoperative follow-up includes fracture healing assessment, rehabilitation, and coordination with the orthopedic trauma team.

## M66.1 Rupture of synovium

1. Operative Note: Patient underwent arthroscopic intervention for a rupture of synovium in the right knee. A small incision was made to access the joint space. The ruptured synovium was identified and carefully resected. Hemostasis was achieved using bipolar cautery. The incision was closed with sutures. Patient tolerated the procedure well and was transferred to the recovery unit in stable condition.

2. Operative Note: Intraoperative findings revealed a rupture of synovium in the left wrist. An open surgical approach was employed. The ruptured synovium was excised, and meticulous hemostasis was achieved. The wound was irrigated with sterile saline solution. Closure was performed using absorbable sutures. The patient's vital signs remained stable throughout the procedure, and no immediate complications were noted.

3. Operative Note: Surgical intervention was performed to address a rupture of synovium in the right ankle. A small arthrotomy was made, allowing visualization of the affected joint. The ruptured synovium was identified and meticulously excised. Adequate hemostasis was ensured, and the wound was closed with sutures. The patient's condition remained stable, and there were no intraoperative complications.

4. Operative Note: The patient presented with a rupture of synovium in the left elbow. A mini-open approach was employed. The synovial rupture was visualized and excised, ensuring complete removal. Hemostasis was achieved using electrocautery. The incision was closed in layers. The patient tolerated the procedure well, and postoperative monitoring showed no immediate complications.

5. Operative Note: The patient underwent arthroscopic repair for a rupture of synovium in the right hip joint. Access was gained using established portals. The ruptured synovium was identified and meticulously debrided. Hemostasis was achieved using saline irrigation and pressure. The procedure was completed without any complications. The patient was transferred to the recovery area in stable condition.

6. Operative Note: Open surgical intervention was performed to address a rupture of synovium in the left shoulder. A deltopectoral approach was utilized. The synovial rupture was identified and meticulously excised. Hemostasis was obtained using electrocautery. Closure was performed in layers, and a sterile dressing was applied. The patient's vital signs remained stable throughout the procedure.

7. Operative Note: The patient underwent an arthroscopic procedure for a rupture of synovium in the right ankle. The joint was accessed through established portals. The ruptured synovium was visualized and meticulously debrided. Hemostasis was achieved using bipolar cautery. The procedure was completed without complications. The patient was transferred to the post-anesthesia care unit in stable condition.

8. Operative Note: An open surgical repair was performed for a rupture of synovium in the right shoulder. An anterior approach was utilized. The ruptured synovium was identified and excised. Hemostasis was achieved using electrocautery and irrigation. The wound was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

9. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium in the left knee. The joint was accessed through established portals. The ruptured synovium was visualized and meticulously resected. Hemostasis was achieved using saline irrigation and pressure. The procedure was completed without any intraoperative complications. The patient was transferred to the recovery area in stable condition.

10. Operative Note: Open surgical repair was performed to address a rupture of synovium in the right wrist. A dorsal approach was utilized. The ruptured synovium

was identified and meticulously excised. Hemostasis was achieved using bipolar cautery. Closure was performed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were noted.

1. Operative Note: The patient underwent an open surgical procedure to repair a rupture of synovium in the left hip joint. A posterior approach was employed. The ruptured synovium was identified and meticulously excised. Hemostasis was achieved using electrocautery and saline irrigation. The wound was closed in layers. The patient's vital signs remained stable throughout the procedure, and no immediate complications were observed.

2. Operative Note: Arthroscopic intervention was performed to address a rupture of synovium in the right shoulder. Standard portals were utilized for joint access. The ruptured synovium was visualized and carefully resected. Hemostasis was achieved using bipolar cautery. The procedure was completed without any intraoperative complications. The patient was transferred to the recovery area in stable condition.

3. Operative Note: Open surgical repair was performed for a rupture of synovium in the left ankle. A medial approach was utilized. The ruptured synovium was identified and meticulously excised. Hemostasis was achieved using electrocautery and local hemostatic agents. Closure was performed in layers. The patient tolerated the procedure well, and no immediate postoperative complications were observed.

4. Operative Note: The patient underwent arthroscopic intervention for a rupture of synovium in the right elbow. Access was obtained through established portals. The ruptured synovium was visualized and meticulously debrided. Hemostasis was ensured using saline irrigation and pressure. The procedure was completed without any complications. The patient was transferred to the post-anesthesia care unit in stable condition.

5. Operative Note: An open surgical procedure was performed to repair a rupture of synovium in the left knee. A midline incision was made. The ruptured synovium was identified and meticulously excised. Hemostasis was achieved using electrocautery. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

6. Operative Note: Arthroscopic intervention was performed for a rupture of synovium in the right wrist. Access was gained through established portals. The ruptured synovium was visualized and carefully debrided. Hemostasis was achieved using saline irrigation and pressure. The procedure was completed without any complications. The patient was transferred to the recovery area in stable condition.

7. Operative Note: The patient underwent an open surgical repair for a rupture of synovium in the left shoulder. A superior approach was utilized. The ruptured synovium was identified and meticulously excised. Hemostasis was achieved using electrocautery and local hemostatic agents. Closure was performed in layers. The patient tolerated the procedure well, and no immediate postoperative complications were noted.

8. Operative Note: Surgical intervention was performed to address a rupture of synovium in the right ankle. An arthrotomy was made, providing access to the joint space. The ruptured synovium was identified and meticulously resected. Hemostasis was achieved using bipolar cautery. The wound was closed with sutures. The patient's condition remained stable throughout the procedure, and no intraoperative complications were encountered.

9. Operative Note: The patient underwent arthroscopic repair for a rupture of synovium in the left hip joint. Established portals were used for joint visualization. The ruptured synovium was identified and meticulously debrided. Hemostasis was achieved using saline irrigation and pressure. The procedure was completed without any complications. The patient was transferred to the post-anesthesia care unit in stable condition.

10. Operative Note: Open surgical repair was performed to address a rupture of synovium in the right knee. A medial parapatellar approach was employed. The ruptured synovium was identified and meticulously excised. Hemostasis was achieved using electrocautery and local hemostatic agents. Closure was performed in layers. The patient tolerated the procedure well, and no immediate postoperative complications were observed.

1. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium in the right shoulder. General anesthesia was administered using a balanced technique with inhalational agents and intravenous opioids. The procedure was performed smoothly, and the patient remained hemodynamically stable throughout. Adequate pain control was ensured postoperatively using multimodal analgesia.

2. Operative Note: Open surgical repair was performed for a rupture of synovium in the left ankle. The procedure was performed under regional anesthesia using a popliteal nerve block and intravenous sedation. The patient remained comfortable and cooperative during the surgery, and there were no intraoperative complications. Postoperative pain was managed effectively with regional anesthesia and oral analgesics.

3. Operative Note: The patient underwent an arthroscopic procedure for a rupture of synovium in the right knee. Monitored anesthesia care (MAC) was administered with intravenous sedation and local anesthesia infiltration. The patient remained responsive and comfortable throughout the procedure. Postoperatively, the patient was managed with oral analgesics and reported satisfactory pain control.

4. Operative Note: Open surgical repair was performed to address a rupture of synovium in the left shoulder. The procedure was conducted under general anesthesia with endotracheal intubation. Anesthesia was maintained using volatile agents and intravenous opioids. The patient's vital signs remained stable, and the surgery proceeded without complications. Postoperative pain was managed with intravenous patient-controlled analgesia (PCA).

5. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium in the right hip joint. General anesthesia was administered using total intravenous anesthesia (TIVA) technique with propofol and remifentanil infusion. The patient was maintained in a stable anesthetic state throughout the procedure. Postoperatively, pain was managed with a combination of intravenous and oral analgesics.

6. Operative Note: Open surgical repair was performed for a rupture of synovium in the left knee. The procedure was conducted under spinal anesthesia with intravenous sedation. The patient remained hemodynamically stable, and there were no intraoperative complications. Effective postoperative pain relief was achieved with a combination of neuraxial analgesia and oral pain medications.

7. Operative Note: The patient underwent an arthroscopic procedure for a rupture of synovium in the right ankle. Ankle block was performed using local anesthetics, providing both surgical anesthesia and postoperative pain control. The patient tolerated the procedure well, and there were no intraoperative difficulties. Postoperatively, pain was managed with oral analgesics.

8. Operative Note: Open surgical repair was performed to address a rupture of synovium in the left shoulder. The procedure was conducted under general anesthesia with a reduced dosage of inhalational agents due to the patient's comorbidities. An intravenous opioid infusion was utilized for intraoperative analgesia. The patient's vital signs remained stable, and there were no immediate postoperative complications.

9. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium in the right knee. Moderate sedation was provided using a combination of intravenous benzodiazepines and opioids. The patient remained responsive and comfortable throughout the procedure. Adequate postoperative pain relief was achieved with oral analgesics and local ice application.

10. Operative Note: Open surgical repair was performed for a rupture of synovium in the left ankle. The procedure was conducted under general anesthesia with a higher dose of intravenous opioids due to the patient's reported higher pain sensitivity. Anesthesia was managed meticulously, and the patient remained stable without any intraoperative complications. Postoperatively, pain was managed using a multimodal approach including opioids and non-opioid analgesics.

1. Operative Note: The patient underwent open surgical repair for a rupture of synovium with associated bone erosion in the right shoulder. An extended deltopectoral approach was utilized. The ruptured synovium was excised, and the eroded bone was carefully debrided. Hemostasis was achieved using electrocautery and local hemostatic agents. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

2. Operative Note: Arthroscopic intervention was performed to address a rupture of synovium with bone erosion in the left knee. Multiple portals were established for joint access. The ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were smoothed and debrided. Hemostasis was achieved using bipolar cautery and saline irrigation. The patient was transferred to the recovery area in stable condition.

3. Operative Note: Open surgical repair was performed for a rupture of synovium with significant bone erosion in the right ankle. A medial approach was utilized. The ruptured synovium was excised, and extensive debridement of the eroded bone was performed. Autograft was used to fill the bone defect. Hemostasis was achieved using electrocautery and bone wax. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

4. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium with bone erosion in the left hip joint. Access was gained using established portals. The ruptured synovium was visualized and meticulously debrided. The eroded bone surfaces were addressed with microfracture technique. Hemostasis was achieved using saline irrigation and pressure. The procedure was completed without any complications. The patient was transferred to the recovery area in stable condition.

5. Operative Note: Open surgical repair was performed to address a rupture of synovium with bone erosion in the right elbow. An extensive lateral approach was utilized. The ruptured synovium was excised, and the eroded bone was carefully debrided. Hemostasis was achieved using electrocautery and bone wax. The wound was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

6. Operative Note: The patient underwent an arthroscopic procedure for a rupture of synovium with bone erosion in the left wrist. Established portals were used for joint visualization. The ruptured synovium was visualized and meticulously debrided. The eroded bone surfaces were addressed with microfracture technique. Hemostasis was achieved using bipolar cautery and saline irrigation. The procedure was completed without any complications. The patient was transferred to the recovery area in stable condition.

7. Operative Note: Open surgical repair was performed for a rupture of synovium with bone erosion in the right hip joint. A posterior approach was utilized. The ruptured synovium was excised, and the eroded bone was carefully debrided. Autograft was used to fill the bone defect. Hemostasis was achieved using electrocautery and bone wax. The wound was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

8. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium with bone erosion in the left ankle. Established portals were used for joint visualization. The ruptured synovium was visualized and meticulously debrided. The eroded bone surfaces were addressed with microfracture technique and bone grafting

. Hemostasis was achieved using bipolar cautery and saline irrigation. The procedure was completed without any complications. The patient was transferred to the recovery area in stable condition.

9. Operative Note: Open surgical repair was performed to address a rupture of synovium with severe bone erosion in the right knee. An extensive medial parapatellar approach was employed. The ruptured synovium was excised, and the eroded bone surfaces were meticulously debrided. Autograft was used to reconstruct the bone defect. Hemostasis was achieved using electrocautery and local hemostatic agents. The patient tolerated the procedure well, and no immediate complications were noted.

10. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium with bone erosion in the left shoulder. Access was obtained through established portals. The ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were addressed using microfracture technique and bone grafting. Hemostasis was achieved using bipolar cautery and saline irrigation. The procedure was completed without any complications. The patient was transferred to the recovery area in stable condition.

1. Operative Note: The patient underwent open surgical repair for a rupture of synovium with severe bone pain in the right shoulder. An extended deltopectoral approach was utilized. The ruptured synovium was excised, and the eroded bone was carefully debrided. Hemostasis was achieved using electrocautery and local hemostatic agents. The patient's severe bone pain was effectively managed with intraoperative local anesthesia and postoperative analgesics.

2. Operative Note: Arthroscopic intervention was performed to address a rupture of synovium with severe bone pain in the left knee. Multiple portals were established for joint access. The ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were smoothed and debrided. Hemostasis was achieved using bipolar cautery and saline irrigation. The patient's severe bone pain was managed with regional anesthesia and intravenous analgesics.

3. Operative Note: Open surgical repair was performed for a rupture of synovium with severe bone pain in the right ankle. A medial approach was utilized. The ruptured synovium was excised, and extensive debridement of the eroded bone was performed. Autograft was used to fill the bone defect. Hemostasis was achieved using electrocautery and bone wax. The patient's severe bone pain was effectively controlled with a combination of regional anesthesia, intravenous analgesics, and postoperative pain management plan.

4. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium with severe bone pain in the left hip joint. Access was gained using established portals. The ruptured synovium was visualized and meticulously debrided. The eroded bone surfaces were addressed with microfracture technique. Hemostasis was achieved using saline irrigation and pressure. The patient's severe bone pain was effectively relieved with regional anesthesia, multimodal analgesia, and postoperative pain medications.

5. Operative Note: Open surgical repair was performed to address a rupture of synovium with severe bone pain in the right elbow. An extensive lateral approach was utilized. The ruptured synovium was excised, and the eroded bone was carefully debrided. Hemostasis was achieved using electrocautery and bone wax. The patient's severe bone pain was effectively managed intraoperatively with regional anesthesia and postoperatively with a combination of oral and intravenous analgesics.

6. Operative Note: The patient underwent an arthroscopic procedure for a rupture of synovium with severe bone pain in the left wrist. Established portals were used for joint visualization. The ruptured synovium was visualized and meticulously debrided. The eroded bone surfaces were addressed with microfracture technique. Hemostasis was achieved using bipolar cautery and saline irrigation. The patient's severe bone pain was effectively controlled with regional anesthesia and a personalized pain management plan.

7. Operative Note: Open surgical repair was performed for a rupture of synovium with severe bone pain in the right hip joint. A posterior approach was utilized. The ruptured synovium was excised, and the eroded bone was carefully debrided. Autograft was used to fill the bone defect. Hemostasis was achieved using electrocautery and bone wax. The patient's severe bone pain was effectively managed with a combination of regional anesthesia, intravenous analgesics, and multimodal pain control.

8. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium with severe bone pain in the left ankle. Established portals

were used for joint visualization. The ruptured synovium was visualized and meticulously debrided. The eroded bone surfaces were addressed with microfracture technique and bone grafting. Hemostasis was achieved using bipolar cautery and saline irrigation. The patient's severe bone pain was effectively relieved with regional anesthesia, intravenous analgesics, and a comprehensive pain management plan.

9. Operative Note: Open surgical repair was performed to address a rupture of synovium with severe bone pain in the right knee. An extensive medial parapatellar approach was employed. The ruptured synovium was excised, and the eroded bone surfaces were meticulously debrided. Autograft was used to reconstruct the bone defect. Hemostasis was achieved using electrocautery and local hemostatic agents. The patient's severe bone pain was effectively controlled with intraoperative regional anesthesia, intravenous analgesics, and a multimodal pain management regimen.

10. Operative Note: The patient underwent an arthroscopic intervention for a rupture of synovium with severe bone pain in the left shoulder. Access was obtained through established portals. The ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were addressed using microfracture technique and bone grafting. Hemostasis was achieved using bipolar cautery and saline irrigation. The patient's severe bone pain was effectively managed with regional anesthesia, intravenous analgesics, and a tailored postoperative pain control plan.

1. Operative Note: The patient underwent an open surgical repair for a ruptured synovium in the right knee. A midline incision was made, and the ruptured synovium was identified and excised. The surrounding structures were carefully examined, and no further abnormalities were noted. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

2. Operative Note: Arthroscopic intervention was performed for a ruptured synovium in the left shoulder. Access was gained using established portals, and the ruptured synovium was visualized and resected. Any loose fragments or debris were removed, and the joint was thoroughly irrigated. Hemostasis was achieved, and the portals were closed. The patient recovered smoothly, and no complications were encountered during the procedure.

3. Operative Note: Open surgical repair was performed to address a ruptured synovium in the right hip joint. A posterior approach was utilized, and the ruptured synovium was carefully excised. The eroded bone surfaces were addressed, and any loose fragments were removed. The joint was irrigated, and hemostasis was achieved. The incision was closed in layers, and the patient was transferred to the recovery area in stable condition.

4. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left ankle. Established portals were used for joint access, and the ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose bodies were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient tolerated the procedure well, and there were no immediate complications.

5. Operative Note: Open surgical repair was performed for a ruptured synovium in the right elbow. An extensive lateral approach was employed, and the ruptured synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient's recovery was uneventful, and no immediate postoperative issues were observed.

6. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left wrist. Established portals were used for joint visualization, and the ruptured synovium was meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The procedure was completed without any complications, and the patient's postoperative course was satisfactory.

7. Operative Note: Open surgical repair was performed to address a ruptured synovium in the right hip joint. A medial approach was utilized, and the ruptured synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

8. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left ankle. Established portals were used for joint access, and the ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose bodies were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's recovery in the immediate postoperative period was uneventful.

9. Operative Note: Open surgical repair was performed for a ruptured synovium in the right knee. A midline incision was made, and the ruptured synovium was identified and excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

10. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left shoulder. Access was gained using established portals, and the ruptured synovium was visualized and resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's recovery following the surgical intervention was unremarkable, and no immediate complications were encountered.

1. Operative Note: The patient underwent open surgical repair for a ruptured synovium in the right hip joint. A posterior approach was utilized, and the ruptured synovium was meticulously excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient's postoperative recovery was uneventful, and no immediate complications were observed.

2. Operative Note: Arthroscopic intervention was performed for a ruptured synovium in the left knee. Access was gained using established portals, and the ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose bodies were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative period was uncomplicated, and they were transferred to the recovery area in stable condition.

3. Operative Note: Open surgical repair was performed to address a ruptured synovium in the right shoulder. An extended deltopectoral approach was employed, and the ruptured synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

4. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left ankle. Established portals were used for joint access, and the ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative recovery was uneventful, and no complications were noted.

5. Operative Note: Open surgical repair was performed for a ruptured synovium in the right elbow. An extensive lateral approach was employed, and the ruptured synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient's postoperative course was uncomplicated, and they were discharged home with appropriate instructions.

6. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left wrist. Established portals were used for joint visualization, and the ruptured synovium was meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative recovery was smooth, and no complications were encountered.

7. Operative Note: Open surgical repair was performed to address a ruptured synovium in the right knee. A medial parapatellar approach was utilized, and the ruptured synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative issues.

8. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left shoulder. Established portals were used for joint access, and the ruptured synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative course

was uneventful, and they were discharged with appropriate follow-up instructions.

9. Operative Note: Open surgical repair was performed for a ruptured synovium in the right hip joint. A posterior approach was utilized, and the ruptured synovium was meticulously excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the incision was closed in layers. The patient's postoperative recovery was satisfactory, and no immediate complications were noted.

1. Operative Note: The patient underwent emergent open surgical intervention for a rupture of synovium with severe infection on the right knee joint. An extensive incision was made, and purulent fluid was drained. The ruptured synovium was excised, and the eroded bone surfaces were debrided. A thorough irrigation was performed with antimicrobial solution. Hemostasis was achieved, and a temporary external fixation device was applied. The patient was started on broad-spectrum antibiotics postoperatively.

2. Operative Note: Surgical exploration and debridement were performed for a rupture of synovium with severe infection on the left shoulder joint. An extended deltopectoral approach was employed. The infected synovium was meticulously excised, and the eroded bone surfaces were debrided. Copious irrigation with antimicrobial solution was carried out. A closed suction drain was placed, and the wound was closed in layers. Intravenous antibiotics were initiated in the postoperative period.

3. Operative Note: Open surgical repair was performed for a rupture of synovium with severe infection on the right hip joint. A posterior approach was utilized, and purulent material was evacuated. The infected synovium was excised, and the eroded bone surfaces were meticulously debrided. Extensive irrigation with antibiotic solution was performed. Hemostasis was achieved, and a wound vacuum-assisted closure system was applied. Intravenous antibiotics were administered postoperatively.

4. Operative Note: The patient underwent arthroscopic intervention for a rupture of synovium with severe infection on the left ankle joint. Established portals were used, and purulent fluid was aspirated. The infected synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and thorough joint irrigation with antibiotic solution was performed. The portals were closed, and a sterile dressing was applied. Intravenous antibiotics were initiated in the immediate postoperative period.

5. Operative Note: Open surgical repair was performed for a rupture of synovium with severe infection on the right elbow joint. An extensive lateral approach was employed, and pus was drained. The infected synovium was excised, and the eroded bone surfaces were carefully debrided. Copious irrigation with antimicrobial solution was carried out. A negative pressure wound therapy system was applied, and the wound was closed in layers. Intravenous antibiotics were started postoperatively.

6. Operative Note: The patient underwent arthroscopic intervention for a rupture of synovium with severe infection on the left wrist joint. Established portals were used, and purulent material was aspirated. The infected synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and thorough joint irrigation with antibiotic solution was performed. The portals were closed, and a sterile dressing was applied. Intravenous antibiotics were initiated to combat the infection.

7. Operative Note: Open surgical repair was performed for a rupture of synovium with severe infection on the right hip joint. A medial approach was utilized, and purulent fluid was drained. The infected synovium was excised, and the eroded bone surfaces were meticulously debrided. Extensive irrigation with antibiotic solution was performed. Hemostasis was achieved, and a wound vacuum-assisted closure system was applied. Intravenous antibiotics were administered to treat the infection.

8. Operative Note: The patient underwent arthroscopic intervention for a rupture of synovium with severe infection on the left ankle joint. Established portals were used, and purulent material was aspirated. The infected synovium was visualized and meticulously

resected. The eroded bone surfaces were addressed, and thorough joint irrigation with antibiotic solution was performed. The portals were closed, and a sterile dressing was applied. Intravenous antibiotics were initiated to control the severe infection.

9. Operative Note: Open surgical repair was performed for a rupture of synovium with severe infection on the right knee joint. An extensive incision was made, and purulent fluid was drained. The infected synovium was excised, and the eroded bone surfaces were carefully debrided. Copious irrigation with antimicrobial solution was carried out. A temporary external fixation device was applied, and a wound vacuum-assisted closure system was utilized. Intravenous antibiotics were started postoperatively.

10. Operative Note: The patient underwent emergent surgical intervention for a rupture of synovium with severe infection on the left shoulder joint. An extended deltopectoral approach was employed. Purulent material was drained, and the infected synovium was meticulously excised. The eroded bone surfaces were debrided, and extensive irrigation with antimicrobial solution was performed. A closed suction drain was placed, and the wound was closed in layers. Intravenous antibiotics were initiated immediately to combat the severe infection.

10. Operative Note: The patient underwent an arthroscopic intervention for a ruptured synovium in the left ankle. Established portals were used for joint visualization, and the ruptured synovium was meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative period was uneventful, and they were discharged home with appropriate postoperative care instructions.

1. Operative Note: The patient underwent open surgical repair for a ruptured synovium with severe inflammation on the right knee joint. An anterior approach was employed, and the inflamed synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient's postoperative recovery was uneventful, with a reduction in inflammation observed.

2. Operative Note: Arthroscopic intervention was performed for a ruptured synovium with moderate inflammation on the left shoulder joint. Established portals were used for joint access, and the inflamed synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose bodies were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative period showed improvement in inflammation.

3. Operative Note: Open surgical repair was performed to address a ruptured synovium with mild inflammation on the right hip joint. A posterior approach was utilized, and the inflamed synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, with a noticeable decrease in inflammation postoperatively.

4. Operative Note: The patient underwent arthroscopic intervention for a ruptured synovium with severe inflammation on the left ankle joint. Established portals were used for joint visualization, and the inflamed synovium was meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative recovery showed significant improvement in inflammation.

5. Operative Note: Open surgical repair was performed for a ruptured synovium with moderate inflammation on the right elbow joint. An extensive lateral approach was employed, and the inflamed synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient's postoperative course showed a notable reduction in inflammation.

6. Operative Note: The patient underwent arthroscopic intervention for a ruptured synovium with mild inflammation on the left wrist joint. Established portals were used for joint access, and the inflamed synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative period demonstrated improvement in inflammation.

7. Operative Note: Open surgical repair was performed to address a ruptured synovium with severe inflammation on the right knee joint. A medial parapatellar approach was utilized, and the inflamed synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the incision was closed in layers. The patient's postoperative recovery showed a reduction in inflammation.

8. Operative Note: The patient underwent arthroscopic intervention for a ruptured synovium with moderate inflammation on the left shoulder joint. Established portals were used for joint access, and the inflamed synovium was visualized and meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative course demonstrated

a decrease in inflammation.

9. Operative Note: Open surgical repair was performed for a ruptured synovium with mild inflammation on the right hip joint. A posterior approach was utilized, and the inflamed synovium was excised. The eroded bone surfaces were carefully debrided, and any loose fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient's postoperative recovery showed improvement in inflammation.

10. Operative Note: The patient underwent arthroscopic intervention for a ruptured synovium with severe inflammation on the left ankle joint. Established portals were used for joint visualization, and the inflamed synovium was meticulously resected. The eroded bone surfaces were addressed, and any loose fragments were removed. Hemostasis was achieved, and the joint was thoroughly irrigated. The patient's immediate postoperative recovery demonstrated a significant reduction in inflammation.

1. Operative Note: The patient underwent open surgical repair for a severe rupture of synovium in the right knee joint. The ruptured synovium was meticulously excised, and the eroded bone surfaces were debrided. Hemostasis was achieved, and the wound was closed in layers. Given the severity of the diagnosis, close monitoring of postoperative range of motion and pain control is recommended. The patient will follow up in two weeks for a postoperative assessment.

2. Operative Note: Arthroscopic intervention was performed for a moderate rupture of synovium in the left shoulder joint. The ruptured synovium was visualized and meticulously resected, and the eroded bone surfaces were addressed. Hemostasis was achieved, and the joint was thoroughly irrigated. Based on the severity of the diagnosis, the patient will follow up in four weeks for a reassessment of symptoms and range of motion.

3. Operative Note: Open surgical repair was performed to address a mild rupture of synovium in the right hip joint. The ruptured synovium was excised, and the eroded bone surfaces were carefully debrided. Hemostasis was achieved, and the wound was closed in layers. Considering the mild severity of the diagnosis, the patient will follow up in six weeks for a routine postoperative evaluation and physical therapy initiation.

4. Operative Note: The patient underwent arthroscopic intervention for a severe rupture of synovium in the left ankle joint. The ruptured synovium was visualized and meticulously resected, and the eroded bone surfaces were addressed. Hemostasis was achieved, and the joint was thoroughly irrigated. Given the severity of the diagnosis, the patient will follow up in one week for a wound check and assessment of early postoperative outcomes.

5. Operative Note: Open surgical repair was performed for a moderate rupture of synovium in the right elbow joint. The ruptured synovium was excised, and the eroded bone surfaces were carefully debrided. Hemostasis was achieved, and the wound was closed in layers. Considering the moderate severity of the diagnosis, the patient will follow up in three weeks for a postoperative examination and initiation of rehabilitation exercises.

6. Operative Note: The patient underwent arthroscopic intervention for a mild rupture of synovium in the left wrist joint. The ruptured synovium was visualized and meticulously resected, and the eroded bone surfaces were addressed. Hemostasis was achieved, and the joint was thoroughly irrigated. Based on the mild severity of the diagnosis, the patient will follow up in eight weeks for a routine postoperative evaluation and implementation of a strengthening program.

7. Operative Note: Open surgical repair was performed to address a severe rupture of synovium in the right knee joint. The ruptured synovium was excised, and the eroded bone surfaces were debrided. Hemostasis was achieved, and the wound was closed in layers. Given the severity of the diagnosis, the patient will follow up in two weeks for a detailed assessment of postoperative pain, range of motion, and a review of imaging studies.

8. Operative Note: The patient underwent arthroscopic intervention for a moderate rupture of synovium in the left shoulder joint. The ruptured synovium was visualized and meticulously resected, and the eroded bone surfaces were addressed. Hemostasis was achieved, and the joint was thoroughly irrigated. Based on the moderate severity of the diagnosis, the patient will follow up in four weeks for a postoperative examination and initiation of physical therapy.

9. Operative

Note: Open surgical repair was performed for a mild rupture of synovium in the right hip joint. The ruptured synovium was excised, and the eroded bone surfaces were carefully debrided. Hemostasis was achieved, and the wound was closed in layers. Considering the mild severity of the diagnosis, the patient will follow up in six weeks for a routine postoperative evaluation and to assess the need for additional rehabilitation.

10. Operative Note: The patient underwent arthroscopic intervention for a severe rupture of synovium in the left ankle joint. The ruptured synovium was visualized and meticulously resected, and the eroded bone surfaces were addressed. Hemostasis was achieved, and the joint was thoroughly irrigated. Given the severity of the diagnosis, the patient will follow up in one week for a wound check, assessment of pain control, and a review of early postoperative outcomes.

## M66.2 Spontaneous rupture of extensor tendons

1. Operative Note - Spontaneous Rupture of Extensor Tendons Repair: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the right hand. A dorsal approach was utilized, and the ruptured tendons were identified. After meticulous debridement, the tendons were repaired using a modified Kessler suture technique. The wound was closed in layers, and a bulky dressing was applied.

2. Operative Note - Extensor Tendon Repair for Spontaneous Rupture: The surgical repair of a spontaneous rupture of extensor tendons in the left hand was performed. A longitudinal incision was made over the dorsum of the hand. The ruptured tendons were identified and meticulously debrided. The tendon ends were sutured together using a modified Bunnell technique. The wound was closed, and a splint was applied for immobilization.

3. Operative Note - Spontaneous Rupture of Extensor Tendons Reconstruction: A patient presented with a spontaneous rupture of extensor tendons in the right wrist. An extensor retinaculum approach was employed. The ruptured tendons were identified and mobilized. The ends were reapproximated using an interlocking figure-of-eight suture technique. The repaired tendons were reinforced with an extensor retinaculum flap. Postoperatively, the hand was immobilized in a dorsal splint.

4. Operative Note - Repair of Spontaneous Extensor Tendon Rupture: The patient underwent surgery for spontaneous rupture of extensor tendons in the right index finger. A dorsal zigzag incision was made, and the extensor tendon was exposed. The ruptured ends were freshened and repaired using a modified Kessler suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization.

5. Operative Note - Spontaneous Rupture of Extensor Tendons Repair: The surgical repair of spontaneous rupture of extensor tendons in the left hand was performed. A dorsal approach was employed, and the ruptured tendons were identified. A step-cut lengthening was performed, and the tendon ends were reapproximated using a Pulvertaft weave technique. The wound was closed in layers, and a volar splint was applied for support.

6. Operative Note - Extensor Tendon Reconstruction for Spontaneous Rupture: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the right hand. A dorsal incision was made, and the ruptured tendons were identified. Tendon ends were mobilized, and a side-to-side repair was performed using a horizontal mattress technique. The wound was closed, and a volar splint was applied to maintain the repair.

7. Operative Note - Spontaneous Rupture of Extensor Tendons Repair: The surgical repair of spontaneous rupture of extensor tendons in the left wrist was performed. A dorsal approach was utilized, and the ruptured tendons were visualized. After meticulous debridement, the tendon ends were repaired using a Krackow suture technique. The wound was closed, and a bulky dressing was applied along with a dorsal splint for immobilization.

8. Operative Note - Extensor Tendon Repair for Spontaneous Rupture: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the right hand. A dorsal approach was used to expose the tendons. The ruptured ends were identified, freshened, and repaired using a modified Bunnell technique. The wound was closed, and a volar splint was applied for postoperative immobilization and support.

9. Operative Note - Spontaneous Rupture of Extensor

Tendons Reconstruction: A patient presented with spontaneous rupture of extensor tendons in the left hand. A dorsal zigzag incision was made to expose the tendons. The ruptured ends were identified and repaired using a double-loop locking suture technique. The wound was closed, and a dorsal splint was applied to protect the repair during the healing process.

10. Operative Note - Repair of Spontaneous Extensor Tendon Rupture: The patient underwent surgical repair for spontaneous rupture of extensor tendons in the right middle finger. A dorsal incision was made, and the extensor tendon was exposed. The ruptured ends were identified and repaired using a figure-of-eight suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and protection.

1. Operative Note - Spontaneous Rupture of Extensor Tendons Repair: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the right hand. A volar approach was employed, and the tendons were identified. The ruptured ends were meticulously debrided and repaired using a modified Kessler technique. The wound was closed, and a volar splint was applied to maintain the repair in proper alignment.

2. Operative Note - Extensor Tendon Reconstruction for Spontaneous Rupture: A patient presented with spontaneous rupture of extensor tendons in the left wrist. A volar incision was made, and the tendons were exposed. The ruptured ends were carefully trimmed, and an end-to-end repair was performed using a four-strand core suture technique. The wound was closed, and a volar splint was applied for immobilization.

3. Operative Note - Spontaneous Rupture of Extensor Tendons Repair: The surgical repair of spontaneous rupture of extensor tendons in the right thumb was performed. A radial approach was utilized, and the tendons were visualized. The ruptured ends were reapproximated using a modified Bunnell suture technique. The wound was closed, and a thumb spica splint was applied for postoperative support and protection.

4. Operative Note - Extensor Tendon Repair for Spontaneous Rupture: The patient underwent surgery for spontaneous rupture of extensor tendons in the left index finger. A radial incision was made, and the tendons were exposed. The ruptured ends were repaired using a single-row locking suture technique. The wound was closed, and a dorsal splint was applied to maintain the repair and promote healing.

5. Operative Note - Spontaneous Rupture of Extensor Tendons Reconstruction: A patient presented with spontaneous rupture of extensor tendons in the right hand. A dorsal incision was made, and the tendons were identified. The ruptured ends were mobilized, and an interlocking horizontal mattress suture technique was used for repair. The wound was closed, and a dorsal splint was applied for postoperative immobilization.

6. Operative Note - Spontaneous Rupture of Extensor Tendons Repair: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the left wrist. A volar approach was employed, and the tendons were exposed. The ruptured ends were repaired using a modified Kessler technique with epitendinous sutures. The wound was closed, and a volar splint was applied for support and protection.

7. Operative Note - Extensor Tendon Reconstruction for Spontaneous Rupture: The surgical repair of spontaneous rupture of extensor tendons in the right hand was performed. A dorsal zigzag incision was made, and the tendons were visualized. The ruptured ends were repaired using a Pulvertaft weave technique. The wound was closed, and a dorsal splint was applied to maintain the repair in proper alignment.

8. Operative Note - Spontaneous Rupture of Extensor Tendons Repair: The patient presented with spontaneous rupture of extensor tendons in the left thumb. A radial incision was made, and the tendons were exposed. The ruptured ends were meticulously debrided and repaired using a modified Kessler suture technique. The wound was closed, and a thumb spica splint was applied for postoperative immobilization.

9. Operative Note - Extensor Tendon Repair for Spontaneous Rupture: The patient underwent surgery for spontaneous rupture of ext

ensor tendons in the right middle finger. A radial incision was made, and the tendons were exposed. The ruptured ends were repaired using a four-strand cross-stitch technique. The wound was closed, and a dorsal splint was applied to protect the repair during the healing process.

10. Operative Note - Spontaneous Rupture of Extensor Tendons Reconstruction: A patient presented with spontaneous rupture of extensor tendons in the left hand. A volar incision was made, and the tendons were visualized. The ruptured ends were reapproximated using a modified Bunnell suture technique. The wound was closed, and a volar splint was applied for postoperative immobilization and support.

1. Operative Note - Spontaneous Rupture of Extensor Tendons Repair under Local Anesthesia: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the right hand under local anesthesia. A dorsal approach was utilized, and the tendons were identified. The ruptured ends were meticulously debrided and repaired using a modified Kessler technique. The wound was closed, and a dorsal splint was applied for immobilization.

2. Operative Note - Extensor Tendon Reconstruction for Spontaneous Rupture under General Anesthesia: A patient presented with spontaneous rupture of extensor tendons in the left wrist and underwent surgical repair under general anesthesia. A volar incision was made, and the tendons were exposed. The ruptured ends were carefully trimmed, and an end-to-end repair was performed using a four-strand core suture technique. The wound was closed, and a volar splint was applied for immobilization.

3. Operative Note - Spontaneous Rupture of Extensor Tendons Repair under Regional Anesthesia: The surgical repair of spontaneous rupture of extensor tendons in the right thumb was performed under regional anesthesia. A radial approach was utilized, and the tendons were visualized. The ruptured ends were reapproximated using a modified Bunnell suture technique. The wound was closed, and a thumb spica splint was applied for postoperative support and protection.

4. Operative Note - Extensor Tendon Repair for Spontaneous Rupture under Local Anesthesia: The patient underwent surgery for spontaneous rupture of extensor tendons in the left index finger under local anesthesia. A radial incision was made, and the tendons were exposed. The ruptured ends were repaired using a single-row locking suture technique. The wound was closed, and a dorsal splint was applied to maintain the repair and promote healing.

5. Operative Note - Spontaneous Rupture of Extensor Tendons Reconstruction under General Anesthesia: A patient presented with spontaneous rupture of extensor tendons in the right hand and underwent surgical intervention under general anesthesia. A dorsal incision was made, and the tendons were identified. The ruptured ends were mobilized, and an interlocking horizontal mattress suture technique was used for repair. The wound was closed, and a dorsal splint was applied for postoperative immobilization.

6. Operative Note - Spontaneous Rupture of Extensor Tendons Repair under Local Anesthesia: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the left wrist under local anesthesia. A volar approach was employed, and the tendons were exposed. The ruptured ends were repaired using a modified Kessler technique with epitendinous sutures. The wound was closed, and a volar splint was applied for support and protection.

7. Operative Note - Extensor Tendon Reconstruction for Spontaneous Rupture under General Anesthesia: The surgical repair of spontaneous rupture of extensor tendons in the right hand was performed under general anesthesia. A dorsal zigzag incision was made, and the tendons were visualized. The ruptured ends were repaired using a Pulvertaft weave technique. The wound was closed, and a dorsal splint was applied to maintain the repair in proper alignment.

8. Operative Note - Spontaneous Rupture of Extensor Tendons Repair under Regional Anesthesia: The patient presented with spontaneous rupture of extensor tendons in the left thumb and underwent surgical repair under regional anesthesia. A radial incision was made, and the tendons were exposed.

The ruptured ends were meticulously debrided and repaired using a modified Kessler suture technique. The wound was closed, and a thumb spica splint was applied for postoperative immobilization.

9. Operative Note - Extensor Tendon Repair for Spontaneous Rupture under Local Anesthesia: The patient underwent surgery for spontaneous rupture of extensor tendons in the right middle finger under local anesthesia. A radial incision was made, and the tendons were exposed. The ruptured ends were repaired using a four-strand cross-stitch technique. The wound was closed, and a dorsal splint was applied to protect the repair during the healing process.

10. Operative Note - Spontaneous Rupture of Extensor Tendons Reconstruction under General Anesthesia: A patient presented with spontaneous rupture of extensor tendons in the left hand and underwent surgical intervention under general anesthesia. A volar incision was made, and the tendons were visualized. The ruptured ends were reapproximated using a modified Bunnell suture technique. The wound was closed, and a volar splint was applied for postoperative immobilization and support.

1. Operative Note - Spontaneous Rupture of Extensor Tendons with Bone Erosion Repair: The patient underwent surgical intervention for spontaneous rupture of extensor tendons with underlying bone erosion in the right hand. A dorsal approach was utilized, and the tendons and eroded bone were visualized. The ruptured tendon ends were repaired using a modified Kessler suture technique, and bone erosion was addressed through meticulous debridement and bone grafting. The wound was closed, and a dorsal splint was applied.

2. Operative Note - Extensor Tendon Reconstruction with Bone Erosion Repair: A patient presented with spontaneous rupture of extensor tendons and bone erosion in the left wrist. A volar incision was made, and the tendons and eroded bone were exposed. The ruptured tendon ends were repaired using a four-strand core suture technique, and bone erosion was managed through bone grafting and stabilization with screws. The wound was closed, and a volar splint was applied for immobilization.

3. Operative Note - Spontaneous Rupture of Extensor Tendons with Bone Erosion Repair: The patient underwent surgery for spontaneous rupture of extensor tendons with bone erosion in the right thumb. A radial approach was utilized, and the tendons and eroded bone were identified. The ruptured tendon ends were repaired using a modified Bunnell suture technique, and bone erosion was addressed through debridement and bone substitute placement. The wound was closed, and a thumb spica splint was applied.

4. Operative Note - Extensor Tendon Repair with Bone Erosion Reconstruction: The patient presented with spontaneous rupture of extensor tendons and bone erosion in the left index finger. A radial incision was made, and the tendons and eroded bone were exposed. The ruptured tendon ends were repaired using a single-row locking suture technique, and bone erosion was managed through debridement and bone grafting. The wound was closed, and a dorsal splint was applied for support.

5. Operative Note - Spontaneous Rupture of Extensor Tendons with Bone Erosion Repair: A patient underwent surgical intervention for spontaneous rupture of extensor tendons with underlying bone erosion in the right hand. A dorsal zigzag incision was made, and the tendons and eroded bone were visualized. The ruptured tendon ends were repaired using a Pulvertaft weave technique, and bone erosion was addressed through thorough debridement and bone graft placement. The wound was closed, and a dorsal splint was applied for immobilization.

6. Operative Note - Spontaneous Rupture of Extensor Tendons with Bone Erosion Repair: The patient presented with spontaneous rupture of extensor tendons with bone erosion in the left wrist. A volar incision was made, and the tendons and eroded bone were exposed. The ruptured tendon ends were repaired using a modified Kessler technique, and bone erosion was managed through meticulous debridement and bone substitute placement. The wound was closed, and a volar splint was applied for postoperative support.

7. Operative Note - Extensor Tendon Reconstruction with Bone Erosion Repair: The surgical repair of spontaneous rupture of extensor tendons with underlying bone erosion in the right hand was performed. A dorsal approach was employed, and the tendons and eroded bone were identified. The ruptured tendon ends were mobilized and repaired using a modified Bunnell suture technique, while bone erosion was addressed through thorough debridement and bone grafting. The wound was

closed, and a dorsal splint was applied for immobilization and protection.

8. Operative Note - Spontaneous Rupture of Extensor Tendons with Bone Erosion Repair: The patient underwent surgery for spontaneous rupture of extensor tendons with bone erosion in the left thumb. A radial incision was made, and the tendons and eroded bone were visualized. The ruptured tendon ends were meticulously debrided and repaired using a four-strand cross-stitch technique, and bone erosion was managed through debridement and bone graft placement. The wound was closed, and a thumb spica splint was applied for support and protection.

9. Operative Note - Extensor Tendon Repair with Bone Erosion Reconstruction: The patient presented with spontaneous rupture of extensor tendons and bone erosion in the right middle finger. A radial approach was utilized, and the tendons and eroded bone were exposed. The ruptured tendon ends were repaired using a single-row locking suture technique, and bone erosion was addressed through thorough debridement and bone grafting. The wound was closed, and a dorsal splint was applied for immobilization and support.

10. Operative Note - Spontaneous Rupture of Extensor Tendons with Bone Erosion Repair: A patient underwent surgical intervention for spontaneous rupture of extensor tendons with underlying bone erosion in the left hand. A volar incision was made, and the tendons and eroded bone were identified. The ruptured tendon ends were repaired using a modified Kessler suture technique, and bone erosion was managed through meticulous debridement and bone graft placement. The wound was closed, and a volar splint was applied for postoperative immobilization and protection.

1. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Bone Pain Repair: The patient underwent surgical intervention for spontaneous rupture of extensor tendons with severe bone pain in the right hand. A dorsal approach was utilized, and the tendons were identified. The ruptured ends were meticulously debrided and repaired using a modified Kessler technique. Additionally, measures were taken to address the underlying bone pain, including local infiltration of analgesics and nerve blocks. The wound was closed, and a dorsal splint was applied.

2. Operative Note - Extensor Tendon Reconstruction with Severe Bone Pain Management: A patient presented with spontaneous rupture of extensor tendons and severe bone pain in the left wrist. A volar incision was made, and the tendons were exposed. The ruptured ends were repaired using a four-strand core suture technique. To manage the severe bone pain, perioperative systemic analgesics and regional anesthesia techniques such as brachial plexus block were employed. The wound was closed, and a volar splint was applied for immobilization.

3. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Bone Pain Repair: The surgical repair of spontaneous rupture of extensor tendons with severe bone pain in the right thumb was performed. A radial approach was utilized, and the tendons were visualized. The ruptured ends were reapproximated using a modified Bunnell suture technique. To alleviate the severe bone pain, a combination of intraoperative analgesics and targeted nerve blocks were administered. The wound was closed, and a thumb spica splint was applied.

4. Operative Note - Extensor Tendon Repair with Severe Bone Pain Management: The patient underwent surgery for spontaneous rupture of extensor tendons with severe bone pain in the left index finger. A radial incision was made, and the tendons were exposed. The ruptured ends were repaired using a single-row locking suture technique. To address the severe bone pain, multimodal analgesic approaches including local infiltration of analgesics and perioperative systemic pain medications were employed. The wound was closed, and a dorsal splint was applied.

5. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Bone Pain Repair: A patient presented with spontaneous rupture of extensor tendons with severe bone pain in the right hand. A dorsal zigzag incision was made, and the tendons were visualized. The ruptured ends were repaired using a Pulvertaft weave technique. To alleviate the severe bone pain, preoperative analgesics, intraoperative regional anesthesia, and postoperative systemic pain management were implemented. The wound was closed, and a dorsal splint was applied for immobilization.

6. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Bone Pain Repair: The patient underwent surgical intervention for spontaneous rupture of extensor tendons with severe bone pain in the left wrist. A volar approach was employed, and the tendons were exposed. The ruptured ends were repaired using a modified Kessler technique with epitendinous sutures. Intraoperative measures were taken to address the severe bone pain, including the administration of analgesics and nerve blocks. The wound was closed, and a volar splint was applied for support and protection.

7. Operative Note - Extensor Tendon Reconstruction with Severe Bone Pain Management: The surgical repair of spontaneous rupture of extensor tendons with severe bone pain in the right hand was performed. A dorsal approach was utilized,

and the tendons were identified. The ruptured ends were mobilized and repaired using a modified Bunnell suture technique. Severe bone pain was managed through a combination of perioperative analgesics, regional anesthesia techniques, and local infiltration of analgesics. The wound was closed, and a dorsal splint was applied for immobilization and support.

8. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Bone Pain Repair: The patient presented with spontaneous rupture of extensor tendons with severe bone pain in the left thumb. A radial incision was made, and the tendons were exposed. The ruptured ends were meticulously debrided and repaired using a four-strand cross-stitch technique. To address the severe bone pain, a comprehensive multimodal pain management approach was implemented, including systemic analgesics and regional anesthesia techniques. The wound was closed, and a thumb spica splint was applied for support and protection.

9. Operative Note - Extensor Tendon Repair with Severe Bone Pain Management: The patient underwent surgery for spontaneous rupture of extensor tendons with severe bone pain in the right middle finger. A radial approach was utilized, and the tendons were exposed. The ruptured ends were repaired using a single-row locking suture technique. To alleviate the severe bone pain, a combination of perioperative analgesics, local anesthetic infiltration, and nerve blocks were employed. The wound was closed, and a dorsal splint was applied for immobilization and support.

10. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Bone Pain Repair: A patient underwent surgical intervention for spontaneous rupture of extensor tendons with severe bone pain in the left hand. A volar incision was made, and the tendons were identified. The ruptured ends were repaired using a modified Kessler suture technique, and measures were taken to manage the severe bone pain, including preoperative analgesics, intraoperative regional anesthesia, and postoperative pain management. The wound was closed, and a volar splint was applied for postoperative immobilization and protection.

1. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: The patient underwent surgical repair for spontaneous rupture of extensor tendons in the right hand. A dorsal approach was employed, and the tendons were visualized. The ruptured ends were meticulously debrided and repaired using a modified Kessler suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and protection.

2. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: A patient presented with spontaneous rupture of extensor tendons in the left wrist. A volar incision was made, and the tendons were exposed. The ruptured ends were repaired using a four-strand core suture technique. The wound was closed, and a volar splint was applied to maintain the repair during the healing process.

3. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: The patient underwent surgery for spontaneous rupture of extensor tendons in the right thumb. A radial incision was made, and the tendons were visualized. The ruptured ends were repaired using a modified Bunnell suture technique. The wound was closed, and a thumb spica splint was applied for postoperative immobilization and support.

4. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient presented with spontaneous rupture of extensor tendons in the left index finger. A radial approach was utilized, and the tendons were identified. The ruptured ends were repaired using a single-row locking suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and protection.

5. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: A patient underwent surgical repair for spontaneous rupture of extensor tendons in the right hand. A dorsal zigzag incision was made, and the tendons were visualized. The ruptured ends were repaired using a Pulvertaft weave technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and support.

6. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient presented with spontaneous rupture of extensor tendons in the left wrist. A volar incision was made, and the tendons were exposed. The ruptured ends were repaired using a modified Kessler technique. The wound was closed, and a volar splint was applied to maintain the repair in proper alignment.

7. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: The surgical repair of spontaneous rupture of extensor tendons in the right hand was performed. A dorsal approach was employed, and the tendons were identified. The ruptured ends were mobilized and repaired using a modified Bunnell suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and protection.

8. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient underwent surgery for spontaneous rupture of extensor tendons in the left thumb. A radial incision was made, and the tendons were exposed. The ruptured ends were meticulously debrided and repaired using a four-strand cross-stitch technique. The wound was closed, and a thumb spica splint was applied for postoperative immobilization and support.

9. Operative Note - Surgical Intervention for Spontaneous Rupt

ure of Extensor Tendons: The patient presented with spontaneous rupture of extensor tendons in the right middle finger. A radial approach was utilized, and the tendons were exposed. The ruptured ends were repaired using a single-row locking suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and support.

10. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: A patient underwent surgical intervention for spontaneous rupture of extensor tendons in the left hand. A volar incision was made, and the tendons were identified. The ruptured ends were repaired using a modified Kessler suture technique. The wound was closed, and a volar splint was applied for postoperative immobilization and protection.

1. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the right hand. A dorsal approach was employed, and the tendons were visualized. The ruptured ends were meticulously debrided and repaired using a modified Bunnell suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and protection.

2. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: A patient presented with spontaneous rupture of extensor tendons in the left wrist. A volar incision was made, and the tendons were exposed. The ruptured ends were repaired using a four-strand core suture technique. The wound was closed, and a volar splint was applied for postoperative immobilization and support.

3. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient presented with spontaneous rupture of extensor tendons in the right thumb. A radial incision was made, and the tendons were visualized. The ruptured ends were repaired using a modified Kessler suture technique. The wound was closed, and a thumb spica splint was applied for postoperative immobilization and support.

4. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: A patient underwent surgical repair for spontaneous rupture of extensor tendons in the left index finger. A radial approach was utilized, and the tendons were identified. The ruptured ends were repaired using a single-row locking suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and protection.

5. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient presented with spontaneous rupture of extensor tendons in the right hand. A dorsal zigzag incision was made, and the tendons were visualized. The ruptured ends were repaired using a Pulvertaft weave technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and support.

6. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: The surgical repair of spontaneous rupture of extensor tendons in the left hand was performed. A volar approach was employed, and the tendons were exposed. The ruptured ends were repaired using a modified Bunnell suture technique. The wound was closed, and a volar splint was applied for postoperative immobilization and protection.

7. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient underwent surgery for spontaneous rupture of extensor tendons in the right middle finger. A radial incision was made, and the tendons were exposed. The ruptured ends were meticulously debrided and repaired using a four-strand cross-stitch technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and support.

8. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: A patient presented with spontaneous rupture of extensor tendons in the left thumb. A radial approach was utilized, and the tendons were visualized. The ruptured ends were repaired using a single-row locking suture technique. The wound was closed, and a thumb spica splint was applied for postoperative immobilization and support.

9. Operative Note - Surgical Repair of Spontaneous Rupture of Extensor Tendons: The patient presented with spontaneous rupture of extensor tendons in the right hand. A dorsal approach was employed, and the tendons were identified. The ruptured ends were mobilized and repaired using a modified Kessler suture technique. The wound was closed, and a dorsal splint was applied for postoperative immobilization and protection.

10. Operative Note - Surgical Intervention for Spontaneous Rupture of Extensor Tendons: A patient underwent surgical repair for spontaneous rupture of extensor tendons in the left wrist. A volar incision was made, and the tendons were exposed. The ruptured ends were repaired using a modified Bunnell technique. The wound was closed, and a volar splint was applied for postoperative immobilization and support.

1. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Joint Infection: The patient underwent surgical intervention for spontaneous rupture of extensor tendons with severe infection on the moving joint of the right hand. A dorsal approach was employed, and the tendons were visualized. The infected tissues were meticulously debrided, and the ruptured ends of the tendons were repaired using a modified Kessler suture technique. Extensive irrigation and drainage of the infected joint were performed. The wound was closed, and appropriate antibiotic therapy was initiated.

2. Operative Note - Extensor Tendon Reconstruction with Severe Joint Infection Management: A patient presented with spontaneous rupture of extensor tendons and severe infection on the moving joint of the left wrist. A volar incision was made, and the tendons were exposed. The infected tissues were thoroughly debrided, and the ruptured ends of the tendons were repaired using a four-strand core suture technique. Adequate irrigation and debridement of the infected joint were performed, followed by application of antibiotic-laden cement spacer. The wound was closed, and postoperative intravenous antibiotic therapy was initiated.

3. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Joint Infection: The surgical repair of spontaneous rupture of extensor tendons with severe infection on the moving joint of the right thumb was performed. A radial approach was utilized, and the tendons were visualized. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a modified Bunnell suture technique. The infected joint was thoroughly irrigated and drained. The wound was closed, and broad-spectrum antibiotics were initiated.

4. Operative Note - Extensor Tendon Repair with Severe Joint Infection Management: The patient underwent surgery for spontaneous rupture of extensor tendons with severe infection on the moving joint of the left index finger. A radial incision was made, and the tendons were exposed. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a single-row locking suture technique. The infected joint was meticulously irrigated and drained. The wound was closed, and appropriate antibiotic therapy was initiated.

5. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Joint Infection: A patient presented with spontaneous rupture of extensor tendons and severe infection on the moving joint of the right hand. A dorsal zigzag incision was made, and the tendons were visualized. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a Pulvertaft weave technique. The infected joint was thoroughly irrigated and drained. The wound was closed, and intravenous antibiotics were initiated.

6. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Joint Infection: The patient underwent surgical intervention for spontaneous rupture of extensor tendons with severe infection on the moving joint of the left wrist. A volar approach was employed, and the tendons were exposed. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a modified Kessler technique. Adequate irrigation and drainage of the infected joint were performed. The wound was closed, and appropriate intravenous antibiotic therapy was initiated.

7. Operative Note - Extensor Tendon Reconstruction with Severe Joint Infection Management: The surgical repair of spontaneous

rupture of extensor tendons with severe infection on the moving joint of the right middle finger was performed. A radial incision was made, and the tendons were exposed. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a four-strand cross-stitch technique. The infected joint was meticulously irrigated and drained. The wound was closed, and broad-spectrum antibiotics were initiated.

8. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Joint Infection: A patient presented with spontaneous rupture of extensor tendons and severe infection on the moving joint of the left thumb. A radial approach was utilized, and the tendons were visualized. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a single-row locking suture technique. The infected joint was thoroughly irrigated and drained. The wound was closed, and intravenous antibiotics were initiated.

9. Operative Note - Extensor Tendon Repair with Severe Joint Infection Management: The patient underwent surgery for spontaneous rupture of extensor tendons with severe infection on the moving joint of the right index finger. A dorsal incision was made, and the tendons were exposed. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a modified Bunnell suture technique. The infected joint was meticulously irrigated and drained. The wound was closed, and appropriate antibiotic therapy was initiated.

10. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Joint Infection: A patient presented with spontaneous rupture of extensor tendons and severe infection on the moving joint of the left hand. A volar incision was made, and the tendons were exposed. Extensive debridement of the infected tissues was performed, and the ruptured ends of the tendons were repaired using a modified Kessler suture technique. The infected joint was thoroughly irrigated and drained. The wound was closed, and intravenous antibiotics were initiated.

1. Operative Note - Spontaneous Rupture of Extensor Tendons with Acute Inflammation: The patient underwent surgical intervention for spontaneous rupture of extensor tendons with acute inflammation in the right hand. A dorsal approach was employed, and the tendons were visualized. The inflamed tissues were carefully dissected, and the ruptured ends of the tendons were repaired using a modified Kessler suture technique. The wound was closed, and anti-inflammatory medication was prescribed postoperatively.

2. Operative Note - Extensor Tendon Repair with Chronic Inflammation Management: A patient presented with spontaneous rupture of extensor tendons and chronic inflammation in the left wrist. A volar incision was made, and the tendons were exposed. The inflamed tissues were meticulously dissected, and the ruptured ends of the tendons were repaired using a four-strand core suture technique. The wound was closed, and a course of oral corticosteroids was initiated for inflammation control.

3. Operative Note - Spontaneous Rupture of Extensor Tendons with Subacute Inflammation: The patient underwent surgery for spontaneous rupture of extensor tendons with subacute inflammation in the right thumb. A radial incision was made, and the tendons were visualized. The inflamed tissues were carefully dissected, and the ruptured ends of the tendons were repaired using a modified Kessler suture technique. The wound was closed, and a nonsteroidal anti-inflammatory drug (NSAID) was prescribed postoperatively.

4. Operative Note - Extensor Tendon Reconstruction with Mild Inflammation Management: The surgical repair of spontaneous rupture of extensor tendons with mild inflammation in the left index finger was performed. A radial approach was utilized, and the tendons were exposed. The mildly inflamed tissues were dissected, and the ruptured ends of the tendons were repaired using a single-row locking suture technique. The wound was closed, and oral anti-inflammatory medication was prescribed.

5. Operative Note - Spontaneous Rupture of Extensor Tendons with Moderate Inflammation: A patient presented with spontaneous rupture of extensor tendons and moderate inflammation in the moving joint of the right hand. A dorsal zigzag incision was made, and the tendons were visualized. The moderately inflamed tissues were meticulously dissected, and the ruptured ends of the tendons were repaired using a Pulvertaft weave technique. The wound was closed, and a short course of oral corticosteroids was prescribed.

6. Operative Note - Spontaneous Rupture of Extensor Tendons with Severe Inflammation: The patient underwent surgical intervention for spontaneous rupture of extensor tendons with severe inflammation in the left hand. A volar approach was employed, and the tendons were exposed. The severely inflamed tissues were carefully dissected, and the ruptured ends of the tendons were repaired using a modified Kessler technique. The wound was closed, and intraoperative corticosteroid injection was administered for inflammation control.

7. Operative Note - Extensor Tendon Repair with Acute Exacerbation of Inflammation: The patient presented with spontaneous rupture of extensor tendons and acute exacerbation of inflammation in the right middle finger. A radial incision was made, and the tendons were exposed. The acutely inflamed tissues were meticulously dissected, and the ruptured ends of the tendons were repaired using a four-strand cross-stitch technique. The wound was closed, and a combination of oral corticosteroids and NSAIDs was prescribed.

8. Operative Note - Spontaneous Rupture of Extensor Tendons with Recurrent Inflammation: A patient underwent surgery for spontaneous rupture of extensor tendons with recurrent inflammation in the left thumb. A radial approach was utilized, and the tendons were visualized. The recurrently inflamed tissues were carefully dissected, and the ruptured ends of the tendons were repaired using a single-row locking suture technique. The wound was closed, and a long-term anti-inflammatory regimen was initiated.

9. Operative Note - Extensor Tendon Reconstruction with Subacute Inflammation Management: The surgical repair of spontaneous rupture of extensor tendons with subacute inflammation in the right index finger was performed. A dorsal incision was made, and the tendons were exposed. The subacutely inflamed tissues were meticulously dissected, and the ruptured ends of the tendons were repaired using a modified Bunnell suture technique. The wound was closed, and a course of oral corticosteroids was prescribed for inflammation control.

10. Operative Note - Spontaneous Rupture of Extensor Tendons with Chronic Inflammation: A patient presented with spontaneous rupture of extensor tendons and chronic inflammation in the moving joint of the left hand. A volar incision was made, and the tendons were exposed. The chronically inflamed tissues were carefully dissected, and the ruptured ends of the tendons were repaired using a modified Kessler suture technique. The wound was closed, and a combination of oral corticosteroids and disease-modifying anti-rheumatic drugs (DMARDs) was prescribed for long-term inflammation management.

1. Operative Note - Spontaneous Rupture of Extensor Tendons: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the right hand. The tendons were repaired using a modified Kessler suture technique. Postoperative follow-up will be scheduled based on the severity of the diagnosis and the patient's response to treatment.

2. Operative Note - Extensor Tendon Reconstruction: A patient presented with spontaneous rupture of extensor tendons in the left wrist. The tendons were repaired using a four-strand core suture technique. The frequency of follow-up visits will be determined based on the severity of the diagnosis and the patient's recovery progress.

3. Operative Note - Spontaneous Rupture of Extensor Tendons: The surgical repair of spontaneous rupture of extensor tendons in the right thumb was performed. The tendons were repaired using a modified Bunnell technique. The need for follow-up appointments will be assessed based on the severity of the diagnosis and the patient's postoperative course.

4. Operative Note - Extensor Tendon Repair: The patient underwent surgery for spontaneous rupture of extensor tendons in the left index finger. The tendons were repaired using a single-row locking suture technique. The frequency and duration of follow-up visits will be determined by the severity of the diagnosis and the patient's response to treatment.

5. Operative Note - Spontaneous Rupture of Extensor Tendons: A patient presented with spontaneous rupture of extensor tendons in the right hand. The tendons were repaired using a Pulvertaft weave technique. The follow-up plan will be tailored to the severity of the diagnosis and the patient's individual needs.

6. Operative Note - Spontaneous Rupture of Extensor Tendons: The patient underwent surgical intervention for spontaneous rupture of extensor tendons in the left wrist. The tendons were repaired using a modified Kessler suture technique. The frequency of follow-up appointments will be determined based on the severity of the diagnosis and the patient's progress during the recovery period.

7. Operative Note - Extensor Tendon Reconstruction: The surgical repair of spontaneous rupture of extensor tendons in the right middle finger was performed. The tendons were repaired using a four-strand cross-stitch technique. The need for follow-up visits will be assessed based on the severity of the diagnosis and the patient's response to the surgical intervention.

8. Operative Note - Spontaneous Rupture of Extensor Tendons: A patient presented with spontaneous rupture of extensor tendons in the left thumb. The tendons were repaired using a single-row locking suture technique. The frequency and duration of follow-up appointments will be determined based on the severity of the diagnosis and the patient's recovery progress.

9. Operative Note - Extensor Tendon Repair: The patient underwent surgery for spontaneous rupture of extensor tendons in the right index finger. The tendons were repaired using a modified Bunnell suture technique. The follow-up plan will be individualized based on the severity of the diagnosis and the patient's specific needs.

10. Operative Note - Spontaneous Rupture of Extensor Tendons: A patient presented with spontaneous rupture of extensor tendons in the left hand. The tendons were repaired using a modified Kessler suture technique. The follow-up schedule will be determined based on the severity of the diagnosis and the patient's recovery trajectory.

## M66.3 Spontaneous rupture of flexor tendons

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair: A dorsal approach was used to expose the affected tendons. The ruptured ends were identified and meticulously debrided. Primary repair was performed using a modified Kessler technique. Tendon integrity was confirmed through passive joint range of motion. Wound closure was achieved using absorbable sutures. Postoperative immobilization and hand therapy were recommended.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Revision: An extensile volar approach was utilized to access the ruptured tendons. Adhesions were meticulously released, and the ends of the tendons were identified. Extensive debridement of nonviable tissue was performed. Tendon ends were reapproximated and secured using a modified Bunnell technique. Adequate tendon excursion was confirmed intraoperatively. Wound closure was achieved using layered sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction: A volar zig-zag incision was made to expose the ruptured tendons. Tendon ends were refreshed and sutured using the Pulvertaft weave technique. Augmentation with an autograft was performed to reinforce the repair. Tendon gliding was ensured intraoperatively, and satisfactory excursion was achieved. Wound closure was accomplished using absorbable sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Tenorrhaphy: A limited volar approach was utilized to access the torn tendons. After thorough debridement, a running epitendinous suture was applied using a modified Kessler technique. Tendon integrity and gliding were confirmed. Subcutaneous tissue and skin were meticulously closed. Postoperative hand therapy and immobilization were advised.

5. Operative Note - Spontaneous Rupture of Flexor Tendons End-to-End Repair: A transverse incision was made to expose the ruptured flexor tendons. The torn ends were identified, debrided, and meticulously approximated. An end-to-end repair was performed using a combination of simple and locking sutures. Adequate tendon excursion was achieved, and the repair was confirmed to be stable. Wound closure was accomplished using interrupted sutures.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer: A volar approach was used to expose the ruptured tendons. After thorough debridement, a neighboring intact tendon was identified for transfer. The transfer was performed using a combination of tendon grafting and tenodesis techniques. Adequate tension and excursion were confirmed intraoperatively. Wound closure was achieved using layered sutures.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Grafting: A dorsal approach was utilized to access the affected tendons. After thorough debridement, a suitable donor tendon was harvested. The graft was sized and sutured to bridge the tendon defect. Adequate tension and suture strength were ensured. Wound closure was accomplished using absorbable sutures. Postoperative rehabilitation and hand therapy were recommended.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Augmented Repair: An extended volar approach was made to expose the ruptured tendons. The ruptured ends were refreshed, and a biological augmentation matrix was placed over the repair site. The tendons were reapproximated using a modified Kessler technique. Adequate excursion and stability were confirmed intraoperatively. Wound closure was achieved using absorbable sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tend

ons Pulley Reconstruction: A volar incision was made to expose the ruptured tendons and affected pulleys. The torn pulleys were reconstructed using a combination of local tissue and autograft. Tendon integrity and gliding were confirmed. The repaired pulleys were securely anchored. Wound closure was accomplished using layered sutures. Postoperative hand therapy was recommended.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon-to-Bone Repair: A volar approach was used to expose the ruptured tendons. The tendon ends were refreshed, and bone tunnels were created at their insertion sites. Sutures were passed through the tendons and secured to the bone. Adequate tension and stability were confirmed. Wound closure was achieved using absorbable sutures. Postoperative immobilization and hand therapy were advised.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis: A volar approach was utilized to expose the adhesions around the ruptured tendons. Extensive adhesiolysis was performed, freeing the tendons and restoring their mobility. Tendon gliding was confirmed intraoperatively. The wound was meticulously closed using layered sutures. Postoperative hand therapy and range of motion exercises were recommended.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Interposition Arthroplasty: A dorsal approach was made to access the affected tendons. The ruptured ends were debrided, and a tendon graft was interposed between them to bridge the gap. Adequate tension and alignment were achieved. The repaired tendons were secured using absorbable sutures. Wound closure was accomplished using interrupted sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Lengthening: A volar incision was made to expose the contracted tendons. Multiple Z-plasty techniques were employed to lengthen the tendons adequately. The lengthened tendons were sutured together using a modified Kessler technique. Tendon excursion and tension were confirmed intraoperatively. Wound closure was achieved using absorbable sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Tenodesis: An extensile dorsal approach was used to access the ruptured tendons. The distal ends of the tendons were identified and prepared for tenodesis. The tendons were securely anchored to a stable structure using absorbable sutures. Adequate tension and stability were achieved. Wound closure was accomplished using layered sutures.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer with Pulley Reconstruction: A volar approach was employed to access the affected tendons and pulleys. A neighboring intact tendon was identified for transfer. The transfer was performed, and the reconstructed pulleys were anchored securely. Adequate tendon excursion and pulley stability were confirmed intraoperatively. Wound closure was achieved using absorbable sutures.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Endoscopic Repair: A minimally invasive endoscopic approach was used to access the ruptured tendons. The torn ends were identified and meticulously debrided. Endoscopic suturing techniques, such as the Mason-Allen stitch, were employed for primary repair. Adequate tendon gliding was confirmed intraoperatively. The portals were closed using absorbable sutures.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Reinforcement with Biologic Augmentation: A volar approach was made to expose the ruptured tendons. The torn ends were refreshed, and a biologic augmentation matrix was applied over the repair site. The tendons were then reapproximated and secured using a combination of sutures. Adequate tension, stability, and augmentation were achieved. Wound closure was accomplished using absorbable sutures.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Excision and Arthrodesis: A dorsal approach was utilized to expose the ruptured tendons and the affected joint. The ruptured tendons were excised, and joint surfaces were prepared for arthrodesis. The joint was stabilized using internal fixation hardware. Adequate joint alignment and stability were confirmed. Wound closure was achieved using layered sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer with Extensor-to-Flexor Conversion: A vol

ar approach was used to access the ruptured tendons. A suitable donor tendon was identified for transfer, and extensor-to-flexor conversion was performed. The transferred tendon was secured to the flexor tendon remnants using sutures. Adequate tension and excursion were achieved. Wound closure was accomplished using absorbable sutures.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Secondary Tendon Repair: A volar approach was made to expose the previously repaired tendons. The integrity of the previous repair was assessed, and any areas of disruption were identified. Tendon ends were debrided, and a secondary repair was performed using appropriate suturing techniques. Adequate tendon gliding and stability were confirmed. Wound closure was achieved using absorbable sutures.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair under Local Anesthesia: The patient was placed under local anesthesia with lidocaine infiltration. A dorsal approach was used to expose the ruptured tendons. Primary repair was performed using a modified Kessler technique. Tendon integrity was confirmed through passive joint range of motion. Wound closure was achieved using absorbable sutures. Postoperative immobilization and hand therapy were recommended.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Revision under General Anesthesia: The patient was induced under general anesthesia with endotracheal intubation. An extensile volar approach was utilized to access the ruptured tendons. Extensive debridement and revision of the previous repair were performed. Tendon ends were reapproximated and secured using a modified Bunnell technique. Adequate tendon excursion was confirmed intraoperatively. Wound closure was achieved using layered sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction under Regional Anesthesia: The patient received regional anesthesia with a brachial plexus block. A volar zig-zag incision was made to expose the ruptured tendons. Tendon ends were refreshed and sutured using the Pulvertaft weave technique. Augmentation with an autograft was performed to reinforce the repair. Tendon gliding was ensured intraoperatively, and satisfactory excursion was achieved. Wound closure was accomplished using absorbable sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Tenorrhaphy under Conscious Sedation: The patient was administered conscious sedation with intravenous medications. A limited volar approach was utilized to access the torn tendons. After thorough debridement, a running epitendinous suture was applied using a modified Kessler technique. Tendon integrity and gliding were confirmed. Subcutaneous tissue and skin were meticulously closed. Postoperative hand therapy and immobilization were advised.

5. Operative Note - Spontaneous Rupture of Flexor Tendons End-to-End Repair under Spinal Anesthesia: The patient underwent spinal anesthesia for the procedure. A transverse incision was made to expose the ruptured flexor tendons. The torn ends were identified, debrided, and meticulously approximated. An end-to-end repair was performed using a combination of simple and locking sutures. Adequate tendon excursion was achieved, and the repair was confirmed to be stable. Wound closure was accomplished using interrupted sutures.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer under General Anesthesia with MAC (Monitored Anesthesia Care): The patient was placed under general anesthesia with monitored anesthesia care. A volar approach was used to expose the ruptured tendons. After thorough debridement, a neighboring intact tendon was identified for transfer. The transfer was performed using a combination of tendon grafting and tenodesis techniques. Adequate tension and excursion were confirmed intraoperatively. Wound closure was achieved using layered sutures.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Grafting under Local Anesthesia: The patient received local anesthesia with lidocaine infiltration. A dorsal approach was utilized to access the affected tendons. After thorough debridement, a suitable donor tendon was harvested. The graft was sized and sutured to bridge the tendon defect. Adequate tension and suture strength were ensured. Wound closure was accomplished using absorbable sutures. Postoperative rehabilitation and hand therapy were recommended.

8. Operative Note - Spontaneous Rupt

ure of Flexor Tendons Augmented Repair under General Anesthesia: The patient was induced under general anesthesia with endotracheal intubation. An extended volar approach was made to expose the ruptured tendons. The ruptured ends were refreshed, and a biological augmentation matrix was placed over the repair site. The tendons were reapproximated using a modified Kessler technique. Adequate excursion and stability were confirmed intraoperatively. Wound closure was achieved using absorbable sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis under Regional Anesthesia: The patient received regional anesthesia with an axillary block. A volar approach was utilized to expose the adhesions around the ruptured tendons. Extensive adhesiolysis was performed, freeing the tendons and restoring their mobility. Tendon gliding was confirmed intraoperatively. The wound was meticulously closed using layered sutures. Postoperative hand therapy and range of motion exercises were recommended.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Interposition Arthroplasty under General Anesthesia with TIVA (Total Intravenous Anesthesia): The patient was induced under general anesthesia with total intravenous anesthesia. A dorsal approach was made to access the affected tendons. The ruptured ends were debrided, and a tendon graft was interposed between them to bridge the gap. Adequate tension and alignment were achieved. The repaired tendons were secured using absorbable sutures. Wound closure was accomplished using interrupted sutures.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Bone Erosion: A dorsal approach was used to expose the ruptured tendons and assess the extent of bone erosion. Significant erosion was noted at the insertion site. Tendon ends were debrided, and bone grafting was performed to reconstruct the eroded area. Tendon repair was then completed using a modified Kessler technique. Adequate tendon excursion and stability were achieved. Wound closure was accomplished using layered sutures.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Extensive Bone Erosion: An extensive volar approach was made to access the ruptured tendons and address the severe bone erosion. The eroded bone was carefully debrided, and a bone graft was harvested to reconstruct the defect. Tendon repair was performed using a combination of sutures and tendon grafts. Adequate tension, tendon excursion, and bone stability were confirmed. Wound closure was achieved using absorbable sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Tenorrhaphy with Bone Erosion: A limited volar approach was utilized to access the ruptured tendons and assess the associated bone erosion. The eroded bone edges were smoothed and debrided. Tendon repair was performed using a modified Kessler technique, and a reinforced suture was passed through the adjacent intact bone for added stability. Adequate tendon gliding and bone support were achieved. Wound closure was accomplished using interrupted sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer with Bone Erosion: A volar approach was employed to address the ruptured tendons and associated bone erosion. The eroded bone was carefully debrided, and a tendon transfer was performed to restore function. The transferred tendon was securely anchored to the intact bone using sutures and bone tunnels. Adequate tension, tendon excursion, and bone stability were confirmed. Wound closure was achieved using layered sutures.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion and Joint Involvement: A combined dorsal and volar approach was used to address the ruptured tendons, extensive bone erosion, and involvement of the adjacent joint. The eroded bone surfaces were thoroughly debrided, and bone grafting was performed. Tendon repair and joint reconstruction were carried out to restore function and stability. Adequate tendon excursion, joint alignment, and bone support were achieved. Wound closure was accomplished using absorbable sutures.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Bone Erosion: The patient presented with tendon adhesions and bone erosion. A volar approach was used to access the adhesions and assess the extent of bone involvement. Adhesiolysis was performed to release the tendons, and bone debridement was conducted to remove the eroded areas. Tendon gliding was restored, and bone surfaces were smoothed. Wound closure was achieved using absorbable sutures. Postoperative hand therapy was recommended.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Extensive Bone Erosion under General Anesthesia: The patient was induced under general anesthesia with endotracheal intubation. A dorsal approach was made to expose the ruptured tendons and assess the extensive bone erosion. Bone grafting was performed to reconstruct the eroded area, followed by meticulous tendon repair using a modified Kessler technique. Adequate tendon excursion, stability, and bone support were achieved. W

ound closure was accomplished using layered sutures.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion and Joint Fusion: The patient presented with severe tendon rupture, extensive bone erosion, and joint instability. A combined dorsal and volar approach was utilized to address these issues. Tendon repair was performed, and the eroded bone surfaces were debrided. Joint fusion was carried out to restore stability. Adequate tendon excursion, joint alignment, and bone fusion were confirmed. Wound closure was achieved using absorbable sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Bone Erosion: The patient underwent revision surgery for recurrent tendon rupture and associated bone erosion. A volar approach was made to expose the affected tendons and assess the extent of bone involvement. The eroded bone was debrided, and bone grafting was performed. Tendon repair was then completed using a modified Bunnell technique. Adequate tendon excursion, stability, and bone support were achieved. Wound closure was accomplished using layered sutures.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion and Joint Arthroplasty: The patient presented with extensive tendon rupture, bone erosion, and joint degeneration. A combined approach was used to address these issues. Tendon repair was performed, and bone grafting was conducted to reconstruct the eroded bone. Joint arthroplasty was carried out to restore joint function. Adequate tendon excursion, joint stability, and bone support were achieved. Wound closure was achieved using absorbable sutures.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Severe Bone Pain: The patient presented with severe bone pain in addition to tendon rupture. A volar approach was used to access the ruptured tendons and assess the underlying bone pathology. The eroded bone surfaces were carefully debrided, and a bone graft was applied to provide structural support. Tendon repair was performed using a modified Kessler technique. Adequate tendon excursion and pain relief were achieved. Wound closure was accomplished using layered sutures.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion and Severe Bone Pain: The patient complained of severe bone pain associated with tendon rupture and bone erosion. A combined dorsal and volar approach was utilized to address these concerns. Bone debridement was performed to alleviate the pain, and bone grafting was conducted to reconstruct the eroded areas. Tendon repair was then carried out using sutures and grafts. Adequate tendon excursion and significant pain relief were achieved. Wound closure was achieved using absorbable sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Tenorrhaphy with Severe Bone Pain: The patient presented with severe bone pain and tendon rupture. A volar approach was made to access the ruptured tendons and evaluate the underlying bone pathology. The eroded bone surfaces were debrided, and a reinforced suture was passed through adjacent healthy bone to stabilize the repair. Adequate tendon gliding and pain relief were achieved. Wound closure was accomplished using interrupted sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer with Severe Bone Pain: The patient reported severe bone pain associated with tendon rupture. A volar approach was employed to address the tendon rupture and bone pathology. Bone debridement was performed to alleviate the pain, and a tendon transfer was carried out to restore function. The transferred tendon was secured to healthy bone using sutures and bone tunnels. Adequate tendon excursion and significant pain relief were achieved. Wound closure was achieved using layered sutures.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Instability, and Severe Bone Pain: The patient presented with severe bone pain, extensive tendon rupture, bone erosion, and joint instability. A combined dorsal and volar approach was used to address these issues. Tendon repair was performed, eroded bone surfaces were debrided, and joint stabilization was achieved. Adequate tendon excursion, joint alignment, and significant pain relief were confirmed. Wound closure was achieved using absorbable sutures.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Bone Pain: The patient reported severe bone pain and restricted hand function due to tendon adhesions. A volar approach was used to access the adhesions and assess the underlying bone involvement. Adhesiolysis was performed to release the tendons, and bone debridement was conducted to alleviate the pain. Tendon gliding was restored, and bone surfaces were smoothed. Wound closure was achieved using absorbable sutures. Postoperative hand therapy was recommended for pain management.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Extensive Bone Erosion and Severe Bone Pain under General Anesthesia: The patient was induced under general anesthesia with endotracheal intubation. A dorsal approach was made to expose the ruptured tendons and address the severe bone erosion and accompanying severe bone pain. Bone grafting was performed to reconstruct

the eroded areas, followed by meticulous tendon repair using a modified Kessler technique. Adequate tendon excursion, stability, and significant pain relief were achieved. Wound closure was accomplished using layered sutures.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Fusion, and Severe Bone Pain: The patient presented with severe bone pain, tendon rupture, extensive bone erosion, and joint instability. A combined dorsal and volar approach was employed to address these issues. Tendon repair was performed, bone debridement was carried out to alleviate the pain, and joint fusion was performed to restore stability. Adequate tendon excursion, joint alignment, and significant pain relief were achieved. Wound closure was achieved using absorbable sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Bone Erosion and Severe Bone Pain: The patient underwent revision surgery for recurrent tendon rupture, bone erosion, and severe bone pain. A volar approach was made to expose the affected tendons and assess the extent of bone involvement. The eroded bone surfaces were debrided, and bone grafting was performed. Tendon repair was then completed using a modified Bunnell technique. Adequate tendon excursion, stability, and significant pain relief were achieved. Wound closure was accomplished using layered sutures.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Arthroplasty, and Severe Bone Pain: The patient presented with severe bone pain, extensive tendon rupture, bone erosion, and joint degeneration. A combined approach was used to address these issues. Tendon repair was performed, bone debridement was conducted to alleviate the pain, and joint arthroplasty was carried out to restore joint function. Adequate tendon excursion, joint stability, and significant pain relief were achieved. Wound closure was achieved using absorbable sutures.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Bone Erosion and Severe Pain: The patient underwent surgical intervention for the spontaneous rupture of flexor tendons, severe bone erosion, and intractable pain. A volar approach was utilized to expose the affected tendons and assess the bone pathology. The eroded bone was meticulously debrided, and a bone graft was applied. Tendon repair was performed using a modified Kessler technique. Adequate tendon excursion, pain relief, and improved bone stability were achieved. Wound closure was accomplished using layered sutures.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Involvement, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion and joint involvement. A combined approach was employed to address the complex pathology. Tendon repair was performed, bone debridement was conducted, and joint reconstruction was carried out. Adequate tendon excursion, joint stability, and improved bone support were achieved. Wound closure was achieved using absorbable sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Tenorrhaphy with Severe Bone Erosion and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion. A volar approach was made to access the tendons and assess the extent of bone involvement. The eroded bone surfaces were carefully debrided, and tendon repair was performed using a modified Kessler technique. Adequate tendon gliding, improved bone stability, and successful surgical intervention were achieved. Wound closure was accomplished using interrupted sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer with Bone Erosion and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion. A volar approach was utilized to address the tendon rupture and bone pathology. Bone debridement was performed, and tendon transfer was carried out to restore hand function. Adequate tendon excursion, improved bone stability, and successful surgical intervention were achieved. Wound closure was achieved using layered sutures.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Fusion, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion and joint instability. A combined approach was employed to address the complex pathology. Tendon repair, bone debridement, and joint fusion were performed. Adequate tendon excursion, joint stability, and successful surgical intervention were achieved. Wound closure was accomplished using absorbable sutures.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Bone Erosion and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion and tendon adhesions. A volar approach was used to access the tendons and assess the underlying bone involvement. Adhesiolysis was performed to release the tendons, and bone debridement was conducted to address the eroded bone. Adequate tendon gliding, improved bone stability, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures. Postoperative hand therapy was recommended.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Extensive Bone Erosion and Surgical Intervention under General Anesthesia: The patient underwent surgical intervention under general anesthesia for the repair of spontaneous rupture

of flexor tendons with extensive bone erosion. A dorsal approach was made to expose the tendons and address the severe bone pathology. Bone grafting was performed to reconstruct the eroded areas, followed by meticulous tendon repair using a modified Kessler technique. Adequate tendon excursion, improved bone stability, and successful surgical intervention were achieved. Wound closure was accomplished using layered sutures.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Fusion, and Surgical Intervention under Regional Anesthesia: The patient underwent surgical intervention under regional anesthesia for the repair of spontaneous rupture of flexor tendons with severe bone erosion and joint instability. A combined dorsal and volar approach was used to address the complex pathology. Tendon repair, bone debridement, and joint fusion were performed. Adequate tendon excursion, joint stability, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Bone Erosion and Surgical Intervention: The patient underwent surgical intervention for revision of spontaneous rupture of flexor tendons with recurrent tendon injury and severe bone erosion. A volar approach was made to expose the tendons and assess the extent of bone involvement. The eroded bone surfaces were debrided, and bone grafting was performed. Tendon repair was then completed using a modified Bunnell technique. Adequate tendon excursion, improved bone stability, and successful surgical intervention were achieved. Wound closure was accomplished using layered sutures.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Arthroplasty, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion, joint degeneration, and functional impairment. A combined approach was used to address the complex pathology. Tendon repair, bone debridement, and joint arthroplasty were performed. Adequate tendon excursion, joint stability, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion and intractable bone pain. A volar approach was utilized to expose the tendons and assess the extent of bone involvement. The eroded bone surfaces were meticulously debrided, and bone grafting was performed. Tendon repair was completed using a modified Kessler technique. Adequate tendon excursion, significant pain relief, and successful surgical intervention were achieved. Wound closure was accomplished using layered sutures.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Tenorrhaphy with Bone Erosion, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion and debilitating bone pain. A volar approach was made to access the tendons and evaluate the underlying bone pathology. The eroded bone surfaces were debrided, and tendon repair was performed using a modified Kessler technique. Adequate tendon gliding, significant pain relief, and successful surgical intervention were achieved. Wound closure was accomplished using interrupted sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Tendon Transfer with Bone Erosion, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion and persistent bone pain. A volar approach was employed to address the tendon rupture and bone pathology. Bone debridement was performed, and tendon transfer was carried out to restore hand function. Adequate tendon excursion, significant pain relief, and successful surgical intervention were achieved. Wound closure was achieved using layered sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Fusion, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion, joint instability, and excruciating bone pain. A combined approach was used to address the complex pathology. Tendon repair, bone debridement, and joint fusion were performed. Adequate tendon excursion, joint stability, significant pain relief, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Bone Erosion, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion, tendon adhesions, and intense bone pain. A volar approach was utilized to access the tendons and assess the underlying bone involvement. Adhesiolysis was performed to release the tendons, and bone debridement was conducted to alleviate the pain. Adequate tendon gliding, significant pain relief, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures. Postoperative hand therapy was recommended.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Extensive Bone Erosion, Severe Bone Pain, and Surgical Intervention under General Anesthesia: The patient underwent surgical intervention under general anesthesia for the repair of spontaneous rupture of flexor tendons with extensive bone erosion, severe bone pain, and limited hand function. A dorsal approach was made to expose the tendons and address the severe bone pathology. Bone grafting was performed to reconstruct the eroded areas, followed by meticulous tendon repair using a modified Kessler technique.

Adequate tendon excursion, significant pain relief, and successful surgical intervention were achieved. Wound closure was accomplished using layered sutures.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Fusion, Severe Bone Pain, and Surgical Intervention under Regional Anesthesia: The patient underwent surgical intervention under regional anesthesia for the repair of spontaneous rupture of flexor tendons with severe bone erosion, joint instability, and incapacitating bone pain. A combined dorsal and volar approach was used to address the complex pathology. Tendon repair, bone debridement, and joint fusion were performed. Adequate tendon excursion, joint stability, significant pain relief, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Bone Erosion, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for revision of spontaneous rupture of flexor tendons with recurrent tendon injury, severe bone erosion, and debilitating bone pain. A volar approach was made to expose the tendons and assess the extent of bone involvement. The eroded bone surfaces were meticulously debrided, and bone grafting was performed. Tendon repair was then completed using a modified Bunnell technique. Adequate tendon excursion, improved bone stability, significant pain relief, and successful surgical intervention were achieved. Wound closure was accomplished using layered sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Bone Erosion, Joint Arthroplasty, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion, joint degeneration, and excruciating bone pain. A combined approach was employed to address the complex pathology. Tendon repair, bone debridement, and joint arthroplasty were performed. Adequate tendon excursion, joint stability, significant pain relief, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Bone Erosion, Severe Bone Pain, and Surgical Intervention: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe bone erosion, tendon adhesions, and incapacitating bone pain. A volar approach was used to access the tendons and assess the underlying bone involvement. Adhesiolysis was performed to release the tendons, and bone debridement was conducted to alleviate the pain. Adequate tendon gliding, significant pain relief, and successful surgical intervention were achieved. Wound closure was achieved using absorbable sutures. Postoperative hand therapy was recommended.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Severe Infection and Bone Erosion on the Extreme Moving Joint: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe infection and bone erosion affecting the extreme moving joint. A thorough debridement of infected tissue and bone was performed, followed by tendon repair using a modified Kessler technique. Adequate tendon excursion, control of infection, and improved joint stability were achieved. Intravenous antibiotics were administered postoperatively. Wound closure was accomplished using layered sutures.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, and Joint Fusion on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, and joint instability on the extreme moving joint. Extensive debridement of infected tissue and bone was performed, followed by joint fusion to restore stability. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, and improved joint function were achieved. Wound closure was accomplished using absorbable sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Severe Infection and Bone Erosion on the Extreme Moving Joint: The patient underwent surgical intervention for the revision of spontaneous rupture of flexor tendons with severe infection and bone erosion affecting the extreme moving joint. A volar approach was made to expose the tendons and assess the extent of infection and bone involvement. Extensive debridement was performed, and bone grafting was done to restore bone integrity. Tendon repair was completed using a modified Bunnell technique. Adequate tendon excursion, infection control, and improved joint stability were achieved. Wound closure was accomplished using layered sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, and Joint Arthroplasty on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, and joint degeneration affecting the extreme moving joint. A combined approach was utilized to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint arthroplasty for joint restoration. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, improved joint function, and reduced pain were achieved. Wound closure was achieved using absorbable sutures.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Infection and Bone Erosion on the Extreme Moving Joint: The patient underwent surgical intervention for the tenolysis of spontaneous rupture of flexor tendons with severe infection and bone erosion affecting the extreme moving joint. A volar approach was used to access the tendons and assess the underlying infection and bone involvement. Extensive debridement was performed to clear the infection, and bone debridement was conducted to address the eroded bone. Adequate tendon gliding, infection control, and improved joint stability were achieved. Wound closure was accomplished using absorbable sutures. Postoperative administration of antibiotics was initiated.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Severe Infection, Bone Erosion, and Joint Fusion on the Extreme Moving Joint under General Anesthesia: The patient underwent surgical intervention under general anesthesia for the repair of spontaneous rupture of flexor tendons with severe infection, bone erosion, and joint instability affecting

the extreme moving joint. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint fusion to restore stability. Tendon repair was completed using a modified Kessler technique. Adequate tendon excursion, infection control, improved joint stability, and successful surgical intervention were achieved. Wound closure was accomplished using layered sutures.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, Joint Fusion, and Severe Bone Pain on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, joint instability, and debilitating bone pain affecting the extreme moving joint. A combined approach was utilized to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint fusion for stability and pain relief. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, improved joint function, and significant pain relief were achieved. Wound closure was accomplished using absorbable sutures.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Severe Infection, Bone Erosion, and Severe Bone Pain on the Extreme Moving Joint: The patient underwent surgical intervention for revision of spontaneous rupture of flexor tendons with severe infection, bone erosion, and excruciating bone pain affecting the extreme moving joint. A volar approach was made to expose the tendons and assess the extent of infection and bone involvement. Extensive debridement was performed, and bone grafting was done to restore bone integrity. Tendon repair was then completed using a modified Bunnell technique. Adequate tendon excursion, infection control, improved joint stability, and significant pain relief were achieved. Wound closure was accomplished using layered sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, Joint Arthroplasty, and Severe Bone Pain on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, joint degeneration, and incapacitating bone pain affecting the extreme moving joint. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint arthroplasty for joint restoration and pain relief. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, improved joint function, and significant pain relief were achieved. Wound closure was achieved using absorbable sutures.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Infection, Bone Erosion, and Severe Bone Pain on the Extreme Moving Joint: The patient underwent surgical intervention for the tenolysis of spontaneous rupture of flexor tendons with severe infection, bone erosion, and excruciating bone pain affecting the extreme moving joint. A volar approach was used to access the tendons and assess the underlying infection and bone involvement. Extensive debridement was performed to clear the infection, and bone debridement was conducted to address the eroded bone. Adequate tendon gliding, infection control, improved joint stability, and significant pain relief were achieved. Wound closure was accomplished using absorbable sutures. Postoperative administration of antibiotics and pain management was initiated.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Severe Infection, Bone Erosion, and Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe infection, bone erosion, and an intense inflammatory response affecting the extreme moving joint. A volar approach was made to expose the tendons and assess the extent of infection, inflammation, and bone involvement. Extensive debridement was performed to remove infected tissue and address the inflamed area. Tendon repair was completed using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of inflammation, and improved joint stability were achieved. Wound closure was accomplished using layered sutures.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, and Chronic Inflammation on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, and chronic inflammation affecting the extreme moving joint. A combined approach was utilized to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint reconstruction to restore stability and alleviate chronic inflammation. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of chronic inflammation, and improved joint function were achieved. Wound closure was accomplished using absorbable sutures.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Severe Infection, Bone Erosion, and Acute Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for revision of spontaneous rupture of flexor tendons with severe infection, bone erosion, and an acute inflammatory response affecting the extreme moving joint. A volar approach was made to expose the tendons and assess the extent of infection, inflammation, and bone involvement. Extensive debridement was performed to remove infected tissue and address the acute inflammatory response. Tendon repair was completed using a modified Bunnell technique. Adequate tendon excursion, infection control, resolution of acute inflammation, and improved joint stability were achieved. Wound closure was accomplished using layered sutures.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, Joint Fusion, and Persistent Inflammation on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, joint instability, and persistent inflammation affecting the extreme moving joint. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint fusion to restore stability and alleviate persistent inflammation. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of persistent inflammation, and improved joint function were achieved. Wound closure was achieved using absorbable sutures.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Infection, Bone Erosion, and Recurrent Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for the tenolysis of spontaneous rupture of flexor tendons with severe infection, bone erosion, and recurrent inflammatory response affecting the extreme moving joint. A volar approach was used to access the tendons and assess the underlying infection, inflammation, and bone involvement. Extensive debridement was performed to remove infected tissue, address the recurrent inflammatory response, and alleviate bone erosion. Adequate tendon gliding, infection control, resolution of recurrent inflammation

, and improved joint stability were achieved. Wound closure was accomplished using absorbable sutures. Postoperative administration of anti-inflammatory medications and antibiotics was initiated.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Severe Infection, Bone Erosion, and Exacerbated Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe infection, bone erosion, and an exacerbated inflammatory response affecting the extreme moving joint. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by tendon repair using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of the exacerbated inflammatory response, and improved joint stability were achieved. Wound closure was accomplished using layered sutures.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, Joint Arthroplasty, and Persistent Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, joint degeneration, and persistent inflammatory response affecting the extreme moving joint. A combined approach was utilized to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint arthroplasty for joint restoration and resolution of the persistent inflammatory response. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of persistent inflammation, improved joint function, and reduced pain were achieved. Wound closure was accomplished using absorbable sutures.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Severe Infection, Bone Erosion, and Chronic Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for revision of spontaneous rupture of flexor tendons with severe infection, bone erosion, and chronic inflammatory response affecting the extreme moving joint. A volar approach was made to expose the tendons and assess the extent of infection, chronic inflammation, and bone involvement. Extensive debridement was performed to remove infected tissue and address the chronic inflammatory response. Tendon repair was completed using a modified Bunnell technique. Adequate tendon excursion, infection control, resolution of chronic inflammation, and improved joint stability were achieved. Wound closure was accomplished using layered sutures.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, Joint Fusion, and Recurrent Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, joint instability, and recurrent inflammatory response affecting the extreme moving joint. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint fusion to restore stability and alleviate the recurrent inflammatory response. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of recurrent inflammation, and improved joint function were achieved. Wound closure was achieved using absorbable sutures.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Infection, Bone Erosion, and Exacerbated Inflammatory Response on the Extreme Moving Joint: The patient underwent surgical intervention for the tenolysis of spontaneous rupture of flexor tendons with severe infection, bone erosion, and an exacerbated inflammatory response affecting the extreme moving joint. A volar approach was used to access the tendons and assess the underlying infection,

exacerbation of inflammation, and bone involvement. Extensive debridement was performed to remove infected tissue, address the exacerbated inflammatory response, and alleviate bone erosion. Adequate tendon gliding, infection control, resolution of the exacerbated inflammatory response, and improved joint stability were achieved. Wound closure was accomplished using absorbable sutures. Postoperative administration of anti-inflammatory medications and antibiotics was initiated.

1. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Severe Infection, Bone Erosion, and Adjacent Nerve Compression: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe infection, bone erosion, and compression of the adjacent nerve. A volar approach was made to expose the tendons and assess the extent of infection, bone erosion, and nerve compression. Extensive debridement was performed to remove infected tissue and alleviate the compression on the nerve. Tendon repair was completed using a modified Kessler technique. Adequate tendon excursion, infection control, decompression of the nerve, and improved joint stability were achieved. Wound closure was accomplished using layered sutures. Postoperative follow-up will include regular assessments of nerve function and appropriate management of infection.

2. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, and Joint Instability Requiring Extended Rehabilitation: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, and significant joint instability. A combined approach was utilized to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint stabilization procedures to restore stability. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, improved joint stability, and restoration of hand function were achieved. Wound closure was accomplished using absorbable sutures. Postoperative follow-up will involve an extended rehabilitation program to optimize joint function and overall recovery.

3. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Severe Infection, Bone Erosion, and Joint Arthroplasty Consideration: The patient underwent surgical intervention for revision of spontaneous rupture of flexor tendons with severe infection, bone erosion, and compromised joint integrity. A volar approach was made to expose the tendons and assess the extent of infection, bone erosion, and joint instability. Extensive debridement was performed to remove infected tissue and address the bone erosion. Tendon repair was completed using a modified Bunnell technique. Adequate tendon excursion, infection control, and improved joint stability were achieved. Postoperative follow-up will involve close monitoring of joint function and consideration for joint arthroplasty if persistent instability is observed.

4. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, and Vascular Compromise: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, and vascular compromise. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by restoration of vascular supply to the affected area. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, improved joint stability, and restoration of vascular flow were achieved. Wound closure was accomplished using layered sutures. Postoperative follow-up will include regular assessments of vascular status and appropriate management of infection.

5. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Infection, Bone Erosion, and Tendon Adhesions: The patient underwent surgical intervention for the tenolysis of spontaneous rupture of flexor tendons with severe infection, bone erosion, and significant tendon adhesions. A volar approach was used to access the tendons and assess the underlying infection, bone erosion, and adhesions. Extensive debridement was performed to remove infected tissue, address the bone erosion, and release

tendon adhesions. Adequate tendon gliding, infection control, resolution of adhesions, and improved joint stability were achieved. Wound closure was accomplished using absorbable sutures. Postoperative follow-up will involve hand therapy to optimize tendon excursion and overall hand function.

6. Operative Note - Spontaneous Rupture of Flexor Tendons Repair with Severe Infection, Bone Erosion, and Ligamentous Injury: The patient underwent surgical intervention for the repair of spontaneous rupture of flexor tendons with severe infection, bone erosion, and associated ligamentous injury. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by repair of the ligamentous injury to restore stability. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of ligamentous injury, and improved joint stability were achieved. Wound closure was accomplished using layered sutures. Postoperative follow-up will include regular assessments of ligament function and appropriate management of infection.

7. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, and Joint Contracture: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, and joint contracture. A combined approach was utilized to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint release procedures to alleviate joint contracture. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, resolution of joint contracture, and improved joint stability were achieved. Wound closure was accomplished using absorbable sutures. Postoperative follow-up will involve hand therapy and regular assessments to prevent recurrent contracture and manage infection.

8. Operative Note - Spontaneous Rupture of Flexor Tendons Revision with Severe Infection, Bone Erosion, and Tendon Transfer Consideration: The patient underwent surgical intervention for revision of spontaneous rupture of flexor tendons with severe infection, bone erosion, and compromised tendon integrity. A volar approach was made to expose the tendons and assess the extent of infection, bone erosion, and tendon deficiency. Extensive debridement was performed to remove infected tissue and address the bone erosion. Tendon repair was completed using a modified Bunnell technique. Adequate tendon excursion, infection control, and improved joint stability were achieved. Postoperative follow-up will involve close monitoring of tendon function, and consideration for tendon transfer may be necessary if persistent deficiency is observed.

9. Operative Note - Spontaneous Rupture of Flexor Tendons Reconstruction with Severe Infection, Bone Erosion, and Joint Fusion Requirement: The patient underwent surgical intervention for the reconstruction of spontaneous rupture of flexor tendons with severe infection, bone erosion, and joint instability requiring joint fusion. A combined approach was employed to address the complex pathology. Extensive debridement of infected tissue and bone was performed, followed by joint fusion procedures to restore stability. Tendon repair was carried out using a modified Kessler technique. Adequate tendon excursion, infection control, improved joint stability, and pain relief were achieved. Wound closure was accomplished using absorbable sutures. Postoperative follow-up will involve radiographic monitoring of joint fusion progress and management of infection.

10. Operative Note - Spontaneous Rupture of Flexor Tendons Tenolysis with Severe Infection, Bone Erosion, and Chronic Tendinopathy: The patient underwent surgical intervention for the tenolysis of spontaneous rupture of flexor tendons with severe infection, bone erosion, and chronic tendinopathy. A volar approach was used to access the tendons and assess the underlying infection, bone erosion, and tendinopathy. Extensive debridement was performed to remove infected tissue, address the bone erosion, and alleviate tendinopathy. Adequate tendon gliding, infection control, resolution of tendinopathy, and improved joint stability were achieved. Wound closure was accomplished using layered sutures. Postoperative follow-up will involve hand therapy, regular assessments of tendon function, and appropriate management of infection.

## M66.4 Spontaneous rupture of other tendons

1. Operative Note: Patient underwent surgical repair for a spontaneous rupture of the Achilles tendon. The ruptured tendon was identified and debrided, followed by primary end-to-end repair using a non-absorbable suture. Postoperatively, the ankle was immobilized in a plaster cast.

2. Operative Note: Surgical intervention was performed for a spontaneous rupture of the quadriceps tendon. The tendon edges were exposed and meticulously debrided, followed by primary repair using suture anchors. Adequate tension was achieved, and the knee was immobilized in a hinged brace postoperatively.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon. Surgical exploration revealed a complete tear, which was repaired using suture anchors. Tendon ends were reapproximated, and the elbow was immobilized in a splint postoperatively. The patient was advised on gradual range of motion exercises.

4. Operative Note: A spontaneous rupture of the patellar tendon was identified and repaired surgically. The tendon ends were meticulously debrided and reapproximated using non-absorbable sutures. A temporary transosseous fixation was performed to enhance stability. Postoperatively, the knee was immobilized in a hinged brace, and weight-bearing was restricted.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon. The tendon was exposed, debrided, and repaired using a double-row suture technique. Adequate tension was achieved, and the wrist was immobilized in a thumb spica cast. Rehabilitation was initiated after cast removal.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon. The torn edges were debrided, and the tendon was reattached to the greater tuberosity using suture anchors. Postoperatively, the shoulder was immobilized in a sling, and a progressive rehabilitation program was initiated after the appropriate healing period.

7. Operative Note: The patient underwent surgical intervention for a spontaneous rupture of the flexor hallucis longus tendon. The tendon was exposed, debrided, and repaired using a modified Kessler technique. Postoperatively, the ankle was immobilized in a cast, and weight-bearing was restricted. Gradual range of motion exercises were started after cast removal.

8. Operative Note: Surgical repair was performed for a spontaneous rupture of the patellar tendon. The torn ends were identified, debrided, and reapproximated using a Krackow suture technique. A reinforcing augmentation was performed using a synthetic graft. Postoperatively, the knee was immobilized in a hinged brace, and a progressive rehabilitation program was initiated.

9. Operative Note: The patient presented with a spontaneous rupture of the flexor digitorum profundus tendon. A volar approach was used to expose the tendon, which was repaired using a core suture technique. The finger was immobilized in a custom splint postoperatively. Active range of motion exercises were started after splint removal.

10. Operative Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon. The ruptured ends were identified, debrided, and repaired using suture anchors. Adequate tension was achieved, and the elbow was immobilized in a hinged brace. Progressive strengthening exercises were initiated after the appropriate healing period.

1. Operative Note: Patient underwent surgical repair for a spontaneous rupture of the flexor pollicis longus tendon. The torn tendon was identified, debrided, and repaired using a two-strand locking technique. Postoperatively, the thumb was immobilized in a thumb spica splint. Rehabilitation was initiated after splint removal to restore thumb function.

2. Operative Note: Surgical intervention was performed for a spontaneous rupture of the peroneal tendons. The tendons were exposed and found to be completely torn. Primary repair was performed using suture anchors, and the ankle was immobilized in a cast. Weight-bearing was gradually allowed after cast removal.

3. Operative Note: The patient presented with a spontaneous rupture of the flexor digitorum superficialis tendon. A volar approach was used to expose the tendon, which was repaired using a modified Becker technique. The finger was immobilized in a buddy taping configuration postoperatively. Active range of motion exercises were initiated after taping removal.

4. Operative Note: Surgical repair was performed for a spontaneous rupture of the extensor carpi ulnaris tendon. The torn tendon was identified, debrided, and repaired using a side-to-side suture technique. Postoperatively, the wrist was immobilized in a splint, and progressive rehabilitation was initiated to restore wrist stability and function.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the pectoralis major tendon. The torn ends of the tendon were exposed and repaired using suture anchors. Postoperatively, the arm was immobilized in a sling for a designated period, followed by a progressive rehabilitation program to regain shoulder strength and function.

6. Operative Note: The patient presented with a spontaneous rupture of the gluteus medius tendon. Surgical exploration revealed a complete tear, which was repaired using suture anchors. The hip was immobilized in a hip abduction brace postoperatively. Progressive weight-bearing and strengthening exercises were initiated after brace discontinuation.

7. Operative Note: Surgical repair was performed for a spontaneous rupture of the flexor hallucis brevis tendon. The torn tendon was identified, debrided, and repaired using a whipstitch technique. Postoperatively, the foot was immobilized in a rigid shoe or cast, and weight-bearing was restricted. Rehabilitation exercises were commenced after immobilization.

8. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the triceps surae tendon. The tendon was exposed, debrided, and repaired using a Krackow suture technique. Postoperatively, the ankle was immobilized in a plantarflexed position using a walking boot. A gradual rehabilitation program was initiated for functional recovery.

9. Operative Note: Surgical repair was performed for a spontaneous rupture of the tibialis posterior tendon. The torn tendon was identified, debrided, and repaired using a Bunnell or modified Mason-Allen technique. Postoperatively, the foot was immobilized in a below-knee cast, followed by a progressive weight-bearing and strengthening regimen.

10. Operative Note: The patient presented with a spontaneous rupture of the extensor pollicis brevis tendon. A dorsal approach was used to expose the tendon, which was repaired using a double-row suture technique. The thumb was immobilized in a thumb spica splint postoperatively. Active range of motion exercises were initiated after splint removal.

1. Operative Note: Patient underwent surgical repair for a spontaneous rupture of the Achilles tendon under general anesthesia. The ruptured tendon was identified and debrided, followed by primary end-to-end repair using a non-absorbable suture. Postoperatively, the ankle was immobilized in a plaster cast.

2. Operative Note: Surgical intervention was performed for a spontaneous rupture of the quadriceps tendon under spinal anesthesia. The tendon edges were exposed and meticulously debrided, followed by primary repair using suture anchors. Adequate tension was achieved, and the knee was immobilized in a hinged brace postoperatively.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon and underwent surgical exploration and repair under local anesthesia with sedation. The complete tear was repaired using suture anchors. The elbow was immobilized in a splint postoperatively, and gradual range of motion exercises were advised.

4. Operative Note: A spontaneous rupture of the patellar tendon was identified and repaired surgically under regional anesthesia. The torn ends were meticulously debrided and reapproximated using non-absorbable sutures. A temporary transosseous fixation was performed to enhance stability. Postoperatively, the knee was immobilized in a hinged brace, and weight-bearing was restricted.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon under local anesthesia with intravenous sedation. The tendon was exposed, debrided, and repaired using a double-row suture technique. Adequate tension was achieved, and the wrist was immobilized in a thumb spica cast. Rehabilitation was initiated after cast removal.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon under general anesthesia. The torn edges were debrided, and the tendon was reattached to the greater tuberosity using suture anchors. Postoperatively, the shoulder was immobilized in a sling, and a progressive rehabilitation program was initiated after the appropriate healing period.

7. Operative Note: The patient underwent surgical intervention for a spontaneous rupture of the flexor hallucis longus tendon under regional anesthesia. The tendon was exposed, debrided, and repaired using a modified Kessler technique. Postoperatively, the ankle was immobilized in a cast, and weight-bearing was restricted. Gradual range of motion exercises were started after cast removal.

8. Operative Note: Surgical repair was performed for a spontaneous rupture of the patellar tendon under spinal anesthesia. The torn ends were identified, debrided, and reapproximated using a Krackow suture technique. A reinforcing augmentation was performed using a synthetic graft. Postoperatively, the knee was immobilized in a hinged brace, and a progressive rehabilitation program was initiated.

9. Operative Note: The patient presented with a spontaneous rupture of the flexor digitorum profundus tendon and underwent surgical repair under local anesthesia with monitored anesthesia care. A volar approach was used to expose the tendon, which was repaired using a core suture technique. The finger was immobilized in a custom splint postoperatively. Active range of motion exercises were started after splint removal.

10. Operative Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon under general anesthesia. The ruptured ends were identified, debrided, and repaired using suture anchors. Adequate tension was achieved, and the elbow was immobilized in a hinged brace. Progressive strengthening exercises were initiated after the appropriate healing period.

1. Operative Note: Patient underwent surgical repair for a spontaneous rupture of the Achilles tendon with associated bone erosion. The ruptured tendon was identified and debrided, followed by primary end-to-end repair using non-absorbable sutures. Bone grafting was performed to address the erosive defect. Postoperatively, the ankle was immobilized in a plaster cast.

2. Operative Note: Surgical intervention was performed for a spontaneous rupture of the quadriceps tendon with underlying bone erosion. The tendon edges were exposed, meticulously debrided, and repaired using suture anchors. Bone augmentation was performed to reconstruct the eroded area. The knee was immobilized in a hinged brace postoperatively.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon accompanied by bone erosion. Surgical exploration revealed a complete tear, which was repaired using suture anchors. The erosive defect was addressed with bone grafting. The elbow was immobilized in a splint postoperatively, and gradual range of motion exercises were advised.

4. Operative Note: A spontaneous rupture of the patellar tendon with significant bone erosion was identified and repaired surgically. The torn ends were meticulously debrided and reapproximated using non-absorbable sutures. Bone grafting was performed to reconstruct the eroded patellar surface. Postoperatively, the knee was immobilized in a hinged brace, and weight-bearing was restricted.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon with associated bone erosion. The tendon was exposed, debrided, and repaired using a double-row suture technique. Bone grafting was performed to address the underlying bone erosion. The wrist was immobilized in a thumb spica cast, and rehabilitation was initiated after cast removal.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon with associated bone erosion. The torn edges were debrided, and the tendon was reattached to the greater tuberosity using suture anchors. Bone augmentation was performed to reconstruct the eroded bony surface. Postoperatively, the shoulder was immobilized in a sling, and a progressive rehabilitation program was initiated after the appropriate healing period.

7. Operative Note: The patient underwent surgical intervention for a spontaneous rupture of the flexor hallucis longus tendon with underlying bone erosion. The tendon was exposed, debrided, and repaired using a modified Kessler technique. Bone grafting was performed to address the erosive defect. Postoperatively, the ankle was immobilized in a cast, and weight-bearing was restricted. Gradual range of motion exercises were started after cast removal.

8. Operative Note: Surgical repair was performed for a spontaneous rupture of the patellar tendon with significant bone erosion under regional anesthesia. The torn ends were identified, debrided, and reapproximated using a Krackow suture technique. Bone grafting was performed to reconstruct the eroded patellar surface. Postoperatively, the knee was immobilized in a hinged brace, and a progressive rehabilitation program was initiated.

9. Operative Note: The patient presented with a spontaneous rupture of the flexor digitorum profundus tendon with associated bone erosion. Surgical repair was performed under local anesthesia with monitored anesthesia care. A volar approach was used to expose the tendon, which was repaired using a core suture technique. Bone grafting was performed to address the underlying bone erosion. The finger was immobilized in a custom splint postoperatively, and active range of motion exercises were started after splint removal.

10. Operative

Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon with accompanying bone erosion. The ruptured ends were identified, debrided, and repaired using suture anchors. Bone grafting was performed to reconstruct the eroded bone. Adequate tension was achieved, and the elbow was immobilized in a hinged brace. Progressive strengthening exercises were initiated after the appropriate healing period.

1. Operative Note: Patient underwent surgical repair for a spontaneous rupture of the Achilles tendon with severe bone pain. The ruptured tendon was identified and debrided, followed by primary end-to-end repair using non-absorbable sutures. Postoperatively, the ankle was immobilized in a plaster cast to alleviate pain and promote healing.

2. Operative Note: Surgical intervention was performed for a spontaneous rupture of the quadriceps tendon with accompanying severe bone pain. The tendon edges were exposed, meticulously debrided, and repaired using suture anchors. Postoperatively, the knee was immobilized in a hinged brace to alleviate pain and facilitate recovery.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon accompanied by severe bone pain. Surgical exploration revealed a complete tear, which was repaired using suture anchors. The elbow was immobilized in a splint postoperatively to alleviate pain and provide stability.

4. Operative Note: A spontaneous rupture of the patellar tendon with significant bone pain was identified and repaired surgically. The torn ends were meticulously debrided and reapproximated using non-absorbable sutures. Postoperatively, the knee was immobilized in a hinged brace to alleviate pain and restrict movement.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon with severe bone pain. The tendon was exposed, debrided, and repaired using a double-row suture technique. Postoperatively, the wrist was immobilized in a thumb spica cast to alleviate pain and support healing.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon with severe bone pain. The torn edges were debrided, and the tendon was reattached to the greater tuberosity using suture anchors. Postoperatively, the shoulder was immobilized in a sling to alleviate pain and promote recovery.

7. Operative Note: The patient underwent surgical intervention for a spontaneous rupture of the flexor hallucis longus tendon with severe bone pain. The tendon was exposed, debrided, and repaired using a modified Kessler technique. Postoperatively, the ankle was immobilized in a cast to alleviate pain and provide stability.

8. Operative Note: Surgical repair was performed for a spontaneous rupture of the patellar tendon with significant bone pain under regional anesthesia. The torn ends were identified, debrided, and reapproximated using a Krackow suture technique. Postoperatively, the knee was immobilized in a hinged brace to alleviate pain and restrict movement.

9. Operative Note: The patient presented with a spontaneous rupture of the flexor digitorum profundus tendon with severe bone pain. Surgical repair was performed under local anesthesia with monitored anesthesia care. A volar approach was used to expose the tendon, which was repaired using a core suture technique. The finger was immobilized in a custom splint postoperatively to alleviate pain and promote healing.

10. Operative Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon with severe bone pain. The ruptured ends were identified, debrided, and repaired using suture anchors. Adequate tension was achieved, and the elbow was immobilized in a hinged brace to alleviate pain and facilitate recovery.

1. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the Achilles tendon. The ruptured tendon was identified and debrided, followed by primary end-to-end repair using non-absorbable sutures. Postoperatively, the ankle was immobilized in a plaster cast, and a progressive rehabilitation program was initiated.

2. Operative Note: Surgical repair was performed for a spontaneous rupture of the quadriceps tendon. The torn ends were meticulously debrided, and the tendon was repaired using suture anchors. Postoperatively, the knee was immobilized in a hinged brace, and a structured rehabilitation protocol was initiated.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon. Surgical exploration revealed a complete tear, which was repaired using suture anchors. The elbow was immobilized in a splint postoperatively, and a gradual range of motion exercise program was started.

4. Operative Note: A spontaneous rupture of the patellar tendon was identified and repaired surgically. The torn ends were meticulously debrided and reapproximated using non-absorbable sutures. Postoperatively, the knee was immobilized in a hinged brace, and a progressive strengthening regimen was initiated.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon. The tendon was exposed, debrided, and repaired using a double-row suture technique. Postoperatively, the wrist was immobilized in a thumb spica cast, and a structured rehabilitation program was commenced.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon. The torn edges were debrided, and the tendon was reattached to the greater tuberosity using suture anchors. Postoperatively, the shoulder was immobilized in a sling, and a progressive rehabilitation program was initiated.

7. Operative Note: The patient presented with a spontaneous rupture of the flexor hallucis longus tendon. Surgical repair was performed using a modified Kessler technique. The ankle was immobilized in a cast postoperatively, and a structured rehabilitation program was started to restore function.

8. Operative Note: Surgical intervention was performed for a spontaneous rupture of the patellar tendon. The torn ends were identified, debrided, and reapproximated using a Krackow suture technique. Postoperatively, the knee was immobilized in a hinged brace, and a gradual rehabilitation program was initiated.

9. Operative Note: The patient underwent surgical repair for a spontaneous rupture of the flexor digitorum profundus tendon. A volar approach was used to expose the tendon, which was repaired using a core suture technique. The finger was immobilized in a custom splint postoperatively, and a structured rehabilitation program was started.

10. Operative Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon. The ruptured ends were identified, debrided, and repaired using suture anchors. Postoperatively, the elbow was immobilized in a hinged brace, and a progressive strengthening program was initiated.

1. Operative Note: Patient underwent surgical repair for a spontaneous rupture of the Achilles tendon. The ruptured tendon was identified and debrided, followed by primary end-to-end repair using non-absorbable sutures. The ankle was immobilized in a plaster cast, and the patient was advised to undergo a comprehensive rehabilitation program for optimal recovery.

2. Operative Note: Surgical intervention was performed for a spontaneous rupture of the quadriceps tendon. The torn ends were meticulously debrided, and the tendon was repaired using suture anchors. Postoperatively, the knee was immobilized in a hinged brace, and the patient was referred to physical therapy for rehabilitation and strengthening exercises.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon. Surgical exploration confirmed the diagnosis, and the tendon was repaired using suture anchors. The elbow was immobilized in a splint, and a customized rehabilitation program was recommended to restore strength and range of motion.

4. Operative Note: A spontaneous rupture of the patellar tendon was identified and surgically repaired. The torn ends were debrided, and a strong repair was achieved using non-absorbable sutures. Postoperatively, the knee was immobilized in a hinged brace, and the patient was advised to engage in a supervised rehabilitation program to regain functional abilities.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon. The tendon was exposed, meticulously debrided, and repaired using a double-row suture technique. The wrist was immobilized in a thumb spica cast, and a progressive hand therapy program was initiated to restore hand function.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon. The torn edges were debrided, and the tendon was reattached to the greater tuberosity using suture anchors. Postoperatively, the shoulder was immobilized in a sling, and a structured rehabilitation program was initiated to regain shoulder strength and mobility.

7. Operative Note: The patient presented with a spontaneous rupture of the flexor hallucis longus tendon. Surgical repair was performed using a modified Kessler technique to ensure a stable and secure tendon repair. The ankle was immobilized in a cast, and a gradual weight-bearing and rehabilitation program was commenced.

8. Operative Note: Surgical intervention was performed for a spontaneous rupture of the patellar tendon. The torn ends were identified, debrided, and reapproximated using a Krackow suture technique. Postoperatively, the knee was immobilized in a hinged brace, and an individualized rehabilitation program was designed to optimize recovery.

9. Operative Note: The patient underwent surgical repair for a spontaneous rupture of the flexor digitorum profundus tendon. The tendon was repaired using a core suture technique to restore the proper function of the finger. A customized hand therapy program was initiated postoperatively to regain finger strength and range of motion.

10. Operative Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon. The torn ends were identified, debrided, and repaired using suture anchors to achieve a secure tendon reattachment. The elbow was immobilized in a hinged brace, and a comprehensive rehabilitation plan was implemented to restore elbow function and strength.

1. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the Achilles tendon with severe infection on the ankle joint. The infected tissues were thoroughly debrided, and the ruptured tendon was repaired using non-absorbable sutures. Intravenous antibiotics were administered postoperatively, and close monitoring of the infection was initiated.

2. Operative Note: Surgical repair was performed for a spontaneous rupture of the quadriceps tendon with a severe infection involving the knee joint. The infected joint was thoroughly irrigated and debrided, followed by tendon repair using suture anchors. Intravenous antibiotics and a joint irrigation catheter were utilized for postoperative infection control.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon accompanied by a severe infection involving the elbow joint. Surgical exploration revealed a complete tear, which was repaired using suture anchors after extensive debridement. Intravenous antibiotics were initiated postoperatively, and joint aspiration was performed for fluid analysis.

4. Operative Note: A spontaneous rupture of the patellar tendon with significant bone pain and severe infection involving the knee joint was identified and repaired surgically. The infected joint was thoroughly debrided, and the ruptured tendon was repaired using non-absorbable sutures. Intravenous antibiotics and immobilization in a hinged brace were implemented for infection control and stability.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon with severe infection on the wrist joint. The infected joint was meticulously debrided, and tendon repair was performed using a double-row suture technique. Intravenous antibiotics and immobilization in a thumb spica cast were initiated for infection control and joint protection.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon with severe infection on the shoulder joint. The infected joint was thoroughly irrigated, debrided, and the tendon was reattached using suture anchors. Intravenous antibiotics were administered postoperatively, and shoulder immobilization in a sling was initiated for infection management and tissue healing.

7. Operative Note: The patient presented with a spontaneous rupture of the flexor hallucis longus tendon accompanied by a severe infection involving the ankle joint. The infected joint was extensively debrided, and tendon repair was performed using a modified Kessler technique. Intravenous antibiotics and immobilization in a cast were implemented for infection control and joint stabilization.

8. Operative Note: Surgical intervention was performed for a spontaneous rupture of the patellar tendon with severe infection involving the knee joint. The infected joint was thoroughly irrigated, debrided, and the ruptured tendon was repaired using a Krackow suture technique. Intravenous antibiotics and immobilization in a hinged brace were initiated for infection management and joint protection.

9. Operative Note: The patient underwent surgical repair for a spontaneous rupture of the flexor digitorum profundus tendon with severe infection on the finger joint. The infected joint was meticulously debrided, and tendon repair was performed using a core suture technique. Intravenous antibiotics and immobilization in a custom splint were initiated for infection control and finger stability.

10. Operative Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon with severe infection on the elbow joint. The infected joint was thoroughly irrigated, debrided, and the ruptured tendon was repaired using suture anchors. Intravenous antibiotics, wound care, and immobilization in a hinged brace were implemented for infection control and joint stability.

1. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the Achilles tendon with marked inflammation. The inflamed tissues were carefully dissected, and the ruptured tendon was repaired using non-absorbable sutures. Postoperatively, anti-inflammatory medications were prescribed, and the ankle was immobilized in a plaster cast to aid in the reduction of inflammation.

2. Operative Note: Surgical repair was performed for a spontaneous rupture of the quadriceps tendon with moderate inflammation. The inflamed tissues were meticulously debrided, and the tendon was repaired using suture anchors. Postoperatively, cryotherapy and non-steroidal anti-inflammatory drugs (NSAIDs) were initiated to manage the inflammation and promote healing.

3. Operative Note: The patient presented with a spontaneous rupture of the biceps tendon accompanied by mild inflammation. Surgical exploration revealed a complete tear, which was repaired using suture anchors after addressing the inflamed tissues. Postoperatively, a course of oral corticosteroids and physical therapy modalities were initiated to reduce inflammation and promote tissue healing.

4. Operative Note: A spontaneous rupture of the patellar tendon with significant bone pain and severe inflammation was identified and repaired surgically. The inflamed tissues were meticulously debrided, and the ruptured tendon was repaired using non-absorbable sutures. Postoperatively, a combination of NSAIDs and local corticosteroid injections were administered to control inflammation and facilitate recovery.

5. Operative Note: Patient underwent surgical intervention for a spontaneous rupture of the extensor pollicis longus tendon with moderate inflammation. The inflamed tissues were carefully managed, and tendon repair was performed using a double-row suture technique. Postoperatively, a regimen of NSAIDs and topical anti-inflammatory creams were prescribed to alleviate inflammation and promote tendon healing.

6. Operative Note: Surgical repair was performed for a spontaneous rupture of the supraspinatus tendon with mild inflammation. The inflamed tissues were addressed, and the tendon was reattached to the greater tuberosity using suture anchors. Postoperatively, a course of oral anti-inflammatory medication and physical therapy exercises were initiated to control inflammation and restore shoulder function.

7. Operative Note: The patient presented with a spontaneous rupture of the flexor hallucis longus tendon accompanied by moderate inflammation. Surgical repair was performed after addressing the inflamed tissues, using a modified Kessler technique. Postoperatively, a combination of oral anti-inflammatory medications and localized cryotherapy were implemented to manage inflammation and support healing.

8. Operative Note: Surgical intervention was performed for a spontaneous rupture of the patellar tendon with mild inflammation. The inflamed tissues were carefully managed, and the ruptured tendon was repaired using a Krackow suture technique. Postoperatively, a course of NSAIDs and physical therapy exercises were initiated to control inflammation and promote functional recovery.

9. Operative Note: The patient underwent surgical repair for a spontaneous rupture of the flexor digitorum profundus tendon with marked inflammation. The inflamed tissues were meticulously addressed, and tendon repair was performed using a core suture technique. Postoperatively, a combination of oral corticosteroids and localized anti-inflammatory treatments were initiated to reduce inflammation and support finger rehabilitation.

10. Operative Note: Surgical intervention was performed for a spontaneous rupture of the triceps tendon with significant inflammation. The inflamed tissues were managed intraoperatively, and the ruptured tendon was repaired using suture anchors. Postoperatively, a course of oral anti-inflammatory medications and physical therapy exercises were prescribed to control inflammation and promote optimal recovery.

1. Operative Note: Patient underwent surgical intervention for a severe spontaneous rupture of the Achilles tendon. The ruptured tendon was repaired using non-absorbable sutures. Given the severity of the injury, an extended period of immobilization in a cast followed by a comprehensive physical therapy program was recommended to facilitate optimal healing and restore function.

2. Operative Note: Surgical repair was performed for a moderate spontaneous rupture of the quadriceps tendon. The torn ends were meticulously debrided, and the tendon was repaired using suture anchors. Considering the moderate severity, the patient was advised to wear a hinged knee brace for a few weeks and undergo a tailored physical therapy program for gradual recovery.

3. Operative Note: The patient presented with a mild spontaneous rupture of the biceps tendon. Surgical exploration confirmed the diagnosis, and the tendon was repaired using suture anchors. Given the mild severity, a short period of immobilization in a splint followed by a focused rehabilitation program was recommended to restore strength and range of motion.

4. Operative Note: A spontaneous rupture of the patellar tendon was identified and surgically repaired. The torn ends were debrided, and a strong repair was achieved using non-absorbable sutures. Considering the severity of the rupture, an extended period of immobilization in a hinged knee brace followed by progressive weight-bearing and physical therapy was prescribed.

5. Operative Note: Patient underwent surgical intervention for a severe spontaneous rupture of the extensor pollicis longus tendon. The tendon was exposed, meticulously debrided, and repaired using a double-row suture technique. Given the severity, a prolonged immobilization in a thumb spica cast followed by a comprehensive hand therapy program was recommended for optimal recovery.

6. Operative Note: Surgical repair was performed for a moderate spontaneous rupture of the supraspinatus tendon. The torn edges were debrided, and the tendon was reattached to the greater tuberosity using suture anchors. Considering the moderate severity, a period of immobilization in a sling followed by a progressive rehabilitation program was advised to regain shoulder strength and mobility.

7. Operative Note: The patient presented with a mild spontaneous rupture of the flexor hallucis longus tendon. Surgical repair was performed using a modified Kessler technique. Given the mild severity, a short period of immobilization in a cast followed by a focused physical therapy program was recommended to restore ankle function.

8. Operative Note: Surgical intervention was performed for a severe spontaneous rupture of the patellar tendon. The torn ends were identified, debrided, and reapproximated using a Krackow suture technique. Given the severity, an extended period of immobilization in a hinged knee brace followed by intensive physical therapy and strengthening exercises was prescribed for optimal recovery.

9. Operative Note: The patient underwent surgical repair for a moderate spontaneous rupture of the flexor digitorum profundus tendon. The tendon was repaired using a core suture technique. Considering the moderate severity, a period of immobilization in a custom splint followed by a structured hand therapy program was recommended for functional recovery.

10. Operative Note: Surgical intervention was performed for a mild spontaneous rupture of the triceps tendon. The torn ends were identified, debrided, and repaired using suture anchors. Given the mild severity, a short period of immobilization in a hinged elbow brace followed by a tailored rehabilitation program was advised to regain elbow function and strength.

## M66.5 Spontaneous rupture of unspecified tendon

1. Operative Note: Spontaneous rupture of an unspecified tendon repaired via an open surgical approach. Tendon edges were identified, debrided, and reapproximated using non-absorbable sutures. Hemostasis was achieved, and wound closed in layers. Postoperative immobilization and rehabilitation protocol were discussed with the patient.

2. Operative Note: Spontaneous rupture of an unspecified tendon repaired arthroscopically. The tendon was visualized using a scope, and a percutaneous technique was employed for repair. Sutures were placed through tendon edges and secured, followed by a thorough irrigation of the joint. Patient received postoperative instructions for activity modification and rehabilitation.

3. Operative Note: Spontaneous rupture of an unspecified tendon repaired through a minimally invasive approach. Tendon ends were identified and repaired using an endoscopic technique. Sutures were placed and secured with appropriate tension. Hemostasis was ensured, and the incision site was closed. Postoperative care instructions were discussed, emphasizing the importance of immobilization and physical therapy.

4. Operative Note: Spontaneous rupture of an unspecified tendon repaired using a tendon graft. A suitable autograft/allograft was harvested and prepared. Tendon ends were debrided, and the graft was securely attached using appropriate sutures. Hemostasis was achieved, and the wound was closed. The patient was advised on postoperative care, including immobilization and a progressive rehabilitation program.

5. Operative Note: Spontaneous rupture of an unspecified tendon repaired utilizing a suture anchor technique. The tendon was debrided, and anchor points were identified and prepared. Sutures were passed through the tendon and anchored securely in the adjacent bone. Hemostasis was achieved, and the wound was closed in layers. Postoperative instructions regarding immobilization and physical therapy were provided.

6. Operative Note: Spontaneous rupture of an unspecified tendon repaired using a biological augmentation technique. A suitable biological scaffold was utilized to reinforce the tendon repair. The tendon ends were sutured and augmented with the scaffold. Adequate fixation was achieved, and the wound was closed. The patient was instructed on postoperative care, including immobilization and a graded rehabilitation program.

7. Operative Note: Spontaneous rupture of an unspecified tendon repaired via an open technique with tendon transfer. A donor tendon was harvested, prepared, and transferred to replace the ruptured tendon. Tendon ends were secured using appropriate sutures. Hemostasis was obtained, and the wound was closed. Postoperative care instructions, including immobilization and a structured rehabilitation plan, were discussed with the patient.

8. Operative Note: Spontaneous rupture of an unspecified tendon repaired using a synthetic graft. A synthetic graft material was selected, sized, and inserted to bridge the tendon defect. The graft was secured with sutures to the tendon ends. Hemostasis was achieved, and the wound was closed in layers. The patient was provided with postoperative instructions for immobilization and a comprehensive rehabilitation program.

9. Operative Note: Spontaneous rupture of an unspecified tendon repaired with a percutaneous technique. The tendon was accessed through small incisions, and a specialized device was used to suture the tendon ends together. Proper tension was applied, and hemostasis was achieved. The incisions were closed, and the patient received postoperative guidelines, emphasizing immobilization and a progressive rehabilitation protocol.

10. Operative Note: Spontaneous rupture of an unspecified tendon repaired using a platelet-rich plasma (PRP) injection technique. PRP was prepared and injected into the tendon defect to stimulate healing. The injection site was properly sealed, and the patient was advised on postoperative care, including activity modification and a tailored rehabilitation plan.

11. Operative Note: Spontaneous rupture of an unspecified tendon repaired using an endoscopic-assisted technique. A small incision was made, and an endoscope was introduced to visualize the tendon. Sutures were passed through the tendon ends and secured using endoscopic instruments. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided, including immobilization and a customized rehabilitation program.

12. Operative Note: Spontaneous rupture of an unspecified tendon repaired with a double-row technique. Tendon edges were prepared, and multiple suture anchors were inserted into the bone. Sutures were passed through the tendon in a double-row fashion and securely tied. Hemostasis was ensured, and the wound was closed in layers. The patient was educated on postoperative care, emphasizing the importance of immobilization and physical therapy.

13. Operative Note: Spontaneous rupture of an unspecified tendon repaired using a minimally invasive percutaneous tenotomy and tenodesis technique. The tendon was released and reattached to the adjacent bone using specialized devices. Proper tension was applied, and hemostasis was achieved. The incision sites were closed, and postoperative instructions were provided, including immobilization and a progressive rehabilitation plan.

14. Operative Note: Spontaneous rupture of an unspecified tendon repaired using a fascial sling technique. A fascial graft was harvested and fashioned into a sling to support the ruptured tendon. The graft was anchored securely, and tendon ends were attached to the sling. Hemostasis was obtained, and the wound was closed. The patient was counseled on postoperative care, including immobilization and a structured rehabilitation program.

15. Operative Note: Spontaneous rupture of an unspecified tendon repaired using an all-inside arthroscopic technique. The tendon was accessed arthroscopically, and specialized instruments were used to repair the rupture. Sutures were passed through the tendon ends and securely tied. Hemostasis was achieved, and the joint was thoroughly irrigated. Postoperative care instructions were provided, including immobilization and a personalized rehabilitation protocol.

16. Operative Note: Spontaneous rupture of an unspecified tendon repaired with a percutaneous suture technique. Multiple percutaneous tunnels were created, and sutures were passed through the tendon and tied. Proper tension was applied, and hemostasis was ensured. The incisions were closed, and the patient was instructed on postoperative care, including immobilization and a progressive physical therapy regimen.

17. Operative Note: Spontaneous rupture of an unspecified tendon repaired using an allograft tendon reconstruction. An appropriate allograft tendon was selected, sized, and secured to replace the ruptured tendon. The graft was sutured to the adjacent tissues and anchored securely. Hemostasis was achieved, and the wound was closed. The patient was provided with postoperative instructions, emphasizing immobilization and a structured rehabilitation plan.

18. Operative Note: Spontaneous rupture of an unspecified tendon repaired with a percutaneous ultrasound-guided technique. Ultrasound was used to locate the tendon ends accurately. Sutures were passed through the tendon using a percutaneous technique under ultrasound guidance. Proper tension was applied, and hemostasis was achieved. The incisions were closed, and postoperative care instructions were discussed, including immobilization and a tailored rehabilitation program.

19. Operative Note: Spontaneous rupture of an unspecified tendon repaired using a biodegradable interference screw technique. The tendon ends were prepared, and an interference screw loaded with a biodegradable material was inserted to secure the tendon. Hemostasis was ensured, and the incision site was closed. The patient received postoperative instructions for immobilization and a progressive rehabilitation protocol.

20. Operative Note: Spontaneous

rupture of an unspecified tendon repaired using a suture bridge technique. The tendon was debrided, and multiple anchors were placed in the bone. Sutures were passed through the tendon, creating a bridge-like configuration, and securely tied. Hemostasis was achieved, and the wound was closed in layers. The patient was advised on postoperative care, including immobilization and a comprehensive rehabilitation program.

21. Operative Note: Spontaneous rupture of an unspecified tendon repaired under general anesthesia. The patient was intubated, and anesthesia was induced and maintained according to standard protocols. Tendon repair was performed using an open surgical technique. Hemostasis was achieved, and the wound was closed. Postoperative instructions regarding immobilization and physical therapy were discussed with the patient.

22. Operative Note: Spontaneous rupture of an unspecified tendon repaired under local anesthesia with sedation. The patient received a local anesthetic injection to numb the surgical area, along with intravenous sedation to ensure comfort throughout the procedure. Tendon repair was performed using an arthroscopic technique. Hemostasis was achieved, and the incisions were closed. Postoperative care instructions were provided, including immobilization and a personalized rehabilitation plan.

23. Operative Note: Spontaneous rupture of an unspecified tendon repaired under regional anesthesia. The patient received a nerve block or epidural anesthesia to provide anesthesia and pain relief in the surgical region. Tendon repair was performed using a minimally invasive technique. Hemostasis was achieved, and the wound was closed. The patient was educated on postoperative care, including immobilization and a structured rehabilitation program.

24. Operative Note: Spontaneous rupture of an unspecified tendon repaired under monitored anesthesia care (MAC). The patient was given intravenous medications to induce a state of sedation and analgesia, while maintaining consciousness and cooperation. Tendon repair was performed using a percutaneous technique. Hemostasis was ensured, and the incisions were closed. Postoperative instructions regarding immobilization and physical therapy were discussed with the patient.

25. Operative Note: Spontaneous rupture of an unspecified tendon repaired under general anesthesia with a nerve block. The patient received general anesthesia for unconsciousness and a nerve block for targeted pain relief during and after the surgery. Tendon repair was performed using an open surgical approach. Hemostasis was achieved, and the wound was closed. The patient was provided with postoperative care instructions, including immobilization and a customized rehabilitation program.

26. Operative Note: Spontaneous rupture of an unspecified tendon repaired under spinal anesthesia. The patient received a spinal anesthetic injection to numb the lower body and lower extremities. Tendon repair was performed using an endoscopic-assisted technique. Hemostasis was achieved, and the incisions were closed. The patient was counseled on postoperative care, including immobilization and a graded rehabilitation plan.

27. Operative Note: Spontaneous rupture of an unspecified tendon repaired under local anesthesia. The patient received a local anesthetic injection at the surgical site for pain relief. Tendon repair was performed using a suture anchor technique. Hemostasis was ensured, and the wound was closed. The patient was instructed on postoperative care, including immobilization and a personalized rehabilitation protocol.

28. Operative Note: Spontaneous rupture of an unspecified tendon repaired under general anesthesia with a regional nerve block. The patient received general anesthesia for unconsciousness and a nerve block for targeted pain management. Tendon repair was performed using a tendon graft technique. Hemostasis was achieved, and the wound was closed. Postoperative care instructions, including immobilization and a progressive rehabilitation program, were discussed with the patient.

29. Operative Note: Spontaneous rupture of an unspecified tendon repaired under local anesthesia with intravenous conscious sedation. The patient received a local anesthetic injection and intravenous medications to induce a state of relaxation and analgesia. Tendon repair was performed using a minimally invasive percutaneous technique. Hemostasis was achieved, and the incisions were closed. The patient was provided with postoperative instructions, emphasizing immobilization and a structured rehabilitation plan.

30. Operative Note: Spontaneous rupture of an unspecified tendon repaired under general anesthesia with deep sedation. The patient was intubated, and anesthesia was induced and maintained at a deeper level of sedation for optimal comfort during the procedure. Tendon repair was performed using an arthroscopic technique. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including immobilization and a tailored rehabilitation program.

31. Operative Note: Spontaneous rupture of an unspecified tendon with associated bone erosion repaired under general anesthesia. The patient was intubated, and anesthesia was induced and maintained. Tendon repair involved debridement of the eroded bone, followed by reconstruction using a tendon graft and bone grafting. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included immobilization, weight-bearing restrictions, and a comprehensive rehabilitation program.

32. Operative Note: Spontaneous rupture of an unspecified tendon with significant bone erosion repaired under regional anesthesia. The patient received a nerve block for anesthesia. Tendon repair involved addressing the bone erosion through open surgical intervention, followed by repair and reconstruction using tendon augmentation techniques. Hemostasis was achieved, and the wound was closed. Postoperative instructions emphasized immobilization, protected weight-bearing, and a customized rehabilitation protocol.

33. Operative Note: Spontaneous rupture of an unspecified tendon with extensive bone erosion repaired under general anesthesia with bone grafting. The patient was intubated, and anesthesia was induced and maintained. Tendon repair included debridement of the eroded bone, followed by tendon reconstruction and bone grafting to promote healing. Hemostasis was ensured, and the incision was closed. Postoperative care instructions encompassed immobilization, restricted weight-bearing, and a comprehensive rehabilitation plan.

34. Operative Note: Spontaneous rupture of an unspecified tendon with localized bone erosion repaired under local anesthesia. The patient received a local anesthetic injection. Tendon repair involved addressing the bone erosion through an arthroscopic approach, followed by repair and reinforcement using sutures and bone anchors. Hemostasis was achieved, and the incision site was closed. Postoperative instructions emphasized immobilization, protected mobilization, and a tailored rehabilitation program.

35. Operative Note: Spontaneous rupture of an unspecified tendon with significant bone erosion repaired under general anesthesia with bone tunneling. The patient was intubated, and anesthesia was induced and maintained. Tendon repair involved creating bone tunnels, securing the tendon within the tunnels, and addressing the bone erosion. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included immobilization, restricted weight-bearing, and a progressive rehabilitation regimen.

36. Operative Note: Spontaneous rupture of an unspecified tendon with associated bone erosion repaired under local anesthesia with bone grafting. The patient received a local anesthetic injection. Tendon repair included debridement of the eroded bone, followed by tendon reconstruction and bone grafting to promote healing. Hemostasis was ensured, and the incision was closed. Postoperative care instructions encompassed immobilization, protected mobilization, and a comprehensive rehabilitation plan.

37. Operative Note: Spontaneous rupture of an unspecified tendon with significant bone erosion repaired under general anesthesia with bone substitute implantation. The patient was intubated, and anesthesia was induced and maintained. Tendon repair involved addressing the bone erosion through an open surgical approach, followed by implanting a bone substitute material. Hemostasis was achieved, and the wound was closed. Postoperative instructions included immobilization, restricted weight-bearing, and a tailored rehabilitation program.

38. Operative Note: Spontaneous rupture of an unspecified tendon with localized bone erosion repaired under regional anesthesia with bone tunneling and augmentation. The patient received a nerve block for anesthesia. Tendon repair involved creating bone tunnels, securing the tendon within the tunnels, and augmenting the eroded bone with graft material. Hemostasis was achieved, and the incision site was closed. Postoperative care instructions emphasized immobilization, protected mobilization, and a progressive rehabilitation regimen.

39. Operative Note: Spontaneous rupture of an unspecified tendon with extensive bone erosion repaired under general anesthesia with bone grafting and plate

fixation. The patient was intubated, and anesthesia was induced and maintained. Tendon repair included debridement of the eroded bone, followed by tendon reconstruction, bone grafting, and fixation using plates and screws. Hemostasis was ensured, and the incision was closed. Postoperative care instructions included immobilization, restricted weight-bearing, and a comprehensive rehabilitation plan.

40. Operative Note: Spontaneous rupture of an unspecified tendon with localized bone erosion repaired under local anesthesia with bone suture anchors. The patient received a local anesthetic injection. Tendon repair involved addressing the bone erosion through an arthroscopic approach, followed by repair and reinforcement using suture anchors placed in the eroded bone. Hemostasis was achieved, and the incision site was closed. Postoperative instructions emphasized immobilization, protected mobilization, and a tailored rehabilitation program.

41. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under general anesthesia. The patient was intubated, and anesthesia was induced and maintained. Tendon repair involved addressing the ruptured tendon as well as addressing the underlying cause of severe bone pain, which included bone debridement, bone grafting, and stabilization. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included immobilization, pain management, and a comprehensive rehabilitation plan.

42. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under regional anesthesia. The patient received a nerve block for anesthesia and pain relief. Tendon repair included exploration of the ruptured tendon, debridement of the affected bone, and stabilization using specialized techniques. Hemostasis was ensured, and the incision was closed. Postoperative instructions emphasized immobilization, pain management, and a personalized rehabilitation program.

43. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under general anesthesia with nerve block. The patient was intubated, and anesthesia was induced and maintained. Tendon repair involved addressing the ruptured tendon and relieving severe bone pain through a combination of bone debridement, stabilization, and the administration of a nerve block for postoperative pain management. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included immobilization, pain control, and a tailored rehabilitation plan.

44. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under local anesthesia with nerve block. The patient received a local anesthetic injection for anesthesia and targeted pain relief. Tendon repair involved addressing the ruptured tendon, relieving severe bone pain through bone debridement, stabilization, and the administration of a nerve block for postoperative pain control. Hemostasis was achieved, and the incision site was closed. Postoperative instructions emphasized immobilization, pain management, and a customized rehabilitation program.

45. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under general anesthesia with enhanced pain management. The patient was intubated, and anesthesia was induced and maintained. Tendon repair included addressing the ruptured tendon as well as implementing specialized pain management techniques to alleviate severe bone pain. Hemostasis was ensured, and the wound was closed. Postoperative care instructions encompassed immobilization, advanced pain control measures, and a comprehensive rehabilitation regimen.

46. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under regional anesthesia with multimodal pain management. The patient received a nerve block for anesthesia and multimodal pain management techniques to address severe bone pain. Tendon repair involved surgical intervention to repair the ruptured tendon and alleviate the underlying cause of bone pain. Hemostasis was achieved, and the incisions were closed. Postoperative care instructions included immobilization, comprehensive pain management, and a personalized rehabilitation plan.

47. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under general anesthesia with targeted pain relief. The patient was intubated, and anesthesia was induced and maintained. Tendon repair involved addressing the ruptured tendon and implementing targeted pain relief techniques to manage severe bone pain. Hemostasis was achieved, and the wound was closed. Postoperative instructions encompassed immobilization, customized pain management, and a graded rehabilitation program.

48. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under local anesthesia with advanced pain control. The patient received a local anesthetic injection for anesthesia and advanced pain control methods to address severe bone pain. Tendon repair involved surgical intervention to repair the ruptured tendon and alleviate the underlying cause of bone pain. Hemostasis was ensured

, and the incision site was closed. Postoperative care instructions emphasized immobilization, comprehensive pain management, and a tailored rehabilitation program.

49. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under general anesthesia with intravenous patient-controlled analgesia (PCA). The patient was intubated, and anesthesia was induced and maintained. Tendon repair involved addressing the ruptured tendon, while intravenous PCA was utilized for effective management of severe bone pain. Hemostasis was achieved, and the wound was closed. Postoperative instructions included immobilization, utilization of PCA for pain relief, and a comprehensive rehabilitation plan.

50. Operative Note: Spontaneous rupture of an unspecified tendon with severe bone pain repaired under regional anesthesia with epidural analgesia. The patient received a nerve block for anesthesia and an epidural catheter for effective pain management. Tendon repair involved surgical intervention to repair the ruptured tendon and alleviate severe bone pain. Hemostasis was achieved, and the incisions were closed. Postoperative care instructions encompassed immobilization, epidural analgesia for pain relief, and a personalized rehabilitation regimen.

51. Operative Note: Spontaneous rupture of an unspecified tendon necessitating surgical intervention due to severe bone pain. Under general anesthesia, an exploratory incision was made, revealing the ruptured tendon and associated bone erosion. Debridement of the eroded bone was performed, followed by tendon repair using sutures and tendon grafting. Hemostasis was achieved, and the wound was closed. Postoperatively, the patient was advised on immobilization, pain management, and a comprehensive rehabilitation program.

52. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under regional anesthesia, a minimally invasive approach was employed. The ruptured tendon was repaired using a combination of suture anchors and bone tunneling techniques. Hemostasis was achieved, and the incisions were closed. Postoperative care instructions were provided, including immobilization, pain control measures, and a tailored rehabilitation plan.

53. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and associated severe bone pain. Under general anesthesia, an open surgical approach was utilized. The ruptured tendon was meticulously repaired, and bone grafting was performed to address the bone erosion. Hemostasis was achieved, and the incision was closed. Postoperative instructions emphasized immobilization, pain management strategies, and a personalized rehabilitation program.

54. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and debilitating bone pain. Under regional anesthesia, an arthroscopic technique was employed. The ruptured tendon was repaired using specialized instruments and suture techniques. Attention was also given to the underlying bone erosion, and bone debridement was performed. Hemostasis was ensured, and the incisions were closed. Postoperatively, the patient was instructed on immobilization, pain relief methods, and a comprehensive rehabilitation plan.

55. Operative Note: Spontaneous rupture of an unspecified tendon necessitated surgical intervention due to severe bone pain. Under general anesthesia, an open surgical procedure was undertaken. The ruptured tendon was meticulously repaired, and bone augmentation was performed to address the bone erosion. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included immobilization, pain management strategies, and a customized rehabilitation regimen.

56. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under local anesthesia, a percutaneous technique was employed. The ruptured tendon was repaired using specialized instruments, and bone erosion was addressed through targeted debridement. Hemostasis was achieved, and the incisions were closed. Postoperative instructions emphasized immobilization, pain management techniques, and a tailored rehabilitation program.

57. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and debilitating bone pain. Under general anesthesia, a tendon reconstruction procedure was performed. The ruptured tendon was repaired using autograft or allograft materials, with concurrent measures taken to address the underlying bone erosion. Hemostasis was ensured, and the wound was closed. Postoperative care instructions included immobilization, pain relief methods, and a comprehensive rehabilitation plan.

58. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under regional anesthesia, an endoscopic-assisted technique was utilized. The ruptured tendon was repaired using specialized instruments and suture techniques, with additional attention given to the bone erosion through targeted debridement. Hemostasis was achieved, and the incisions were closed. Postoperatively, the patient was instructed on immobilization, pain management strategies, and a personalized rehabilitation program.

59. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and associated severe bone pain. Under general anesthesia, an open surgical approach was adopted. The ruptured tendon was meticulously repaired, and bone grafting was employed to address the underlying bone erosion. Hemostasis was achieved, and the incision was closed. Postoperative instructions encompassed immobilization, pain control measures, and a tailored rehabilitation regimen.

60. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under regional anesthesia, a combination of open and arthroscopic techniques was utilized. The ruptured tendon was repaired using suture anchors, and targeted bone debridement was performed to alleviate the bone pain. Hemostasis was ensured, and the incisions were closed. Postoperative care instructions included immobilization, pain management strategies, and a customized rehabilitation plan.

61. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under general anesthesia, an open reduction and internal fixation (ORIF) procedure was undertaken. The ruptured tendon was repaired, and bone fragments were realigned and secured using plates and screws. Hemostasis was achieved, and the incisions were closed. Postoperative instructions included immobilization, pain management strategies, and a comprehensive rehabilitation program.

62. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and debilitating bone pain. Under regional anesthesia, a tendon transfer procedure was performed. The ruptured tendon was reconstructed using an adjacent tendon as a graft, and bone debridement was undertaken to alleviate the bone pain. Hemostasis was ensured, and the incisions were closed. Postoperatively, the patient was advised on immobilization, pain relief measures, and a tailored rehabilitation plan.

63. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under general anesthesia, an open surgical procedure with bone reshaping was performed. The ruptured tendon was repaired, and bone reshaping techniques were employed to correct the underlying bone abnormalities causing the pain. Hemostasis was achieved, and the wound was closed. Postoperative care instructions encompassed immobilization, pain management strategies, and a personalized rehabilitation regimen.

64. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under regional anesthesia, an endoscopic-assisted tendon repair procedure was conducted. The ruptured tendon was repaired using specialized endoscopic instruments, with concurrent measures taken to alleviate the bone pain through targeted bone debridement. Hemostasis was achieved, and the incisions were closed. Postoperative instructions emphasized immobilization, pain management techniques, and a comprehensive rehabilitation program.

65. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under general anesthesia, an open surgical approach with osteotomy was employed. The ruptured tendon was repaired, and osteotomy was performed to realign the affected bone and relieve the bone pain. Hemostasis was ensured, and the incisions were closed. Postoperative care instructions included immobilization, pain control measures, and a tailored rehabilitation plan.

66. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under regional anesthesia, a tendon transfer with bone grafting procedure was undertaken. The ruptured tendon was reconstructed using a tendon transfer, and bone grafting was performed to address the bone erosion and alleviate the bone pain. Hemostasis was achieved, and the incisions were closed. Postoperative instructions encompassed immobilization, pain management strategies, and a personalized rehabilitation regimen.

67. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and debilitating bone pain. Under general anesthesia, a tendon augmentation procedure with bone fusion was performed. The ruptured tendon was repaired and reinforced using tendon augmentation techniques, while bone fusion was employed to stabilize the affected bone and relieve the bone pain. Hemostasis was ensured, and the wound was closed. Postoperative care instructions included immobilization, pain relief measures, and a comprehensive rehabilitation plan.

68. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under regional anesthesia, an arthroscopic-assisted procedure was performed. The ruptured tendon was repaired using arthroscopic techniques, and targeted bone debridement was undertaken to alleviate the bone pain. Hemostasis was achieved, and the incisions were closed. Postoperative instructions emphasized immobilization, pain management strategies, and a customized rehabilitation program.

69. Operative Note

: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe bone pain. Under general anesthesia, a tendon reconstruction with bone grafting procedure was undertaken. The ruptured tendon was repaired using specialized techniques, while bone grafting was performed to address the bone erosion and relieve the bone pain. Hemostasis was achieved, and the incision was closed. Postoperative care instructions included immobilization, pain management techniques, and a tailored rehabilitation plan.

70. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and debilitating bone pain. Under regional anesthesia, a tenodesis procedure with bone stabilization was performed. The ruptured tendon was addressed through tenodesis, and bone stabilization techniques were employed to alleviate the bone pain and provide stability. Hemostasis was ensured, and the incisions were closed. Postoperatively, the patient was advised on immobilization, pain relief measures, and a comprehensive rehabilitation program.

71. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe infection on the extreme moving joint. Under general anesthesia, an open surgical approach was employed. The infected joint was thoroughly debrided, and the ruptured tendon was repaired. Antibiotic irrigation was used to flush out the infection, and a drain was inserted for postoperative drainage. Hemostasis was achieved, and the incisions were closed. Postoperative instructions included immobilization, aggressive antibiotic therapy, wound care, and a tailored rehabilitation plan.

72. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under regional anesthesia, an arthroscopic procedure was performed. The infected joint was thoroughly debrided, and the ruptured tendon was repaired using specialized instruments and techniques. Antibiotic irrigation was used intraoperatively to treat the infection. Hemostasis was ensured, and the incisions were closed. Postoperatively, the patient was instructed on immobilization, antibiotic therapy, wound care, and a comprehensive rehabilitation program.

73. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under general anesthesia, an open reduction and debridement procedure were performed. The infected joint was thoroughly debrided, and the ruptured tendon was repaired. Antibiotic-impregnated cement spacer was used to control the infection. Hemostasis was achieved, and the wound was closed. Postoperative instructions encompassed immobilization, aggressive antibiotic therapy, wound care, and a tailored rehabilitation regimen.

74. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under regional anesthesia, an open surgical approach was utilized. The infected joint was thoroughly debrided, and the ruptured tendon was repaired using specialized techniques. Antibiotic-laden bone cement was used to address the infection. Hemostasis was ensured, and the incisions were closed. Postoperative care instructions included immobilization, intensive antibiotic therapy, wound care, and a comprehensive rehabilitation plan.

75. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under general anesthesia, an open surgical procedure with joint exploration was undertaken. The infected joint was extensively debrided, and the ruptured tendon was repaired. Antibiotic-impregnated beads were placed in the joint space to treat the infection. Hemostasis was achieved, and the incision was closed. Postoperative instructions emphasized immobilization, targeted antibiotic therapy, wound care, and a tailored rehabilitation program.

76. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under regional anesthesia, an arthroscopic-assisted debridement procedure was performed. The infected joint was meticulously debrided, and the ruptured tendon was repaired using arthroscopic techniques. Antibiotic irrigation was used intraoperatively to control the infection. Hemostasis was achieved, and the incisions were closed. Postoperative instructions included immobilization, aggressive antibiotic therapy, wound care, and a customized rehabilitation regimen.

77. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under general anesthesia, an open surgical approach with joint washout was employed. The infected joint was thoroughly debrided, and the ruptured tendon was repaired. Antibiotic irrigation and a closed suction drain were used to manage the infection. Hemostasis was ensured, and the wound was closed. Postoperative care instructions encompassed immobilization, intensive antibiotic therapy, wound care

, and a comprehensive rehabilitation plan.

78. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under regional anesthesia, an arthroscopic debridement and tendon repair procedure were undertaken. The infected joint was meticulously debrided, and the ruptured tendon was repaired using specialized arthroscopic techniques. Antibiotic irrigation was performed intraoperatively to treat the infection. Hemostasis was achieved, and the incisions were closed. Postoperatively, the patient was instructed on immobilization, targeted antibiotic therapy, wound care, and a tailored rehabilitation program.

79. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under general anesthesia, an open surgical procedure with joint debridement was performed. The infected joint was extensively debrided, and the ruptured tendon was repaired. Antibiotic-impregnated sponges were placed in the joint space to control the infection. Hemostasis was ensured, and the incisions were closed. Postoperative instructions emphasized immobilization, intensive antibiotic therapy, wound care, and a personalized rehabilitation regimen.

80. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and a severe infection on the extreme moving joint. Under regional anesthesia, an open reduction and joint irrigation procedure were performed. The infected joint was thoroughly debrided, and the ruptured tendon was repaired. Antibiotic irrigation was utilized to treat the infection, and a drain was placed for postoperative drainage. Hemostasis was achieved, and the wound was closed. Postoperative care instructions included immobilization, aggressive antibiotic therapy, wound care, and a comprehensive rehabilitation plan.

81. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon with severe inflammation on the surrounding tissues. Under general anesthesia, an open surgical approach was employed. The inflamed tissues were carefully dissected and excised, and the ruptured tendon was repaired. Hemostasis was achieved, and the incisions were closed. Postoperative instructions included immobilization, anti-inflammatory medication, cold therapy, and a tailored rehabilitation plan.

82. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and significant inflammation in the adjacent area. Under regional anesthesia, an arthroscopic-assisted procedure was performed. The inflamed tissues were meticulously addressed and debrided, and the ruptured tendon was repaired using specialized techniques. Hemostasis was ensured, and the incisions were closed. Postoperatively, the patient was instructed on immobilization, anti-inflammatory medication, cold therapy, and a comprehensive rehabilitation program.

83. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe inflammation in the surrounding area. Under general anesthesia, an open reduction and debridement procedure were undertaken. The inflamed tissues were extensively debrided, and the ruptured tendon was repaired. Hemostasis was achieved, and the wound was closed. Postoperative care instructions encompassed immobilization, anti-inflammatory medication, cold therapy, and a personalized rehabilitation regimen.

84. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and significant inflammation in the adjacent tissues. Under regional anesthesia, an arthroscopic procedure was performed. The inflamed tissues were meticulously addressed and debrided, and the ruptured tendon was repaired using specialized arthroscopic techniques. Hemostasis was achieved, and the incisions were closed. Postoperative instructions emphasized immobilization, anti-inflammatory medication, cold therapy, and a customized rehabilitation plan.

85. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and severe inflammation in the surrounding area. Under general anesthesia, an open surgical approach with tissue debridement was employed. The inflamed tissues were carefully excised and debrided, and the ruptured tendon was repaired. Hemostasis was ensured, and the incisions were closed. Postoperative instructions included immobilization, anti-inflammatory medication, cold therapy, and a comprehensive rehabilitation program.

86. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and significant inflammation in the surrounding area. Under regional anesthesia, an arthroscopic debridement and tendon repair procedure were performed. The inflamed tissues were meticulously addressed and debrided, and the ruptured tendon was repaired using specialized arthroscopic techniques. Hemostasis was achieved, and the incisions were closed. Postoperatively, the patient was instructed on immobilization, anti-inflammatory medication, cold therapy, and a tailored rehabilitation program.

87. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and severe inflammation in the adjacent tissues. Under general anesthesia, an open surgical procedure with tissue excision and repair was performed. The inflamed tissues were excised and debrided, and the ruptured tendon was repaired. Hemostasis was achieved, and the wound was closed. Postoperative care instructions encompassed immobilization, anti-inflammatory medication, cold therapy, and a personalized rehabilitation regimen.

88. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon and significant inflammation in the surrounding area. Under regional anesthesia, an arthroscopic-assisted debridement and tendon repair procedure were undertaken. The inflamed tissues were meticulously addressed and debrided, and the ruptured tendon was repaired using specialized arthroscopic techniques. Hemostasis was ensured

, and the incisions were closed. Postoperative instructions included immobilization, anti-inflammatory medication, cold therapy, and a customized rehabilitation plan.

89. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon and severe inflammation in the surrounding area. Under general anesthesia, an open reduction and debridement procedure were performed. The inflamed tissues were extensively debrided, and the ruptured tendon was repaired. Hemostasis was achieved, and the wound was closed. Postoperative instructions emphasized immobilization, anti-inflammatory medication, cold therapy, and a comprehensive rehabilitation program.

90. Operative Note: Surgical intervention was undertaken to address the spontaneous rupture of an unspecified tendon and significant inflammation in the adjacent tissues. Under regional anesthesia, an arthroscopic procedure with tissue debridement was performed. The inflamed tissues were meticulously addressed and debrided, and the ruptured tendon was repaired using specialized arthroscopic techniques. Hemostasis was achieved, and the incisions were closed. Postoperative care instructions encompassed immobilization, anti-inflammatory medication, cold therapy, and a tailored rehabilitation regimen.

91. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon. The severity of the diagnosis indicated the need for a thorough exploration. Under general anesthesia, an open surgical approach was employed. The ruptured tendon was repaired using specialized techniques, and thorough irrigation was performed. Hemostasis was achieved, and the incisions were closed. Postoperative care instructions and follow-up appointments were scheduled based on the severity of the diagnosis to monitor the patient's progress and determine the need for further interventions.

92. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon. Due to the severity of the diagnosis, an extensive repair procedure was undertaken. Under regional anesthesia, the ruptured tendon was repaired using advanced techniques. Special attention was given to assess and address any accompanying tissue damage. Hemostasis was ensured, and the incisions were closed. The patient's follow-up appointments and postoperative care were tailored based on the severity of the diagnosis to optimize recovery and monitor treatment outcomes.

93. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon. The severity of the diagnosis necessitated an in-depth evaluation. Under general anesthesia, the ruptured tendon was repaired, and additional procedures were performed to address associated complications. Hemostasis was achieved, and the incisions were closed meticulously. Postoperative care and follow-up appointments were planned based on the severity of the diagnosis to closely monitor the patient's condition and ensure appropriate treatment and rehabilitation.

94. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon. Given the severity of the diagnosis, an extensive repair procedure was performed. Under regional anesthesia, the ruptured tendon was repaired using advanced techniques. Concurrent procedures were undertaken to address any accompanying tissue damage or inflammation. Hemostasis was ensured, and the incisions were meticulously closed. The patient's follow-up plan was determined based on the severity of the diagnosis to evaluate treatment outcomes and adjust the rehabilitation program accordingly.

95. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon. The severity of the diagnosis warranted a comprehensive procedure. Under general anesthesia, the ruptured tendon was repaired using specialized techniques, and thorough irrigation was performed. Adjacent structures were evaluated for any secondary damage. Hemostasis was achieved, and the incisions were meticulously closed. Postoperative care and follow-up appointments were individualized based on the severity of the diagnosis to monitor the patient's progress and determine the need for additional interventions.

96. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon. Given the severity of the diagnosis, an extensive repair procedure was undertaken. Under regional anesthesia, the ruptured tendon was meticulously repaired, and meticulous irrigation was performed. The surrounding tissues were assessed for any signs of additional damage. Hemostasis was ensured, and the incisions were closed with precision. The patient's follow-up appointments and postoperative care were customized based on the severity of the diagnosis to optimize recovery and address any potential complications.

97. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon. The severity of the diagnosis necessitated an extensive exploration and repair. Under general anesthesia, the ruptured tendon was meticulously repaired using specialized techniques. Adjacent structures were thoroughly examined for any signs of secondary damage. Hemostasis was achieved, and the incisions were closed meticulously. The patient's follow-up plan and postoperative care were determined based on the severity of the diagnosis to monitor progress and provide necessary interventions as needed.

98. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon. Given the severity of the diagnosis, a comprehensive repair procedure was undertaken. Under regional anesthesia, the ruptured tendon was repaired using advanced techniques

. Concurrent procedures were performed to assess and treat any associated complications. Hemostasis was ensured, and the incisions were meticulously closed. The patient's follow-up appointments and postoperative care were tailored based on the severity of the diagnosis to optimize recovery and address individual needs.

99. Operative Note: Surgical intervention was performed to address the spontaneous rupture of an unspecified tendon. The severity of the diagnosis necessitated an extensive repair procedure. Under general anesthesia, the ruptured tendon was meticulously repaired using specialized techniques. Adjacent structures were carefully evaluated for any additional damage. Hemostasis was achieved, and the incisions were meticulously closed. The patient's follow-up plan and postoperative care were individualized based on the severity of the diagnosis to monitor progress and ensure the best possible outcome.

100. Operative Note: Surgical intervention was required to address the spontaneous rupture of an unspecified tendon. Given the severity of the diagnosis, an in-depth repair procedure was undertaken. Under regional anesthesia, the ruptured tendon was meticulously repaired using advanced techniques. Concurrent procedures were performed to address any accompanying complications or secondary damage. Hemostasis was ensured, and the incisions were meticulously closed. The patient's follow-up appointments and postoperative care were customized based on the severity of the diagnosis to monitor progress, optimize recovery, and address any ongoing needs.

## M67.0 Short Achilles tendon (acquired)

1. Patient underwent surgical correction of a short Achilles tendon using the Silfverskiöld technique. An incision was made over the posterior ankle, and the tendon was lengthened through a Z-plasty. The wound was closed with absorbable sutures. Postoperative immobilization in a below-knee cast was initiated.

2. Operative procedure involved a gastrocnemius recession for correction of a short Achilles tendon. A longitudinal incision was made in the calf muscle, and the gastrocnemius tendon was partially released to lengthen the Achilles tendon. The wound was closed with interrupted sutures. Patient was placed in a posterior splint for immobilization.

3. Patient underwent percutaneous Achilles tendon lengthening for a short Achilles tendon. A small incision was made over the Achilles tendon, and multiple percutaneous releases were performed using a specialized instrument. The wound was closed with steri-strips, and a below-knee cast was applied for postoperative immobilization.

4. Surgical correction of a short Achilles tendon was performed using the V-Y lengthening technique. A transverse incision was made at the level of the Achilles tendon insertion, and the tendon was lengthened by creating a V-shaped cut and mobilizing the ends. The wound was closed with absorbable sutures, and a below-knee cast was applied.

5. Operative procedure involved a FHL transfer for correction of a short Achilles tendon. An incision was made over the medial foot, and the flexor hallucis longus tendon was identified, detached from its insertion, and transferred to the Achilles tendon. The wound was closed with sutures, and a below-knee cast was applied for immobilization.

6. Patient underwent a Z-lengthening procedure for correction of a short Achilles tendon. Two parallel incisions were made over the posterior ankle, and the Achilles tendon was divided in a Z-pattern to increase its length. The tendon ends were sutured together, and the wound was closed. Postoperative immobilization was achieved with a below-knee cast.

7. Surgical correction of a short Achilles tendon was performed using a turndown procedure. An incision was made over the posterior ankle, and a flap of tissue was created by mobilizing the adjacent skin. The Achilles tendon was lengthened by attaching the flap to its distal end. The wound was closed, and a posterior splint was applied.

8. Operative procedure involved an Achilles tendon lengthening using the Ponseti technique. A small incision was made over the Achilles tendon, and the tendon was divided longitudinally to create two separate strands. The strands were then sutured together to lengthen the tendon. The wound was closed, and postoperative immobilization was achieved with a below-knee cast.

9. Patient underwent an endoscopic gastrocnemius recession for correction of a short Achilles tendon. Two small incisions were made in the calf muscle, and an endoscope was used to visualize the gastrocnemius tendon. The tendon was partially released to increase the length of the Achilles tendon. The incisions were closed with sutures, and a posterior splint was applied.

10. Surgical correction of a short Achilles tendon was performed using the triple hemisection technique. Three incisions were made over the Achilles tendon, and each hemisection was performed at a different level. The tendon segments were then sutured together, effectively lengthening the tendon. The wounds were closed, and postoperative immobilization was achieved with a below-knee cast.

1. Patient underwent a minimally invasive percutaneous Achilles tendon lengthening procedure for correction of a short tendon. Multiple small incisions were made over the Achilles tendon, and specialized instruments were used to release the tight fibers and lengthen the tendon. The incisions were closed with steri-strips, and the patient was placed in a below-knee boot for postoperative support.

2. Operative procedure involved an open Z-plasty Achilles tendon lengthening for correction of a short tendon. An incision was made over the Achilles tendon, and a Z-shaped pattern was created to increase the tendon's length. The Z-plasty was secured with sutures, and the wound was closed with absorbable stitches. Patient received a below-knee cast for immobilization.

3. Patient underwent a peroneus brevis tendon transfer for correction of a short Achilles tendon. An incision was made over the lateral ankle, and the peroneus brevis tendon was harvested and transferred to the Achilles tendon. The tendon transfer was secured with sutures, and the incision was closed. Patient was placed in a below-knee cast for postoperative immobilization.

4. Surgical correction of a short Achilles tendon was performed using the Girdlestone-Taylor procedure. An incision was made over the posterior ankle, and a section of the calcaneus bone was removed to lengthen the tendon. The bone was fixed with screws, and the wound was closed. Patient received a below-knee cast for immobilization.

5. Operative procedure involved a triple V-Y lengthening for correction of a short Achilles tendon. Three V-shaped incisions were made over the Achilles tendon, and the tendon was mobilized and lengthened. The V-Y flaps were sutured together, and the wounds were closed with sutures. Patient was placed in a below-knee cast for postoperative support.

6. Patient underwent an endoscopic gastrocnemius fascial release for correction of a short Achilles tendon. Two small incisions were made over the calf, and an endoscope was used to visualize and release the tight fascia. The procedure allowed for lengthening of the Achilles tendon. The incisions were closed with sutures, and the patient was immobilized with a posterior splint.

7. Surgical correction of a short Achilles tendon was performed using the Evans technique. An incision was made over the calcaneus, and a section of bone was removed to lengthen the tendon. The bone was fixed in an elevated position with a plate and screws, and the wound was closed. Patient received a below-knee cast for postoperative immobilization.

8. Operative procedure involved an allograft Achilles tendon augmentation for correction of a short tendon. An incision was made over the Achilles tendon, and a donor tendon was implanted to augment the length of the native tendon. The graft was secured with sutures, and the wound was closed. Patient was placed in a below-knee cast for postoperative support.

9. Patient underwent a minimally invasive endoscopic Achilles tendon lengthening using the Percutaneous Needle Technique (PNT). Small incisions were made, and a needle was inserted to divide the tight fibers and lengthen the tendon. The incisions were closed with steri-strips, and the patient was placed in a below-knee boot for postoperative immobilization.

10. Surgical correction of a short Achilles tendon was performed using the Strayer procedure. An incision was made over the distal calf, and a section of the gastrocnemius muscle was removed to lengthen the tendon. The muscle was reattached using sutures, and the wound was closed. Patient received a below-knee cast for immobilization.

1. Patient underwent surgical correction of a short Achilles tendon using the Silfverskiöld technique under local anesthesia. An incision was made over the posterior ankle, and the tendon was lengthened through a Z-plasty. The wound was closed with absorbable sutures. Postoperative immobilization in a below-knee cast was initiated.

2. Operative procedure involved a gastrocnemius recession for correction of a short Achilles tendon under spinal anesthesia. A longitudinal incision was made in the calf muscle, and the gastrocnemius tendon was partially released to lengthen the Achilles tendon. The wound was closed with interrupted sutures. Patient was placed in a posterior splint for immobilization.

3. Patient underwent percutaneous Achilles tendon lengthening for a short Achilles tendon under general anesthesia. A small incision was made over the Achilles tendon, and multiple percutaneous releases were performed using a specialized instrument. The wound was closed with steri-strips, and a below-knee cast was applied for postoperative immobilization.

4. Surgical correction of a short Achilles tendon was performed using the V-Y lengthening technique under regional anesthesia. A transverse incision was made at the level of the Achilles tendon insertion, and the tendon was lengthened by creating a V-shaped cut and mobilizing the ends. The wound was closed with absorbable sutures, and a below-knee cast was applied.

5. Operative procedure involved an Achilles tendon lengthening using the Ponseti technique under local anesthesia. A small incision was made over the Achilles tendon, and the tendon was divided longitudinally to create two separate strands. The strands were then sutured together to lengthen the tendon. The wound was closed, and postoperative immobilization was achieved with a below-knee cast.

6. Patient underwent a Z-lengthening procedure for correction of a short Achilles tendon under general anesthesia. Two parallel incisions were made over the posterior ankle, and the Achilles tendon was divided in a Z-pattern to increase its length. The tendon ends were sutured together, and the wound was closed. Postoperative immobilization was achieved with a below-knee cast.

7. Surgical correction of a short Achilles tendon was performed using the triple hemisection technique under regional anesthesia. Three incisions were made over the Achilles tendon, and each hemisection was performed at a different level. The tendon segments were then sutured together, effectively lengthening the tendon. The wounds were closed, and postoperative immobilization was achieved with a below-knee cast.

8. Operative procedure involved an open Z-plasty Achilles tendon lengthening for correction of a short tendon under local anesthesia. An incision was made over the Achilles tendon, and a Z-shaped pattern was created to increase the tendon's length. The Z-plasty was secured with sutures, and the wound was closed with absorbable stitches. Patient received a below-knee cast for immobilization.

9. Patient underwent a peroneus brevis tendon transfer for correction of a short Achilles tendon under spinal anesthesia. An incision was made over the lateral ankle, and the peroneus brevis tendon was harvested and transferred to the Achilles tendon. The tendon transfer was secured with sutures, and the incision was closed. Patient was placed in a below-knee cast for postoperative immobilization.

10. Surgical correction of a short Achilles tendon was performed using the Girdlestone-Taylor procedure under general anesthesia. An incision was made over the posterior ankle, and a section of the calcaneus bone was removed to lengthen the tendon. The bone was fixed with screws, and the wound was closed. Patient received a below-knee cast for immobilization.

1. Patient presented with a short Achilles tendon and bone erosion at the calcaneal insertion. Surgical intervention was performed under general anesthesia. A posterior midline incision was made, and the eroded bone was debrided. The Achilles tendon was lengthened using a V-Y plasty technique. The wound was closed with sutures, and the patient was placed in a below-knee cast for immobilization.

2. Operative procedure involved correction of a short Achilles tendon with associated bone erosion using a gastrocnemius recession. Under regional anesthesia, an incision was made over the calf muscle, and the eroded bone was debrided. The gastrocnemius tendon was partially released to lengthen the Achilles tendon. The wound was closed, and the patient received a posterior splint for immobilization.

3. Patient underwent surgical correction of a short Achilles tendon with bone erosion at the calcaneus under spinal anesthesia. An incision was made over the posterior ankle, and the eroded bone was meticulously debrided. The Achilles tendon was lengthened using a Silfverskiöld technique. The wound was closed, and postoperative immobilization was achieved with a below-knee cast.

4. Surgical correction of a short Achilles tendon with bone erosion was performed under general anesthesia. An open Z-plasty technique was employed. The eroded bone was excised, and the Achilles tendon was lengthened. The wound was closed with absorbable sutures, and the patient was placed in a below-knee cast for postoperative support.

5. Operative procedure involved correction of a short Achilles tendon with significant bone erosion under local anesthesia. An incision was made over the posterior ankle, and the eroded bone was debrided. The Achilles tendon was augmented using an allograft, and the wound was closed. Patient received a below-knee cast for immobilization.

6. Patient presented with a short Achilles tendon and bone erosion, necessitating surgical intervention under general anesthesia. A triple hemisection technique was employed to address the tendon shortening, while the eroded bone was meticulously debrided. The tendon segments were sutured together, and the wound was closed. Postoperative immobilization was achieved with a below-knee cast.

7. Surgical correction of a short Achilles tendon with bone erosion was performed using the FHL transfer technique under regional anesthesia. The eroded bone was excised, and the flexor hallucis longus tendon was harvested and transferred to augment the Achilles tendon. The wound was closed, and the patient received a below-knee cast for postoperative support.

8. Operative procedure involved correction of a short Achilles tendon with bone erosion using the Evans technique under local anesthesia. The eroded bone was carefully debrided, and a section of the calcaneus was removed to lengthen the tendon. The bone was fixed with screws, and the wound was closed. Patient received a below-knee cast for immobilization.

9. Patient presented with a short Achilles tendon and bone erosion, requiring surgical correction under spinal anesthesia. An endoscopic approach was utilized, allowing visualization and debridement of the eroded bone. The Achilles tendon was lengthened using percutaneous releases. The incisions were closed, and the patient was placed in a below-knee cast for postoperative immobilization.

10. Surgical correction of a short Achilles tendon with bone erosion was performed using an allograft augmentation technique under general anesthesia. The eroded bone was debrided, and the allograft was implanted to reconstruct and lengthen the tendon. The wound was closed, and the patient received a below-knee cast for postoperative support.

1. Patient presented with severe bone pain due to a short Achilles tendon and associated bone erosion. Surgical correction was performed under general anesthesia. The eroded bone was meticulously debrided, and the Achilles tendon was lengthened using a modified Strayer procedure. The wound was closed, and the patient received postoperative pain management along with a below-knee cast for immobilization.

2. Operative procedure involved correction of a short Achilles tendon with severe bone pain using a gastrocnemius recession. Under regional anesthesia, the eroded bone was debrided, and the gastrocnemius tendon was partially released to lengthen the Achilles tendon. The wound was closed, and the patient was provided with postoperative pain medication and a posterior splint for immobilization.

3. Patient underwent surgical correction of a short Achilles tendon with severe bone pain under spinal anesthesia. An incision was made over the posterior ankle, and meticulous debridement of the eroded bone was performed. The Achilles tendon was lengthened using a Z-lengthening procedure. The wound was closed, and the patient received postoperative pain management along with a below-knee cast.

4. Surgical correction of a short Achilles tendon with severe bone pain was performed under general anesthesia. An open Z-plasty technique was employed, involving debridement of the eroded bone and lengthening of the Achilles tendon. The wound was closed with absorbable sutures, and the patient was provided with postoperative pain relief along with a below-knee cast for immobilization.

5. Operative procedure involved correction of a short Achilles tendon with severe bone pain under local anesthesia. An incision was made over the posterior ankle, and meticulous debridement of the eroded bone was performed. The Achilles tendon was augmented using an allograft, and the wound was closed. Patient received postoperative pain medication and a below-knee cast.

6. Patient presented with severe bone pain associated with a short Achilles tendon and bone erosion, requiring surgical intervention under general anesthesia. The eroded bone was meticulously debrided, and the Achilles tendon was lengthened using a triple hemisection technique. The wound was closed, and the patient was provided with postoperative pain management and a below-knee cast for immobilization.

7. Surgical correction of a short Achilles tendon with severe bone pain was performed using the FHL transfer technique under regional anesthesia. The eroded bone was debrided, and the flexor hallucis longus tendon was harvested and transferred to augment the Achilles tendon. The wound was closed, and the patient received postoperative pain relief along with a below-knee cast.

8. Operative procedure involved correction of a short Achilles tendon with severe bone pain using the Evans technique under local anesthesia. The eroded bone was carefully debrided, and a section of the calcaneus was removed to lengthen the tendon. The bone was fixed with screws, and the wound was closed. Patient received postoperative pain management and a below-knee cast.

9. Patient presented with severe bone pain due to a short Achilles tendon and associated bone erosion, necessitating surgical correction under spinal anesthesia. An endoscopic approach was utilized to visualize and debride the eroded bone. The Achilles tendon was lengthened using percutaneous releases. The incisions were closed, and the patient was provided with postoperative pain relief along with a below-knee cast for immobilization.

10. Surgical correction of a short Achilles tendon with severe bone pain was performed using an allograft augmentation technique under general anesthesia. The eroded bone was debrided, and the allograft was implanted to reconstruct and lengthen the tendon. The wound was closed, and the patient received postoperative pain management along with a below-knee cast for support.

1. Patient with severe bone pain and a short Achilles tendon underwent surgical intervention using the V-Y lengthening technique. Under general anesthesia, an incision was made over the posterior ankle, and the eroded bone was meticulously debrided. The Achilles tendon was mobilized and lengthened using the V-Y flaps. The wound was closed, and the patient received postoperative pain management and a below-knee cast for immobilization.

2. Operative procedure involved surgical intervention for a short Achilles tendon with severe bone pain using the Percutaneous Needle Technique (PNT). Under regional anesthesia, multiple small incisions were made, and a needle was inserted to divide the tight fibers and lengthen the tendon. The incisions were closed, and the patient received postoperative pain relief along with a below-knee cast.

3. Patient underwent surgical correction for a short Achilles tendon with severe bone pain using the Silfverskiöld technique. Under spinal anesthesia, an incision was made over the posterior ankle, and the eroded bone was debrided. The Achilles tendon was lengthened by performing a distal Z-plasty. The wound was closed, and the patient received postoperative pain management along with a below-knee cast.

4. Surgical intervention was performed for a short Achilles tendon with severe bone pain using the Girdlestone-Taylor procedure. Under general anesthesia, an incision was made over the posterior ankle, and the eroded bone was excised to lengthen the tendon. The bone was fixed with screws, and the wound was closed. The patient received postoperative pain relief and a below-knee cast for immobilization.

5. Operative procedure involved surgical correction of a short Achilles tendon with severe bone pain using an allograft augmentation. Under local anesthesia, an incision was made over the Achilles tendon, and the eroded bone was debrided. An allograft was implanted to reconstruct and lengthen the tendon. The wound was closed, and the patient received postoperative pain management along with a below-knee cast.

6. Patient underwent surgical intervention for a short Achilles tendon with severe bone pain using the Evans technique. Under regional anesthesia, an incision was made over the calcaneus, and the eroded bone was meticulously debrided. A section of the bone was removed to lengthen the tendon, which was then fixed with screws. The wound was closed, and the patient received postoperative pain relief and a below-knee cast.

7. Surgical correction was performed for a short Achilles tendon with severe bone pain using the FHL transfer technique. Under general anesthesia, the eroded bone was debrided, and the flexor hallucis longus tendon was harvested and transferred to augment the Achilles tendon. The wound was closed, and the patient received postoperative pain management along with a below-knee cast for immobilization.

8. Operative procedure involved surgical intervention for a short Achilles tendon with severe bone pain using the Z-lengthening technique. Under local anesthesia, an incision was made over the posterior ankle, and the eroded bone was debrided. The Achilles tendon was lengthened through a Z-shaped incision pattern. The wound was closed, and the patient received postoperative pain relief and a below-knee cast.

9. Patient underwent surgical correction for a short Achilles tendon with severe bone pain using an endoscopic approach. Under spinal anesthesia, the eroded bone was meticulously debrided using an endoscope. The Achilles tendon was lengthened through percutaneous releases. The incisions were closed, and the patient received postoperative pain management along with a below-knee cast.

10. Surgical intervention was performed for a short Achilles tendon with severe bone pain using the modified Strayer procedure. Under general anesthesia, an incision was made over the

posterior ankle, and the eroded bone was debrided. The Achilles tendon was lengthened by performing a partial detachment of the gastrocnemius muscle. The wound was closed, and the patient received postoperative pain relief along with a below-knee cast.

1. Patient underwent surgical intervention for a short Achilles tendon with severe bone pain using the peroneus brevis tendon transfer technique. Under regional anesthesia, an incision was made over the lateral ankle, and the peroneus brevis tendon was harvested and transferred to augment the Achilles tendon. The wound was closed, and the patient received postoperative pain management along with a below-knee cast for immobilization.

2. Operative procedure involved surgical correction of a short Achilles tendon with severe bone pain using the Bosworth technique. Under local anesthesia, an incision was made over the posterior ankle, and the eroded bone was meticulously debrided. A bone block was created and fixed with screws to lengthen the tendon. The wound was closed, and the patient received postoperative pain relief along with a below-knee cast.

3. Patient presented with severe bone pain due to a short Achilles tendon and underwent surgical intervention using the McGlamry technique. Under general anesthesia, an incision was made over the posterior ankle, and the eroded bone was debrided. The Achilles tendon was lengthened by performing a central tenotomy and Z-plasty. The wound was closed, and the patient received postoperative pain management along with a below-knee cast.

4. Surgical intervention was performed for a short Achilles tendon with severe bone pain using the Lindholm technique. Under spinal anesthesia, an incision was made over the posterior ankle, and the eroded bone was meticulously debrided. The Achilles tendon was lengthened through a combined V-Y plasty and central tenotomy. The wound was closed, and the patient received postoperative pain relief and a below-knee cast for immobilization.

5. Operative procedure involved surgical correction of a short Achilles tendon with severe bone pain using the Meary technique. Under local anesthesia, an incision was made over the posterior ankle, and the eroded bone was debrided. The Achilles tendon was lengthened by performing multiple percutaneous releases. The wound was closed, and the patient received postoperative pain management along with a below-knee cast.

6. Patient underwent surgical intervention for a short Achilles tendon with severe bone pain using the Brunelli technique. Under general anesthesia, an incision was made over the posterior ankle, and the eroded bone was debrided. The Achilles tendon was lengthened through a Z-lengthening procedure. The wound was closed, and the patient received postoperative pain relief along with a below-knee cast.

7. Surgical correction was performed for a short Achilles tendon with severe bone pain using the Rankin technique. Under regional anesthesia, the eroded bone was meticulously debrided, and a wedge osteotomy was performed to lengthen the tendon. The bone was fixed with screws, and the wound was closed. The patient received postoperative pain management and a below-knee cast for immobilization.

8. Operative procedure involved surgical intervention for a short Achilles tendon with severe bone pain using the Hoke technique. Under local anesthesia, an incision was made over the posterior ankle, and the eroded bone was debrided. The Achilles tendon was lengthened by performing a Z-lengthening with an additional calcaneal slide osteotomy. The wound was closed, and the patient received postoperative pain relief along with a below-knee cast.

9. Patient underwent surgical correction for a short Achilles tendon with severe bone pain using the Lindgren-Turan technique. Under spinal anesthesia, the eroded bone was debrided, and a calcaneal sliding osteotomy was performed to lengthen the tendon. The bone was fixed with screws, and the wound was closed. The patient received postoperative pain management and a below-knee cast for immobilization.

10. Surgical intervention was performed for a short Achilles tendon with severe bone pain using

the Pomeroy technique. Under general anesthesia, an incision was made over the posterior ankle, and the eroded bone was meticulously debrided. The Achilles tendon was lengthened through a combination of central tenotomy and V-Y plasty. The wound was closed, and the patient received postoperative pain relief along with a below-knee cast.

1. Patient presented with a severe infection on the extreme moving joint of a short Achilles tendon, necessitating surgical intervention. Under general anesthesia, an extensive debridement of the infected tissues was performed, including the eroded bone. The Achilles tendon was lengthened using a modified Strayer procedure. Antibiotic irrigation was administered, and the wound was closed. The patient received postoperative intravenous antibiotics and a below-knee cast for immobilization.

2. Operative procedure involved surgical correction of a short Achilles tendon with a severe infection on the extreme moving joint. Under regional anesthesia, the infected tissues, including the eroded bone, were meticulously debrided. The Achilles tendon was lengthened using a gastrocnemius recession. The wound was thoroughly irrigated and closed. The patient received postoperative intravenous antibiotics and a below-knee cast for immobilization.

3. Patient underwent surgical intervention for a short Achilles tendon with a severe infection on the extreme moving joint. Under spinal anesthesia, the infected tissues, along with the eroded bone, were debrided. The Achilles tendon was lengthened using a Z-lengthening procedure. The wound was thoroughly irrigated, and a wound vacuum was applied. The patient received postoperative intravenous antibiotics and a below-knee cast for immobilization.

4. Surgical correction was performed for a short Achilles tendon with a severe infection on the extreme moving joint. Under general anesthesia, an open Z-plasty technique was employed, involving debridement of the infected tissues, including the eroded bone. The Achilles tendon was lengthened, and a local flap was used to cover the wound. The patient received postoperative intravenous antibiotics and a below-knee cast for immobilization.

5. Operative procedure involved surgical intervention for a short Achilles tendon with a severe infection on the extreme moving joint using the Masquelet technique. Under local anesthesia, the infected tissues and eroded bone were debrided. A temporary antibiotic spacer was placed, and the Achilles tendon was lengthened using an allograft. The wound was closed, and the patient received postoperative intravenous antibiotics and a below-knee cast.

6. Patient presented with a severe infection on the extreme moving joint of a short Achilles tendon, requiring surgical intervention. Under general anesthesia, an incision was made to access the infected tissues and eroded bone, which were meticulously debrided. The Achilles tendon was lengthened using a triple hemisection technique. The wound was thoroughly irrigated, and a negative pressure wound therapy device was applied. The patient received postoperative intravenous antibiotics and a below-knee cast.

7. Surgical correction was performed for a short Achilles tendon with a severe infection on the extreme moving joint using the Girdlestone-Taylor procedure. Under regional anesthesia, an extensive debridement of the infected tissues, including the eroded bone, was performed. The Achilles tendon was lengthened, and the wound was left open for secondary healing. The patient received postoperative intravenous antibiotics and a below-knee cast for immobilization.

8. Operative procedure involved surgical intervention for a short Achilles tendon with a severe infection on the extreme moving joint using the Vacuum-Assisted Closure (VAC) therapy. Under local anesthesia, the infected tissues, along with the eroded bone, were debrided. The Achilles tendon was lengthened, and a VAC dressing was applied to promote wound healing. The patient received postoperative intravenous antibiotics and a below-knee cast.

9. Patient underwent surgical correction for a short Achilles tendon with a severe infection on the extreme moving joint using the staged procedure. Under spinal anesthesia, an incision was made to access the infected tissues and eroded bone, which were meticulously debrided. A temporary antibiotic spacer was placed, and the Achilles tendon was lengthened during

a subsequent procedure. The patient received postoperative intravenous antibiotics and a below-knee cast for immobilization.

10. Surgical intervention was performed for a short Achilles tendon with a severe infection on the extreme moving joint using the Ilizarov technique. Under general anesthesia, the infected tissues, including the eroded bone, were debrided. The Achilles tendon was lengthened using the Ilizarov external fixator, which allowed for gradual correction and stabilization. The patient received postoperative intravenous antibiotics and a below-knee cast for immobilization.

1. Patient presented with a short Achilles tendon and severe inflammation on the extreme moving joint, requiring surgical intervention. Under general anesthesia, the inflamed tissues, along with the eroded bone, were meticulously debrided. The Achilles tendon was lengthened using a modified Krackow technique. Anti-inflammatory medication was administered, and the wound was closed. The patient received postoperative pain management and a below-knee cast for immobilization.

2. Operative procedure involved surgical correction of a short Achilles tendon with moderate inflammation on the extreme moving joint. Under regional anesthesia, the inflamed tissues, including the eroded bone, were debrided. The Achilles tendon was lengthened using a percutaneous Z-lengthening technique. The wound was closed, and the patient received postoperative anti-inflammatory medication along with a below-knee cast.

3. Patient underwent surgical intervention for a short Achilles tendon with mild inflammation on the extreme moving joint. Under spinal anesthesia, the inflamed tissues, along with the eroded bone, were debrided. The Achilles tendon was lengthened using a V-Y lengthening procedure. The wound was closed, and the patient received postoperative anti-inflammatory medication and a below-knee cast for immobilization.

4. Surgical correction was performed for a short Achilles tendon with severe inflammation on the extreme moving joint. Under general anesthesia, an open Z-plasty technique was employed, involving debridement of the inflamed tissues, including the eroded bone. The Achilles tendon was lengthened, and a local flap was used to cover the wound. The patient received postoperative anti-inflammatory medication and a below-knee cast for immobilization.

5. Operative procedure involved surgical intervention for a short Achilles tendon with chronic inflammation on the extreme moving joint using the Silfverskiöld technique. Under local anesthesia, the inflamed tissues and eroded bone were debrided. The Achilles tendon was lengthened through a distal Z-plasty. The wound was closed, and the patient received postoperative anti-inflammatory medication along with a below-knee cast.

6. Patient presented with a short Achilles tendon and acute inflammation on the extreme moving joint, necessitating surgical intervention. Under general anesthesia, an incision was made to access the inflamed tissues and eroded bone, which were meticulously debrided. The Achilles tendon was lengthened using a triple hemisection technique. Anti-inflammatory medication was administered, and the wound was closed. The patient received postoperative pain management and a below-knee cast.

7. Surgical correction was performed for a short Achilles tendon with moderate inflammation on the extreme moving joint using the Girdlestone-Taylor procedure. Under regional anesthesia, an extensive debridement of the inflamed tissues, including the eroded bone, was performed. The Achilles tendon was lengthened, and the wound was left open for secondary healing. The patient received postoperative anti-inflammatory medication and a below-knee cast for immobilization.

8. Operative procedure involved surgical intervention for a short Achilles tendon with mild inflammation on the extreme moving joint using the Vacuum-Assisted Closure (VAC) therapy. Under local anesthesia, the inflamed tissues, along with the eroded bone, were debrided. The Achilles tendon was lengthened, and a VAC dressing was applied to promote wound healing and reduce inflammation. The patient received postoperative pain management and a below-knee cast.

9. Patient underwent surgical correction for a short Achilles tendon with severe inflammation on the extreme moving joint using the staged procedure. Under spinal anesthesia, an incision was made to access the inflamed tissues and eroded bone, which were meticulously debrided. A temporary antibiotic spacer was placed, and the Achilles tendon was lengthened during a subsequent procedure. The patient received postoperative anti-inflammatory medication and a below-knee cast for immobilization.

10. Surgical intervention was performed for a short Achilles tendon with moderate inflammation on the extreme moving joint using the Ilizarov technique. Under general anesthesia, the inflamed tissues, including the eroded bone, were debrided. The Achilles tendon was lengthened using the Ilizarov external fixator, which allowed for gradual correction and provided anti-inflammatory effects. The patient received postoperative pain management and a below-knee cast for immobilization.

1. Patient diagnosed with a mild short Achilles tendon underwent surgical correction. Follow-up includes regular physical therapy sessions to optimize healing and restore full range of motion. Patient advised to gradually increase weight-bearing activities under the guidance of a therapist. Follow-up visits scheduled at 2-week intervals to monitor progress and address any concerns.

2. Patient diagnosed with a moderate short Achilles tendon underwent surgical correction. Follow-up includes regular physical therapy sessions for strengthening and stretching exercises. Patient advised to use a heel lift to support the tendon during weight-bearing activities. Follow-up visits scheduled at 4-week intervals to assess healing, adjust therapy, and monitor overall recovery.

3. Patient diagnosed with a severe short Achilles tendon underwent extensive surgical intervention. Follow-up includes a combination of physical therapy, occupational therapy, and pain management. Patient prescribed a customized rehabilitation program with a gradual increase in intensity. Regular follow-up visits scheduled at 6-week intervals to assess tendon healing, functional outcomes, and address any complications or concerns.

4. Patient diagnosed with a mild short Achilles tendon received conservative treatment with physical therapy and orthotic devices. Follow-up includes regular therapy sessions to monitor progress, adjust exercises, and ensure proper use of orthotics. Follow-up visits scheduled at 4-week intervals to assess response to treatment, make necessary modifications, and evaluate overall improvement.

5. Patient diagnosed with a moderate short Achilles tendon underwent a minimally invasive procedure. Follow-up includes physical therapy sessions focused on strengthening and stretching exercises. Patient advised to gradually resume weight-bearing activities and wear supportive footwear. Follow-up visits scheduled at 6-week intervals to assess healing, functional outcomes, and provide further guidance on rehabilitation.

6. Patient diagnosed with a severe short Achilles tendon underwent complex surgical intervention. Follow-up includes a multidisciplinary approach involving physical therapy, pain management, and orthopedic consultations. Patient scheduled for frequent follow-up visits, ranging from weekly to biweekly, depending on the severity of the condition and individual progress. Treatment plan and rehabilitation program adjusted accordingly during each visit.

7. Patient diagnosed with a mild short Achilles tendon received non-surgical treatment with immobilization and physical therapy. Follow-up includes regular therapy sessions to monitor progress, modify exercises, and assess the need for additional interventions. Follow-up visits scheduled at 2 to 4-week intervals to evaluate response to treatment, adjust therapy, and ensure optimal recovery.

8. Patient diagnosed with a moderate short Achilles tendon underwent a combination of surgical correction and conservative measures. Follow-up includes a comprehensive rehabilitation program consisting of physical therapy, orthotics, and activity modification. Patient scheduled for regular follow-up visits at 4 to 6-week intervals to track healing, assess functional outcomes, and provide guidance on further rehabilitation.

9. Patient diagnosed with a severe short Achilles tendon underwent extensive surgical intervention followed by immobilization and specialized rehabilitation. Follow-up includes a closely monitored rehabilitation program tailored to the patient's specific needs. Regular follow-up visits scheduled at 4 to 8-week intervals to assess progress, adjust therapy, and address any complications or concerns that may arise.

10. Patient diagnosed with a mild short Achilles tendon received conservative treatment with a combination of physical therapy, orthotics, and lifestyle modifications. Follow-up includes regular therapy sessions to monitor progress, adjust exercises, and assess the effectiveness of orthotic devices. Follow-up visits scheduled at 4 to 6-week intervals to evaluate treatment response, make necessary modifications, and ensure continued improvement.

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## M67.1 Other contracture of tendon (sheath)

1. Operative Note: Patient presented with other contracture of the tendon. The surgical team performed a tendon release procedure under general anesthesia. A longitudinal incision was made over the affected tendon. Dissection was carried out to expose the contracted tendon fibers. Tendon sheath was released, and adhesions were carefully dissected and excised. The tendon was mobilized and tested for adequate range of motion. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were provided to the patient.

2. Operative Note: The patient underwent surgical intervention for other contracture of the tendon. A standard dorsal approach was employed under local anesthesia. The contracted tendon was identified and carefully dissected. Release of the tendon sheath was performed, followed by meticulous removal of fibrous adhesions. The tendon was then stretched to achieve full extension. Hemostasis was secured, and the wound was sutured. The patient was advised on postoperative rehabilitation and follow-up.

3. Operative Note: Intraoperative findings revealed other contracture of the tendon. The patient was placed under regional anesthesia, and a transverse incision was made over the affected tendon. Dissection was carried out to expose the contracted tendon and surrounding structures. Tenolysis was performed to release adhesions, and the tendon was freed from its constraints. The surgical site was irrigated and closed meticulously. Postoperative instructions were provided, emphasizing the importance of early mobilization.

4. Operative Note: Patient presented with other contracture of the tendon requiring surgical correction. The affected limb was prepared and draped in a sterile manner. A curved incision was made over the contracted tendon, allowing access to the underlying structures. Tenotomy was performed, followed by meticulous exploration of the adhesions. The contracted tendon was gradually released, ensuring preservation of surrounding neurovascular structures. Hemostasis was achieved, and the wound was closed using appropriate sutures.

5. Operative Note: Surgical intervention was indicated for other contracture of the tendon. The patient was placed under general anesthesia, and a longitudinal incision was made over the affected tendon. The tendon sheath was carefully opened, allowing visualization of the contracted tendon. Adhesions were meticulously dissected and removed. Passive range of motion was tested to ensure adequate release. The surgical site was thoroughly irrigated and closed in layers. Postoperative care instructions were given.

6. Operative Note: Other contracture of the tendon necessitated surgical management. The patient was positioned appropriately, and a longitudinal incision was made to expose the contracted tendon. Careful dissection was performed, releasing the tendon from surrounding adhesions. Full extension was achieved through sequential stretching and manipulation. Hemostasis was secured, and the wound was closed meticulously. The patient was educated about postoperative care and instructed to initiate early rehabilitation.

7. Operative Note: The patient underwent surgical correction for other contracture of the tendon. The affected limb was prepared and draped. An oblique incision was made over the contracted tendon. Tendon sheath was opened, revealing tight adhesions. Adhesiolysis was carried out, and the contracted tendon was released gradually. Adequate tendon excursion was confirmed. Hemostasis was achieved, and the wound was closed meticulously. Postoperative instructions were provided for wound care and rehabilitation.

8. Operative Note: Other contracture of the tendon necessitated surgical intervention. The patient was placed under regional anesthesia, and a transverse incision was made over the affected tendon. Careful dissection allowed identification of the contracted tendon. Adhesions were meticulously dissected and excised, ensuring preservation of surrounding structures. The tendon was then mobilized and assessed for satisfactory range of motion. Hemostasis was achieved, and the wound was closed

in layers. Postoperative rehabilitation plan was discussed.

9. Operative Note: Surgical correction was performed for other contracture of the tendon. The patient was positioned appropriately, and a longitudinal incision was made over the contracted tendon. Tendon sheath was opened, revealing tight fibrous adhesions. Adhesiolysis was meticulously carried out, allowing for gradual release of the tendon. Extensive stretching was performed to ensure full extension. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative care instructions were given.

10. Operative Note: The patient underwent surgical management for other contracture of the tendon. Under regional anesthesia, a curved incision was made over the affected tendon. Careful dissection revealed the contracted tendon and surrounding adhesions. Adhesiolysis was performed to release the tendon, followed by thorough stretching to regain full range of motion. Hemostasis was secured, and the wound was meticulously closed. Postoperative rehabilitation protocol was discussed with the patient.

1. Operative Note: The patient presented with other contracture of the tendon requiring surgical intervention. A transverse incision was made over the affected tendon, exposing the contracted fibers. Precise dissection was performed to release the tendon from surrounding adhesions. Controlled stretching maneuvers were applied to restore optimal tendon length. Hemostasis was achieved, and the wound was closed meticulously. The patient was instructed on postoperative care and the importance of early rehabilitation.

2. Operative Note: Surgical correction was performed for other contracture of the tendon. Under general anesthesia, a longitudinal incision was made over the contracted tendon. The tendon sheath was meticulously opened, revealing tight adhesions. Adhesiolysis was carried out, freeing the tendon from its constraints. Full range of motion was achieved through careful manipulation and stretching. Hemostasis was ensured, and the wound was closed in layers. Postoperative instructions were provided to the patient.

3. Operative Note: The patient underwent surgical intervention for other contracture of the tendon. A dorsal approach was employed under regional anesthesia. An oblique incision was made, allowing access to the contracted tendon. Adhesions were dissected and meticulously released. Gradual mobilization of the tendon was performed to restore functional movement. The wound was irrigated, and closure was achieved with appropriate sutures. Postoperative rehabilitation plan was discussed with the patient.

4. Operative Note: Intraoperative assessment revealed other contracture of the tendon. The patient was placed under regional anesthesia, and a transverse incision was made over the affected tendon. The tendon sheath was opened, exposing the contracted fibers. Adhesions were meticulously dissected and removed to facilitate optimal tendon excursion. The tendon was carefully stretched and tested for adequate range of motion. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were given.

5. Operative Note: Other contracture of the tendon necessitated surgical correction. The patient was positioned appropriately, and a longitudinal incision was made to expose the contracted tendon. Precise dissection was performed to release the tendon from surrounding adhesions. Sequential stretching and manipulation were carried out to restore full function. Hemostasis was secured, and the wound was meticulously closed. The patient was educated about postoperative care and scheduled for follow-up.

6. Operative Note: Surgical intervention was performed for other contracture of the tendon. Under general anesthesia, a curved incision was made over the affected tendon. The tendon sheath was meticulously opened, revealing tight fibrous adhesions. Adhesiolysis was performed to release the contracted tendon, followed by controlled stretching maneuvers to restore proper length and function. Hemostasis was ensured, and the wound was closed in layers. Postoperative rehabilitation plan was discussed with the patient.

7. Operative Note: The patient underwent surgical correction for other contracture of the tendon. A standard approach was employed under regional anesthesia. An oblique incision was made, providing access to the contracted tendon. Adhesions were meticulously dissected and released, allowing for gradual restoration of tendon mobility. Hemostasis was achieved, and the wound was closed meticulously. The patient received instructions regarding postoperative care and the importance of rehabilitation for optimal recovery.

8. Operative Note: Other contracture of the tendon necessitated surgical management. The patient was placed under general anesthesia, and a longitudinal incision was made over the affected tendon. Careful dissection was performed, releasing the tendon from surrounding adhesions. Controlled stretching techniques were applied to achieve full extension and restore functional movement. Hemostasis was secured, and the wound was closed using appropriate sutures. The patient was counseled

on postoperative care and rehabilitation protocols.

9. Operative Note: Surgical intervention was performed to address other contracture of the tendon. The patient was positioned appropriately, and a transverse incision was made over the contracted tendon. The tendon sheath was meticulously opened, exposing tight adhesions. Adhesiolysis was performed to release the tendon, followed by gradual stretching to restore its normal range of motion. Hemostasis was achieved, and the wound was closed meticulously. The patient was provided with postoperative instructions and scheduled for follow-up.

10. Operative Note: The patient presented with other contracture of the tendon requiring surgical correction. Under regional anesthesia, a curved incision was made over the contracted tendon. Dissection was performed meticulously, releasing the tendon from surrounding adhesions. Controlled stretching and manipulation were applied to regain full extension and functional mobility. Hemostasis was ensured, and the wound was closed using appropriate sutures. Postoperative care and rehabilitation guidelines were discussed with the patient.

1. Operative Note: The patient presented with other contracture of the tendon and was placed under general anesthesia. A longitudinal incision was made over the contracted tendon. Careful dissection was performed to release the tendon from surrounding adhesions. Controlled stretching maneuvers were applied to restore optimal tendon length. Hemostasis was achieved, and the wound was closed meticulously. The patient's anesthesia dosage was tailored based on their specific needs and medical history, ensuring safe and effective pain management throughout the procedure.

2. Operative Note: Surgical correction was performed for other contracture of the tendon. Under regional anesthesia with adjusted dosage, a longitudinal incision was made over the contracted tendon. The tendon sheath was meticulously opened, revealing tight adhesions. Adhesiolysis was carried out, freeing the tendon from its constraints. Full range of motion was achieved through careful manipulation and stretching. Hemostasis was ensured, and the wound was closed in layers. The patient's anesthesia dosage was monitored and adjusted as needed to maintain optimal pain control.

3. Operative Note: The patient underwent surgical intervention for other contracture of the tendon. A dorsal approach was employed, and anesthesia dosage was adjusted accordingly. An oblique incision was made, allowing access to the contracted tendon. Adhesions were dissected and meticulously released. Gradual mobilization of the tendon was performed to restore functional movement. The wound was irrigated, and closure was achieved with appropriate sutures. Throughout the procedure, the patient's anesthesia dosage was carefully managed to ensure their comfort and safety.

4. Operative Note: Intraoperative assessment revealed other contracture of the tendon, and the patient was placed under general anesthesia with modified dosage. A transverse incision was made over the affected tendon. The tendon sheath was opened, exposing the contracted fibers. Adhesions were meticulously dissected and removed to facilitate optimal tendon excursion. The tendon was carefully stretched and tested for adequate range of motion. Hemostasis was achieved, and the wound was closed meticulously. The patient's anesthesia dosage was closely monitored and adjusted throughout the procedure to maintain their stability and pain management.

5. Operative Note: Other contracture of the tendon necessitated surgical correction. The patient was positioned appropriately, and anesthesia dosage was tailored to their specific requirements. A longitudinal incision was made to expose the contracted tendon. Precise dissection was performed to release the tendon from surrounding adhesions. Sequential stretching and manipulation were carried out to restore full function. Hemostasis was secured, and the wound was meticulously closed. Throughout the procedure, the patient's anesthesia dosage was carefully adjusted to ensure their comfort and safety.

6. Operative Note: Surgical intervention was performed for other contracture of the tendon, and the patient received regional anesthesia with adjusted dosage. Under general monitoring, a curved incision was made over the affected tendon. The tendon sheath was meticulously opened, revealing tight fibrous adhesions. Adhesiolysis was performed to release the contracted tendon, followed by controlled stretching maneuvers to restore proper length and function. Hemostasis was ensured, and the wound was closed using appropriate sutures. The patient's anesthesia dosage was closely managed to maintain their stability and pain control.

7. Operative Note: The patient underwent surgical correction for other contracture of the tendon. Under regional anesthesia with modified dosage, a standard approach was employed. An oblique incision was made, providing access to the contracted tendon. Adhesions were meticulously dissected and released, allowing for gradual restoration of tendon mobility. Hemostasis was achieved, and the wound was closed meticulously. Throughout the procedure, the patient's anesthesia dosage was carefully adjusted to ensure their comfort

and safety.

8. Operative Note: Other contracture of the tendon necessitated surgical management. The patient was placed under general anesthesia with adjusted dosage, and a longitudinal incision was made over the affected tendon. Careful dissection was performed, releasing the tendon from surrounding adhesions. Controlled stretching techniques were applied to achieve full extension and restore functional movement. Hemostasis was secured, and the wound was closed using appropriate sutures. The patient's anesthesia dosage was monitored and tailored to their needs throughout the procedure.

9. Operative Note: Surgical intervention was performed to address other contracture of the tendon. The patient received regional anesthesia with modified dosage, and a transverse incision was made over the contracted tendon. The tendon sheath was meticulously opened, exposing tight adhesions. Adhesiolysis was meticulously performed to release the tendon, followed by gradual stretching to restore its normal range of motion. Hemostasis was achieved, and the wound was closed meticulously. The patient's anesthesia dosage was closely monitored and adjusted throughout the procedure to maintain their stability and pain management.

10. Operative Note: The patient presented with other contracture of the tendon requiring surgical correction. Under general anesthesia with tailored dosage, a curved incision was made over the contracted tendon. Dissection was performed meticulously, releasing the tendon from surrounding adhesions. Controlled stretching and manipulation were applied to regain full extension and functional mobility. Hemostasis was ensured, and the wound was closed using appropriate suture techniques. The patient's anesthesia dosage was closely monitored and adjusted as necessary to provide optimal pain control and maintain their stability throughout the procedure.

1. Operative Note: The patient presented with other contracture of the tendon accompanied by bone erosion. Under general anesthesia, a longitudinal incision was made over the contracted tendon. Extensive dissection was performed, revealing both the contracted tendon and the eroded bone. Adhesiolysis was meticulously carried out, freeing the tendon from adhesions, while bone debridement and grafting were performed to address the erosion. Tendon length was restored through careful stretching and mobilization. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care and rehabilitation were discussed with the patient.

2. Operative Note: Surgical correction was performed for other contracture of the tendon with associated bone erosion. The patient was placed under regional anesthesia, and an oblique incision was made over the contracted tendon. Intraoperative findings revealed erosion of the adjacent bone. Adhesiolysis was performed, freeing the tendon from adhesions, while bone debridement and grafting were carried out to address the erosion. Tendon mobilization was achieved through controlled stretching maneuvers. Hemostasis was ensured, and the wound was closed in layers. Postoperative instructions were provided to the patient.

3. Operative Note: The patient underwent surgical intervention for other contracture of the tendon complicated by bone erosion. A dorsal approach was employed under general anesthesia, and a transverse incision was made to access the affected area. Intraoperative examination revealed erosion of the underlying bone. Adhesiolysis was meticulously performed, releasing the contracted tendon, while bone debridement and reconstruction were carried out to address the erosion. Tendon mobilization was achieved through controlled stretching. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were provided to the patient, emphasizing the importance of bone healing and rehabilitation.

4. Operative Note: Intraoperative findings confirmed other contracture of the tendon with concurrent bone erosion. The patient was placed under regional anesthesia, and a longitudinal incision was made over the affected tendon. Extensive dissection exposed both the contracted tendon and the eroded bone. Adhesiolysis was performed, freeing the tendon from adhesions, while bone debridement and augmentation were conducted to address the erosion. Tendon mobilization and stretching were carefully executed. Hemostasis was secured, and the wound was closed in layers. The patient received postoperative instructions for bone healing and rehabilitation.

5. Operative Note: Other contracture of the tendon with bone erosion necessitated surgical correction. Under general anesthesia, a curved incision was made over the affected tendon. Intraoperative assessment revealed erosion of the adjacent bone. Adhesiolysis was meticulously performed, releasing the contracted tendon, while bone debridement and reconstruction were undertaken to address the erosion. Controlled stretching and mobilization of the tendon were executed. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative care instructions were provided, focusing on bone healing and rehabilitation.

6. Operative Note: Surgical intervention was performed for other contracture of the tendon with associated bone erosion. The patient was placed under regional anesthesia, and a transverse incision was made over the contracted tendon. Intraoperative examination revealed erosion of the underlying bone. Adhesiolysis was meticulously performed, releasing the contracted tendon, while bone debridement and grafting were carried out to address the erosion. Controlled stretching and mobilization of the tendon were achieved. Hemostasis was ensured, and the wound was closed meticulously. The patient received postoperative instructions emphasizing bone healing and rehabilitation.

7. Operative Note: The patient presented with other contracture of the tendon accompanied by bone erosion. Under general

anesthesia, a longitudinal incision was made over the contracted tendon. Intraoperative evaluation confirmed erosion of the adjacent bone. Adhesiolysis was meticulously performed, freeing the contracted tendon, while bone debridement and reconstruction were conducted to address the erosion. Controlled stretching and mobilization of the tendon were performed. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were provided, emphasizing the importance of bone healing and rehabilitation.

8. Operative Note: Other contracture of the tendon with bone erosion necessitated surgical management. The patient was placed under regional anesthesia, and an oblique incision was made over the affected tendon. Intraoperative findings revealed erosion of the underlying bone. Adhesiolysis was meticulously performed, releasing the contracted tendon, while bone debridement and grafting were carried out to address the erosion. Controlled stretching and mobilization of the tendon were achieved. Hemostasis was secured, and the wound was closed using appropriate sutures. The patient received postoperative instructions emphasizing bone healing and rehabilitation.

9. Operative Note: The patient underwent surgical correction for other contracture of the tendon complicated by bone erosion. Under general anesthesia, a dorsal approach was employed, and a transverse incision was made to access the affected area. Intraoperative evaluation confirmed erosion of the adjacent bone. Adhesiolysis was meticulously performed, freeing the contracted tendon, while bone debridement and reconstruction were conducted to address the erosion. Controlled stretching and mobilization of the tendon were executed. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were provided, focusing on bone healing and rehabilitation.

10. Operative Note: Intraoperative findings confirmed other contracture of the tendon with concurrent bone erosion. The patient was placed under regional anesthesia, and a longitudinal incision was made over the affected tendon. Extensive dissection exposed both the contracted tendon and the eroded bone. Adhesiolysis was performed, freeing the tendon from adhesions, while bone debridement and augmentation were conducted to address the erosion. Tendon mobilization and stretching were carefully executed. Hemostasis was secured, and the wound was closed in layers. The patient received postoperative instructions for bone healing and rehabilitation.

1. Operative Note: The patient presented with other contracture of the tendon accompanied by severe bone pain. Under general anesthesia, a longitudinal incision was made over the contracted tendon. Extensive dissection was performed to release the contracted tendon, while attention was given to address the underlying bone pathology causing the severe pain. Adhesiolysis and bone debridement were meticulously carried out to alleviate the pain. Controlled stretching maneuvers were applied to restore optimal tendon length. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management strategies were discussed with the patient.

2. Operative Note: Surgical correction was performed for other contracture of the tendon with associated severe bone pain. The patient was placed under regional anesthesia, and an oblique incision was made over the contracted tendon. Intraoperative findings revealed significant bone pathology contributing to the severe pain. Adhesiolysis and bone debridement were meticulously performed, addressing the source of pain. Tendon mobilization and controlled stretching techniques were employed to restore full function. Hemostasis was ensured, and the wound was closed in layers. Postoperative pain control measures were discussed with the patient.

3. Operative Note: The patient underwent surgical intervention for other contracture of the tendon complicated by severe bone pain. A dorsal approach was employed under general anesthesia, and a transverse incision was made to access the affected area. Intraoperative examination confirmed the presence of significant bone pathology contributing to the severe pain. Adhesiolysis, bone debridement, and reconstruction were performed meticulously to alleviate the pain and restore normal bone function. Tendon mobilization was achieved through controlled stretching. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management strategies were discussed with the patient.

4. Operative Note: Intraoperative findings confirmed other contracture of the tendon with concurrent severe bone pain. The patient was placed under regional anesthesia, and a longitudinal incision was made over the affected tendon. Extensive dissection exposed both the contracted tendon and the underlying bone pathology causing severe pain. Adhesiolysis, bone debridement, and reconstruction were meticulously performed to address the source of pain. Controlled stretching and mobilization of the tendon were executed. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative pain management plans were discussed with the patient.

5. Operative Note: Other contracture of the tendon with severe bone pain necessitated surgical correction. Under general anesthesia, a curved incision was made over the affected tendon. Intraoperative evaluation revealed significant bone pathology contributing to the severe pain. Adhesiolysis, bone debridement, and reconstruction were undertaken meticulously to alleviate the pain and restore normal bone function. Controlled stretching and mobilization of the tendon were performed. Hemostasis was ensured, and the wound was closed meticulously. Postoperative pain control measures were discussed with the patient.

6. Operative Note: Surgical intervention was performed for other contracture of the tendon with associated severe bone pain. The patient received regional anesthesia with adjusted dosage, and a transverse incision was made over the contracted tendon. The tendon sheath was meticulously opened, exposing tight adhesions. Adhesiolysis was meticulously performed to release the tendon, while bone debridement and reconstruction were carried out to alleviate the severe bone pain. Controlled stretching and mobilization of the tendon were achieved. Hemostasis was ensured, and the wound was closed using appropriate sutures. Postoperative pain management strategies were discussed with the patient.

7. Operative Note: The patient presented with other contracture of the tendon accompanied by severe bone pain. Under general anesthesia, a longitudinal incision was

made over the contracted tendon. Intraoperative examination revealed significant bone pathology contributing to the severe pain. Adhesiolysis, bone debridement, and reconstruction were meticulously performed to address the source of pain. Controlled stretching and mobilization of the tendon were executed. Hemostasis was achieved, and the wound was closed in layers. Postoperative pain control measures were discussed with the patient.

8. Operative Note: Other contracture of the tendon with severe bone pain necessitated surgical management. The patient was placed under regional anesthesia, and an oblique incision was made over the affected tendon. Intraoperative findings revealed significant bone pathology causing severe pain. Adhesiolysis, bone debridement, and reconstruction were meticulously performed to alleviate the pain and restore normal bone function. Controlled stretching and mobilization of the tendon were achieved. Hemostasis was secured, and the wound was closed using appropriate sutures. Postoperative pain management strategies were discussed with the patient.

9. Operative Note: The patient underwent surgical correction for other contracture of the tendon complicated by severe bone pain. A dorsal approach was employed under general anesthesia, and a transverse incision was made to access the affected area. Intraoperative evaluation confirmed significant bone pathology contributing to the severe pain. Adhesiolysis, bone debridement, and reconstruction were performed meticulously to alleviate the pain and restore normal bone function. Controlled stretching and mobilization of the tendon were executed. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management strategies were discussed with the patient.

10. Operative Note: Intraoperative findings confirmed other contracture of the tendon with concurrent severe bone pain. The patient was placed under regional anesthesia, and a longitudinal incision was made over the affected tendon. Extensive dissection exposed both the contracted tendon and the underlying bone pathology causing severe pain. Adhesiolysis, bone debridement, and reconstruction were meticulously performed to alleviate the pain and restore normal bone function. Controlled stretching and mobilization of the tendon were executed. Hemostasis was secured, and the wound was closed in layers. The patient received detailed postoperative instructions for pain management and rehabilitation.

1. Operative Note: A surgical intervention was performed to address other contracture of the tendon. The patient was placed under general anesthesia, and a longitudinal incision was made over the contracted tendon. Careful dissection was carried out, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were applied to restore full extension. Hemostasis was achieved, and the wound was closed meticulously using appropriate sutures. Postoperative instructions regarding wound care and rehabilitation were provided to the patient.

2. Operative Note: The patient underwent a surgical intervention for other contracture of the tendon. Under general anesthesia, an oblique incision was made over the contracted tendon. Adhesiolysis was performed meticulously, releasing the tendon from adhesions. Controlled stretching maneuvers were applied to restore optimal tendon length. Hemostasis was achieved, and the wound was closed in layers using appropriate sutures. The patient was provided with postoperative instructions, emphasizing the importance of rehabilitation for optimal recovery.

3. Operative Note: Surgical intervention was performed to address other contracture of the tendon. The patient received regional anesthesia, and a transverse incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were employed to restore normal range of motion. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed with the patient, including the importance of physical therapy for successful rehabilitation.

4. Operative Note: A surgical intervention was undertaken to correct other contracture of the tendon. The patient was placed under general anesthesia, and a curved incision was made over the affected tendon. Extensive dissection was performed, releasing the tendon from adhesions. Controlled stretching and mobilization maneuvers were applied to restore full extension and functional movement. Hemostasis was ensured, and the wound was closed using appropriate sutures. Postoperative instructions were provided to the patient, emphasizing the need for rehabilitation to optimize recovery.

5. Operative Note: Surgical intervention was performed for other contracture of the tendon. Under general anesthesia, a longitudinal incision was made over the contracted tendon. Adhesiolysis was meticulously performed, freeing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were employed to restore full range of motion. Hemostasis was achieved, and the wound was closed meticulously. The patient was instructed on postoperative care, including the importance of rehabilitation exercises for a successful recovery.

6. Operative Note: The patient underwent a surgical intervention to address other contracture of the tendon. Under regional anesthesia, an oblique incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from adhesions. Controlled stretching and mobilization maneuvers were applied to restore normal tendon function. Hemostasis was achieved, and the wound was closed using appropriate sutures. The patient received postoperative instructions, highlighting the significance of rehabilitation for optimal outcomes.

7. Operative Note: A surgical intervention was performed to correct other contracture of the tendon. The patient received regional anesthesia, and a transverse incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were employed to restore full range of motion. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed with the patient, emphasizing the importance of rehabilitation exercises for successful recovery.

8. Operative Note: Surgical intervention was performed to address other contracture of the tendon. The patient was placed under general anesthesia, and a curved incision was made over the

affected tendon. Extensive dissection was performed, releasing the tendon from adhesions. Controlled stretching and mobilization maneuvers were applied to restore normal function. Hemostasis was ensured, and the wound was closed using appropriate sutures. Postoperative instructions were provided to the patient, stressing the need for rehabilitation for optimal outcomes.

9. Operative Note: A surgical intervention was undertaken to correct other contracture of the tendon. Under regional anesthesia, a longitudinal incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were applied to restore normal tendon function. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing the importance of rehabilitation exercises for successful recovery.

10. Operative Note: Surgical intervention was performed for other contracture of the tendon. Under general anesthesia, an oblique incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from adhesions. Controlled stretching and mobilization maneuvers were applied to restore full range of motion. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative care instructions were discussed with the patient, emphasizing the importance of rehabilitation for successful recovery.

Certainly! Here are 10 more synthetic operative notes pertaining to other contracture of the tendon with a surgical intervention:

1. Operative Note: The patient underwent a surgical intervention to address other contracture of the tendon. Under general anesthesia, a longitudinal incision was made over the contracted tendon. Adhesiolysis was meticulously performed, freeing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were applied to restore optimal tendon function. Hemostasis was achieved, and the wound was closed meticulously. The patient was instructed on postoperative care, including the importance of physical therapy for successful rehabilitation.

2. Operative Note: A surgical intervention was performed to correct other contracture of the tendon. The patient received regional anesthesia, and a transverse incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization maneuvers were employed to restore full range of motion. Hemostasis was ensured, and the wound was closed using appropriate sutures. Postoperative care instructions were discussed with the patient, emphasizing the need for rehabilitation to optimize recovery.

3. Operative Note: Surgical intervention was performed for other contracture of the tendon. Under general anesthesia, a curved incision was made over the affected tendon. Extensive dissection was performed, releasing the tendon from adhesions. Controlled stretching and mobilization techniques were applied to restore full extension and functional movement. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative instructions were provided to the patient, emphasizing the importance of rehabilitation to optimize recovery.

4. Operative Note: The patient underwent a surgical intervention to address other contracture of the tendon. Under regional anesthesia, an oblique incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from adhesions. Controlled stretching and mobilization maneuvers were applied to restore normal tendon function. Hemostasis was achieved, and the wound was closed using appropriate sutures. The patient received postoperative instructions, highlighting the significance of rehabilitation for optimal outcomes.

5. Operative Note: A surgical intervention was performed to correct other contracture of the tendon. The patient received general anesthesia, and a transverse incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from adhesions. Controlled stretching and mobilization techniques were employed to restore normal function. Hemostasis was ensured, and the wound was closed using appropriate sutures. Postoperative care instructions were discussed with the patient, emphasizing the importance of rehabilitation exercises for successful recovery.

6. Operative Note: Surgical intervention was performed to address other contracture of the tendon. The patient underwent regional anesthesia, and a longitudinal incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were employed to restore full range of motion. Hemostasis was achieved, and the wound was closed meticulously. Postoperative instructions were provided to the patient, stressing the need for rehabilitation for optimal outcomes.

7. Operative Note: The patient underwent a surgical intervention to correct other contracture of the tendon. Under general anesthesia, an oblique incision was made over the affected tendon. Adhesiolysis was meticulously performed, releasing the tendon from adhesions. Controlled stretching and mobilization maneuvers were applied to restore normal function. Hemostasis was achieved, and the wound was closed using appropriate sutures. The patient received postoperative instructions, emphasizing the importance of rehabilitation exercises for successful recovery.

8. Operative Note: A surgical intervention was undertaken to address other contracture of the tendon. The patient received regional anesthesia, and a transverse incision was made over the contracted tendon.

Adhesiolysis was meticulously performed, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were applied to restore normal tendon function. Hemostasis was ensured, and the wound was closed meticulously. Postoperative care instructions were discussed with the patient, emphasizing the importance of rehabilitation exercises for successful recovery.

9. Operative Note: Surgical intervention was performed for other contracture of the tendon. Under general anesthesia, a curved incision was made over the contracted tendon. Extensive dissection was performed, releasing the tendon from adhesions. Controlled stretching and mobilization maneuvers were applied to restore full range of motion. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative instructions were provided to the patient, stressing the need for rehabilitation for optimal outcomes.

10. Operative Note: The patient underwent a surgical intervention to address other contracture of the tendon. Under regional anesthesia, a longitudinal incision was made over the contracted tendon. Adhesiolysis was meticulously performed, releasing the tendon from surrounding adhesions. Controlled stretching and mobilization techniques were employed to restore normal tendon function. Hemostasis was achieved, and the wound was closed meticulously. The patient received postoperative instructions, emphasizing the importance of rehabilitation exercises for successful recovery.

1. Operative Note: A surgical intervention was performed to address other contracture of the tendon complicated by a severe infection on the extreme moving joint. The patient was placed under general anesthesia, and an incision was made over the affected tendon. Intraoperative evaluation confirmed the presence of a severe infection. Debridement of the infected tissue and meticulous cleansing of the joint were carried out. Adhesiolysis and tendon reconstruction were performed to restore normal function. The wound was closed using appropriate sutures. Postoperative antibiotic therapy and close monitoring of the infection were discussed with the patient.

2. Operative Note: The patient underwent a surgical intervention for other contracture of the tendon with a severe infection on the extreme moving joint. Under general anesthesia, an incision was made over the contracted tendon. Intraoperative findings revealed extensive infection on the joint. Debridement, thorough irrigation, and removal of infected tissue were performed meticulously. Adhesiolysis and tendon release were executed to restore optimal joint mobility. The wound was closed meticulously. Postoperative management included antibiotic therapy and close monitoring of the infection.

3. Operative Note: Surgical intervention was performed to address other contracture of the tendon complicated by a severe infection on the extreme moving joint. The patient received general anesthesia, and an incision was made over the contracted tendon. Intraoperative examination confirmed the presence of a severe joint infection. Extensive debridement and meticulous irrigation of the joint were performed. Adhesiolysis and tendon release were carried out to restore normal joint function. The wound was closed using appropriate sutures. Postoperatively, the patient was prescribed antibiotics and closely monitored for infection control.

4. Operative Note: A surgical intervention was undertaken to correct other contracture of the tendon complicated by a severe infection on the extreme moving joint. The patient was placed under general anesthesia, and an incision was made over the affected tendon. Intraoperative evaluation revealed the presence of a severe joint infection. Debridement, thorough irrigation, and excision of infected tissue were meticulously performed. Adhesiolysis and tendon reconstruction were carried out to restore normal joint function. The wound was closed meticulously. Postoperative antibiotic therapy and infection monitoring were discussed with the patient.

5. Operative Note: Surgical intervention was performed for other contracture of the tendon with a severe infection on the extreme moving joint. Under general anesthesia, an incision was made over the contracted tendon. Intraoperative findings confirmed the presence of a severe joint infection. Debridement, meticulous irrigation, and removal of infected tissue were carried out. Adhesiolysis and tendon reconstruction were performed to restore optimal joint mobility. The wound was closed using appropriate sutures. Postoperative management included antibiotic therapy and rigorous infection control measures.

6. Operative Note: The patient underwent a surgical intervention to address other contracture of the tendon complicated by a severe infection on the extreme moving joint. Under general anesthesia, an incision was made over the contracted tendon. Intraoperative examination revealed the presence of a severe joint infection. Extensive debridement and meticulous irrigation of the joint were performed. Adhesiolysis and tendon release were executed to restore normal joint function. The wound was closed meticulously. The patient was prescribed postoperative antibiotics and closely monitored for infection control.

7. Operative Note: A surgical intervention was performed to correct other contracture of the tendon with a severe infection on the extreme moving joint. The patient received general anesthesia, and an incision was made over the affected tendon. Intraoperative evaluation confirmed the presence of a severe joint infection. Debridement, thorough irrigation, and excision of infected tissue were meticulously performed. Adhes

iolysis and tendon reconstruction were carried out to restore normal joint function. The wound was closed using appropriate sutures. Postoperative antibiotic therapy and infection monitoring were discussed with the patient.

8. Operative Note: Surgical intervention was undertaken to address other contracture of the tendon complicated by a severe infection on the extreme moving joint. The patient was placed under general anesthesia, and an incision was made over the contracted tendon. Intraoperative findings revealed the presence of a severe joint infection. Extensive debridement, thorough irrigation, and removal of infected tissue were meticulously performed. Adhesiolysis and tendon reconstruction were carried out to restore optimal joint mobility. The wound was closed meticulously. Postoperative antibiotic therapy and infection control measures were discussed with the patient.

9. Operative Note: A surgical intervention was performed for other contracture of the tendon with a severe infection on the extreme moving joint. Under general anesthesia, an incision was made over the contracted tendon. Intraoperative examination confirmed the presence of a severe joint infection. Debridement, meticulous irrigation, and removal of infected tissue were carried out. Adhesiolysis and tendon reconstruction were performed to restore normal joint function. The wound was closed using appropriate sutures. The patient was prescribed postoperative antibiotics and closely monitored for infection control.

10. Operative Note: Surgical intervention was performed to address other contracture of the tendon complicated by a severe infection on the extreme moving joint. The patient received general anesthesia, and an incision was made over the affected tendon. Intraoperative evaluation revealed the presence of a severe joint infection. Debridement, thorough irrigation, and excision of infected tissue were meticulously performed. Adhesiolysis and tendon release were executed to restore normal joint function. The wound was closed meticulously. Postoperative antibiotic therapy and infection monitoring were discussed with the patient.

1. Operative Note: A surgical intervention was performed to address other contracture of the tendon with severe inflammation. The patient received general anesthesia, and an incision was made over the contracted tendon. Intraoperative assessment revealed significant inflammation in the surrounding tissues. Careful dissection and adhesiolysis were performed to release the tendon and alleviate inflammation. Controlled stretching and mobilization maneuvers were applied to restore normal tendon function. Hemostasis was achieved, and the wound was closed meticulously. Postoperative anti-inflammatory measures were discussed with the patient.

2. Operative Note: Surgical intervention was undertaken to correct other contracture of the tendon complicated by moderate inflammation. Under regional anesthesia, an incision was made over the affected tendon. Intraoperative examination confirmed the presence of inflammation in the surrounding tissues. Adhesiolysis and meticulous dissection were performed to release the tendon and reduce inflammation. Controlled stretching and mobilization techniques were employed to restore full range of motion. Hemostasis was ensured, and the wound was closed using appropriate sutures. Postoperative anti-inflammatory medications were prescribed.

3. Operative Note: The patient underwent a surgical intervention for other contracture of the tendon with mild inflammation. Under general anesthesia, an incision was made over the contracted tendon. Intraoperative evaluation revealed mild inflammation in the surrounding tissues. Adhesiolysis and careful dissection were performed to release the tendon and address inflammation. Controlled stretching and mobilization maneuvers were applied to restore normal tendon function. Hemostasis was achieved, and the wound was closed meticulously. Postoperative measures to manage inflammation, such as cold compresses and anti-inflammatory medication, were discussed with the patient.

4. Operative Note: A surgical intervention was performed to address other contracture of the tendon accompanied by severe inflammation. The patient received regional anesthesia, and an incision was made over the contracted tendon. Intraoperative findings confirmed significant inflammation in the surrounding tissues. Meticulous adhesiolysis and dissection were carried out to release the tendon and reduce inflammation. Controlled stretching and mobilization techniques were employed to restore optimal tendon function. Hemostasis was ensured, and the wound was closed meticulously. Postoperative anti-inflammatory strategies were discussed with the patient.

5. Operative Note: Surgical intervention was performed for other contracture of the tendon complicated by moderate inflammation. Under general anesthesia, an incision was made over the affected tendon. Intraoperative examination revealed moderate inflammation in the surrounding tissues. Adhesiolysis and meticulous dissection were performed to release the tendon and address inflammation. Controlled stretching and mobilization maneuvers were executed to restore normal tendon function. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative management included anti-inflammatory measures and close monitoring of inflammation.

6. Operative Note: The patient underwent a surgical intervention to correct other contracture of the tendon with mild inflammation. Under regional anesthesia, an incision was made over the contracted tendon. Intraoperative evaluation confirmed the presence of mild inflammation in the surrounding tissues. Adhesiolysis and careful dissection were performed to release the tendon and alleviate inflammation. Controlled stretching and mobilization techniques were applied to restore full range of motion. Hemostasis was ensured, and the wound was closed meticulously. Postoperative measures to manage inflammation, including rest and anti-inflammatory medication, were discussed with the patient.

7. Operative Note: A surgical intervention was performed to address other contracture of the tendon with severe inflammation. The patient received general anesthesia, and an incision was made over the contracted tendon. Intraoperative findings revealed significant inflammation in the surrounding tissues. Meticulous adhesiolysis and dissection were carried out to release the tendon and reduce

inflammation. Controlled stretching and mobilization techniques were employed to restore optimal tendon function. Hemostasis was ensured, and the wound was closed meticulously. Postoperative anti-inflammatory strategies, including medication and physical therapy, were discussed with the patient.

8. Operative Note: Surgical intervention was performed for other contracture of the tendon complicated by moderate inflammation. Under regional anesthesia, an incision was made over the affected tendon. Intraoperative examination confirmed moderate inflammation in the surrounding tissues. Adhesiolysis and meticulous dissection were performed to release the tendon and address inflammation. Controlled stretching and mobilization maneuvers were executed to restore normal tendon function. Hemostasis was achieved, and the wound was closed using appropriate sutures. Postoperative management included anti-inflammatory measures, such as medication and rest.

9. Operative Note: The patient underwent a surgical intervention to correct other contracture of the tendon with mild inflammation. Under general anesthesia, an incision was made over the contracted tendon. Intraoperative evaluation revealed mild inflammation in the surrounding tissues. Adhesiolysis and careful dissection were performed to release the tendon and alleviate inflammation. Controlled stretching and mobilization techniques were applied to restore full range of motion. Hemostasis was ensured, and the wound was closed meticulously. Postoperative measures to manage inflammation, including the use of anti-inflammatory medication, were discussed with the patient.

10. Operative Note: A surgical intervention was performed to address other contracture of the tendon accompanied by severe inflammation. The patient received regional anesthesia, and an incision was made over the contracted tendon. Intraoperative findings confirmed significant inflammation in the surrounding tissues. Meticulous adhesiolysis and dissection were carried out to release the tendon and reduce inflammation. Controlled stretching and mobilization techniques were employed to restore optimal tendon function. Hemostasis was ensured, and the wound was closed meticulously. Postoperative anti-inflammatory measures, including medication and icing, were recommended to the patient.

1. Operative Note: A surgical intervention was performed for other contracture of the tendon. Under general anesthesia, an incision was made over the contracted tendon. Adhesiolysis and tendon release were meticulously performed. The severity of the contracture required close postoperative follow-up appointments at 2 weeks, 6 weeks, and 3 months to monitor the progress and adjust rehabilitation accordingly.

2. Operative Note: Surgical intervention was undertaken to address other contracture of the tendon. The patient received regional anesthesia, and an incision was made over the affected tendon. Adhesiolysis and controlled stretching techniques were employed. Due to the moderate severity of the contracture, postoperative follow-up visits were scheduled at 4 weeks, 8 weeks, and 6 months for assessment and guided rehabilitation.

3. Operative Note: The patient underwent a surgical intervention to correct other contracture of the tendon. Under general anesthesia, an incision was made over the contracted tendon. Adhesiolysis and meticulous mobilization were performed to alleviate the mild severity of the contracture. Postoperative follow-up appointments were scheduled at 6 weeks and 3 months to evaluate progress and provide necessary guidance for rehabilitation exercises.

4. Operative Note: A surgical intervention was performed to address other contracture of the tendon. The patient received regional anesthesia, and an incision was made over the contracted tendon. Adhesiolysis and controlled stretching techniques were applied to manage the moderate severity of the contracture. Follow-up visits were planned at 4 weeks and 3 months to monitor the patient's recovery and adjust rehabilitation accordingly.

5. Operative Note: Surgical intervention was performed for other contracture of the tendon. Under general anesthesia, an incision was made over the affected tendon. Adhesiolysis and careful mobilization techniques were utilized to address the mild severity of the contracture. Postoperative follow-up appointments were scheduled at 8 weeks and 6 months to assess the patient's progress and provide guidance for further rehabilitation.

6. Operative Note: The patient underwent a surgical intervention to correct other contracture of the tendon. Under regional anesthesia, an incision was made over the contracted tendon. Adhesiolysis and meticulous mobilization were performed to manage the moderate severity of the contracture. Follow-up visits were planned at 6 weeks, 3 months, and 1 year to evaluate the patient's recovery and provide appropriate guidance for rehabilitation.

7. Operative Note: A surgical intervention was performed to address other contracture of the tendon. The patient received general anesthesia, and an incision was made over the contracted tendon. Adhesiolysis and controlled stretching techniques were applied to manage the mild severity of the contracture. Follow-up appointments were scheduled at 4 weeks and 6 months to assess the patient's progress and provide guidance for further rehabilitation.

8. Operative Note: Surgical intervention was undertaken to correct other contracture of the tendon. Under regional anesthesia, an incision was made over the affected tendon. Adhesiolysis and careful mobilization techniques were utilized to manage the mild severity of the contracture. Postoperative follow-up visits were scheduled at 8 weeks and 1 year to evaluate the patient's progress and provide necessary guidance for rehabilitation exercises.

9. Operative Note: The patient underwent a surgical intervention to address other contracture of the tendon. Under general anesthesia, an incision was made over the contracted tendon. Adhesiolysis and meticulous mobilization were performed to manage the moderate severity of the contracture. Follow-up appointments were planned at 6 weeks, 3 months, and 6 months to evaluate the patient's recovery and provide appropriate guidance for rehabilitation.

10. Operative Note: A surgical intervention was performed to correct other contracture of the tendon. The patient received regional anesthesia, and an incision was made over the contracted tendon. Adhesiolysis and controlled stretching techniques were applied to manage the mild severity of the contracture. Follow-up visits were scheduled at 4 weeks, 8 weeks, and 6 months to assess the patient's progress and provide guidance for further rehabilitation.

## M67.2 Synovial hypertrophy, not elsewhere classified

1. Patient underwent arthroscopic examination revealing synovial hypertrophy in the right knee. Following meticulous debridement and synovectomy, the hypertrophic synovium was excised. Hemostasis achieved. Postoperative X-rays confirmed optimal joint alignment. Patient tolerated the procedure well without complications.

2. Operative findings included significant synovial hypertrophy in the left shoulder joint. An arthroscopic approach was employed for synovectomy and removal of hypertrophic tissue. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion. The patient experienced an uneventful recovery.

3. During open joint exploration, synovial hypertrophy was identified in the right hip. A synovectomy was performed, excising the hypertrophic tissue. Hemostasis was obtained, and the joint was stabilized. The patient's pain and discomfort improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Arthroscopic examination revealed extensive synovial hypertrophy in the right ankle joint. A synovectomy was carried out, removing the hypertrophic synovium. The procedure was uneventful, and the patient reported reduced pain and improved mobility during the postoperative period.

5. Intraoperative evaluation revealed synovial hypertrophy in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient's symptoms significantly improved after the procedure, and there were no postoperative complications.

6. Open exploration of the left wrist joint revealed synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion and decreased pain postoperatively, without any notable complications.

7. Arthroscopic examination demonstrated synovial hypertrophy in the right temporomandibular joint. A thorough synovectomy was performed, excising the hypertrophic synovium. Hemostasis was ensured, and the joint was stabilized. The patient experienced relief from jaw pain and improved mouth opening following the procedure, with no complications observed.

8. During arthroscopic examination of the left hip joint, synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced hip pain and improved function after the procedure, without any postoperative issues.

9. Open joint exploration revealed synovial hypertrophy in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient experienced decreased shoulder pain and improved range of motion postoperatively, with no complications encountered.

10. Arthroscopic examination demonstrated synovial hypertrophy in the left knee joint. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced knee pain and increased stability after the procedure, without any significant postoperative complications.

1. Intraoperative evaluation revealed synovial hypertrophy in the right wrist joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced improved grip strength and reduced wrist pain postoperatively, without any notable complications.

2. Open exploration of the left ankle joint revealed synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported decreased swelling and enhanced joint mobility after the procedure, with no postoperative issues.

3. Arthroscopic examination demonstrated synovial hypertrophy in the right temporomandibular joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced relief from jaw pain and improved chewing ability following the procedure, without any complications observed.

4. During open joint exploration, synovial hypertrophy was identified in the left hip. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient's hip pain significantly improved postoperatively, with progressive restoration of hip function. No complications were noted.

5. Operative findings included synovial hypertrophy in the right shoulder joint. An arthroscopic approach was employed for synovectomy and removal of hypertrophic tissue. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion and reduced shoulder pain. The patient had an uneventful recovery.

6. Intraoperative examination revealed synovial hypertrophy in the left knee joint. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced reduced knee pain and increased stability postoperatively, without any notable complications.

7. Arthroscopic examination demonstrated extensive synovial hypertrophy in the right elbow joint. A thorough synovectomy was performed, excising the hypertrophic synovium. Hemostasis was ensured, and the joint was stabilized. The patient reported relief from elbow pain and improved range of motion following the procedure, with no complications observed.

8. Open exploration of the left temporomandibular joint revealed synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced decreased jaw pain and improved mouth opening after the procedure, without any significant postoperative issues.

9. During arthroscopic examination of the right ankle joint, synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced ankle pain and enhanced mobility after the procedure, without any notable complications.

10. Operative findings included synovial hypertrophy in the left shoulder joint. An arthroscopic approach was employed for synovectomy and removal of hypertrophic tissue. Adequate hemostasis was achieved, and the joint was stabilized. Postoperatively, the patient experienced improved shoulder function and reduced pain, with an uneventful recovery.

1. Under general anesthesia, the patient underwent arthroscopic examination revealing synovial hypertrophy in the right knee. Following meticulous debridement and synovectomy, the hypertrophic synovium was excised. Hemostasis achieved. Postoperative X-rays confirmed optimal joint alignment. The patient tolerated the procedure well without complications.

2. Local anesthesia with sedation was administered as the patient underwent arthroscopic examination of the left shoulder joint. Synovial hypertrophy was identified, and a synovectomy was performed to excise the hypertrophic synovium. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion. The patient experienced an uneventful recovery.

3. Spinal anesthesia was administered for open joint exploration, revealing synovial hypertrophy in the right hip. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient's pain and discomfort improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Regional anesthesia with a peripheral nerve block was performed for arthroscopic examination of the right ankle joint. Synovial hypertrophy was identified, and a synovectomy was carried out to remove the hypertrophic tissue. The procedure was uneventful, and the patient reported reduced pain and improved mobility during the postoperative period.

5. General anesthesia was administered during intraoperative evaluation, revealing synovial hypertrophy in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient's symptoms significantly improved after the procedure, and there were no postoperative complications.

6. Local anesthesia with sedation was utilized for open exploration of the left wrist joint, where synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion and decreased pain postoperatively, without any notable complications.

7. Regional anesthesia with a nerve block was administered for arthroscopic examination of the right temporomandibular joint. Synovial hypertrophy was identified, and a thorough synovectomy was performed, excising the hypertrophic synovium. Hemostasis was ensured, and the joint was stabilized. The patient experienced relief from jaw pain and improved mouth opening following the procedure, with no complications observed.

8. Spinal anesthesia was administered for open joint exploration of the left hip, revealing synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced hip pain and improved function after the procedure, without any postoperative issues.

9. General anesthesia was administered during arthroscopic examination of the left knee joint, where synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced knee pain and increased stability after the procedure, without any significant postoperative complications.

10. Regional anesthesia with a peripheral nerve block was utilized for open joint exploration, revealing synovial hypertrophy in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient experienced decreased shoulder pain and improved range of motion postoperatively, with no complications encountered.

1. Under general anesthesia, arthroscopic examination revealed synovial hypertrophy and bone erosion in the right knee joint. Extensive synovectomy and debridement were performed, and the eroded bone surfaces were smoothed. Hemostasis achieved. Postoperative imaging showed improved joint alignment. The patient tolerated the procedure well without complications.

2. Local anesthesia with sedation was administered as the patient underwent arthroscopic examination of the left shoulder joint. Synovial hypertrophy and bone erosion were identified. A synovectomy was performed, and the eroded bone surfaces were debrided. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion. The patient experienced an uneventful recovery.

3. Spinal anesthesia was administered for open joint exploration, revealing synovial hypertrophy and significant bone erosion in the right hip. A synovectomy was performed, excising the hypertrophic synovium. Bone grafting was performed to restore the eroded areas. Hemostasis was obtained, and the joint was stabilized. The patient's pain and discomfort improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Regional anesthesia with a peripheral nerve block was performed for arthroscopic examination of the right ankle joint. Synovial hypertrophy and bone erosion were identified. A synovectomy was carried out, removing the hypertrophic tissue. The eroded bone surfaces were debrided and treated. The procedure was uneventful, and the patient reported reduced pain and improved mobility during the postoperative period.

5. General anesthesia was administered during intraoperative evaluation, revealing synovial hypertrophy and bone erosion in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and smoothed. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient's symptoms significantly improved after the procedure, and there were no postoperative complications.

6. Local anesthesia with sedation was utilized for open exploration of the left wrist joint, where synovial hypertrophy and bone erosion were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and repaired. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion and decreased pain postoperatively, without any notable complications.

7. Regional anesthesia with a nerve block was administered for arthroscopic examination of the right temporomandibular joint. Synovial hypertrophy and bone erosion were identified. A thorough synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and reconstructed. Hemostasis was ensured, and the joint was stabilized. The patient experienced relief from jaw pain and improved mouth opening following the procedure, with no complications observed.

8. Spinal anesthesia was administered for open joint exploration of the left hip, revealing synovial hypertrophy and significant bone erosion. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and reinforced with bone grafts. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced hip pain and improved function after the procedure, without any postoperative issues.

9. General anesthesia was administered during arthroscopic examination of the left knee joint, where synovial hypertrophy and bone erosion were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and reconstructed. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced knee pain and increased stability after the procedure

, without any significant postoperative complications.

10. Regional anesthesia with a peripheral nerve block was utilized for open joint exploration, revealing synovial hypertrophy and bone erosion in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. The eroded bone surfaces were debrided and treated. Hemostasis was obtained, and the joint was stabilized. The patient experienced decreased shoulder pain and improved range of motion postoperatively, with no complications encountered.

1. Under general anesthesia, arthroscopic examination revealed synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right knee joint. Extensive synovectomy, debridement, and bone grafting were performed to address the pathology. Hemostasis achieved. Postoperative imaging showed improved joint alignment and reduced bone pain. The patient tolerated the procedure well without complications.

2. Local anesthesia with sedation was administered as the patient underwent arthroscopic examination of the left shoulder joint. Synovial hypertrophy, severe bone erosion, and excruciating bone pain were identified. A synovectomy was performed, and the eroded bone surfaces were debrided. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion and significant relief from bone pain. The patient experienced an uneventful recovery.

3. Spinal anesthesia was administered for open joint exploration, revealing synovial hypertrophy, extensive bone erosion, and severe bone pain in the right hip. A synovectomy was performed, excising the hypertrophic synovium. Bone grafting and stabilization procedures were implemented to alleviate the bone pain. Hemostasis was obtained, and the joint was stabilized. The patient's bone pain and discomfort significantly improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Regional anesthesia with a peripheral nerve block was performed for arthroscopic examination of the right ankle joint. Synovial hypertrophy, severe bone erosion, and debilitating bone pain were identified. A synovectomy was carried out, removing the hypertrophic tissue. The eroded bone surfaces were debrided and treated to alleviate the bone pain. The procedure was uneventful, and the patient reported a remarkable reduction in bone pain and improved mobility during the postoperative period.

5. General anesthesia was administered during intraoperative evaluation, revealing synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and stabilized to alleviate the bone pain. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient experienced significant relief from bone pain, improved range of motion, and there were no postoperative complications.

6. Local anesthesia with sedation was utilized for open exploration of the left wrist joint, where synovial hypertrophy, severe bone erosion, and debilitating bone pain were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, stabilized, and treated to alleviate the bone pain. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion, a substantial reduction in bone pain, and decreased discomfort postoperatively, without any notable complications.

7. Regional anesthesia with a nerve block was administered for arthroscopic examination of the right temporomandibular joint. Synovial hypertrophy, severe bone erosion, and excruciating bone pain were identified. A thorough synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, reconstructed, and treated to alleviate the bone pain. Hemostasis was ensured, and the joint was stabilized. The patient experienced significant relief from jaw pain, improved mouth opening, and a remarkable reduction in bone pain following the procedure, with no complications observed.

8. Spinal anesthesia was administered for open joint exploration of the left hip, revealing synovial hypertrophy, severe bone erosion, and debilitating bone pain. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, reconstructed

, and treated to alleviate the bone pain. Hemostasis was achieved, and the joint was stabilized. The patient reported a substantial reduction in hip pain, improved function, and significant relief from bone pain after the procedure, without any postoperative issues.

9. General anesthesia was administered during arthroscopic examination of the left knee joint, where synovial hypertrophy, severe bone erosion, and excruciating bone pain were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, stabilized, and treated to alleviate the bone pain. Hemostasis was achieved, and the joint was stabilized. The patient reported a significant reduction in bone pain, increased stability, and improved mobility after the procedure, without any significant postoperative complications.

10. Regional anesthesia with a peripheral nerve block was utilized for open joint exploration, revealing synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. The eroded bone surfaces were debrided, reconstructed, and treated to alleviate the bone pain. Hemostasis was obtained, and the joint was stabilized. The patient experienced a remarkable reduction in shoulder pain, improved range of motion, and significant relief from bone pain postoperatively, with no complications encountered.

1. Surgical intervention was performed under general anesthesia for synovial hypertrophy with severe bone erosion and intractable bone pain in the right knee joint. A comprehensive synovectomy and debridement were carried out, followed by bone grafting and stabilization. The procedure successfully alleviated the bone pain and restored joint function. The patient had a smooth recovery without any postoperative complications.

2. The patient underwent surgical intervention with local anesthesia and sedation for synovial hypertrophy, extensive bone erosion, and excruciating bone pain in the left shoulder joint. A thorough synovectomy was performed, accompanied by meticulous debridement and repair of the eroded bone surfaces. The procedure significantly reduced the bone pain, resulting in improved shoulder mobility and function. The patient experienced an uneventful postoperative course.

3. Open joint surgery was performed under spinal anesthesia to address synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right hip joint. The surgical intervention involved a synovectomy, extensive debridement, and bone reconstruction. The procedure successfully relieved the bone pain and restored hip joint stability. The patient achieved a favorable postoperative recovery without any complications.

4. Arthroscopic surgical intervention was performed with regional anesthesia for synovial hypertrophy, significant bone erosion, and severe bone pain in the right ankle joint. The procedure included synovectomy, meticulous debridement, and bone smoothing. The surgical intervention effectively alleviated the bone pain, resulting in improved ankle joint function and reduced discomfort during the recovery period.

5. The patient underwent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left elbow joint. The procedure involved a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored elbow joint stability, and improved range of motion. The patient had a smooth postoperative course without complications.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left wrist joint. The surgical intervention included a synovectomy, meticulous debridement, and bone grafting. The procedure significantly reduced the bone pain and improved wrist joint mobility. The patient had a satisfactory recovery without any postoperative issues.

7. Surgical intervention was performed with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the right temporomandibular joint. The procedure included a thorough synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention effectively alleviated the bone pain, resulting in improved jaw function and reduced discomfort. The patient had an uneventful postoperative course.

8. A surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left hip joint. The procedure involved a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored hip joint stability, and improved the patient's mobility. The postoperative period was uneventful without any complications.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left knee joint. The procedure included a thorough synovectomy, meticulous bone debridement, and stabilization. The surgical intervention effectively reduced the bone pain, resulting in improved knee joint function and decreased discomfort during the recovery phase. The patient had a smooth postoperative course.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the right shoulder joint. The procedure involved a comprehensive synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored shoulder joint stability, and improved range of motion. The patient experienced an uneventful postoperative recovery without complications.

1. The patient underwent surgical intervention under general anesthesia to address severe synovial hypertrophy, extensive bone erosion, and debilitating bone pain in the right knee joint. A comprehensive synovectomy and bone reconstruction procedure were performed, leading to significant relief of bone pain and improved joint function. The patient experienced a smooth recovery without any postoperative complications.

2. Surgical intervention was performed with local anesthesia and sedation for the treatment of synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left ankle joint. The procedure involved a synovectomy, meticulous debridement, and bone grafting. The surgical intervention successfully alleviated the bone pain, resulting in improved ankle joint mobility and reduced discomfort during the recovery period.

3. Open joint surgery was performed under spinal anesthesia to address synovial hypertrophy, significant bone erosion, and severe bone pain in the right shoulder joint. The surgical intervention included a synovectomy, extensive debridement, and reconstruction of the eroded bone surfaces. The procedure effectively relieved the bone pain and restored shoulder joint stability. The patient had a favorable postoperative recovery without any complications.

4. Arthroscopic surgical intervention was performed with regional anesthesia for synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left hip joint. The procedure involved a synovectomy, meticulous debridement, and bone smoothing. The surgical intervention successfully alleviated the bone pain, resulting in improved hip joint function and reduced discomfort during the recovery period.

5. The patient underwent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the right elbow joint. The procedure included a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention effectively relieved the bone pain, restored elbow joint stability, and improved range of motion. The patient had a smooth postoperative course without complications.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left temporomandibular joint. The surgical intervention involved a synovectomy, meticulous debridement, and bone grafting. The procedure significantly reduced the bone pain and improved jaw joint function. The patient had a satisfactory recovery without any postoperative issues.

7. Surgical intervention was performed with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the right wrist joint. The procedure included a thorough synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention effectively alleviated the bone pain, resulting in improved wrist joint mobility and reduced discomfort. The patient had an uneventful postoperative course.

8. A surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left temporomandibular joint. The procedure involved a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored jaw joint stability, and improved the patient's ability to chew and speak. The postoperative period was uneventful without any complications.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right hip joint. The procedure included a thorough synovectomy, meticulous bone debridement, and stabilization. The surgical intervention effectively reduced the bone pain, resulting in improved hip joint function and decreased discomfort during the recovery phase. The patient had a smooth postoperative course.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the left shoulder joint. The procedure

involved a comprehensive synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored shoulder joint stability, and improved range of motion. The patient experienced an uneventful postoperative recovery without complications.

1. Urgent surgical intervention was performed under general anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection involving the extreme moving joint of the right knee. A thorough synovectomy, aggressive debridement, and extensive irrigation were carried out to address the infection. Antibiotic therapy was initiated, and the joint was stabilized. The patient's condition improved with reduced infection, relieved bone pain, and enhanced joint function postoperatively.

2. The patient underwent immediate surgical intervention with local anesthesia and sedation to manage synovial hypertrophy, extensive bone erosion, and a severe infection affecting the extreme moving joint of the left shoulder. A comprehensive synovectomy, meticulous debridement, and intensive irrigation were performed to control the infection. Postoperatively, the patient showed significant improvement with reduced infection, diminished bone pain, and improved shoulder mobility.

3. Open joint surgery was conducted under spinal anesthesia to address synovial hypertrophy, severe bone erosion, and a severe infection in the extreme moving joint of the right hip. The surgical intervention involved a thorough synovectomy, extensive debridement of infected tissues, and thorough irrigation. The joint was stabilized, and appropriate antibiotic treatment was initiated. The patient's condition improved postoperatively with reduced infection, relieved bone pain, and restored hip joint function.

4. Surgical intervention was performed with regional anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection affecting the extreme moving joint of the left ankle. A synovectomy, meticulous debridement, and intensive irrigation were carried out to address the infection. The joint was stabilized, and systemic antibiotics were administered. The patient demonstrated a positive response, with reduced infection, alleviated bone pain, and improved mobility during the postoperative period.

5. The patient underwent urgent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection involving the extreme moving joint of the right elbow. A comprehensive synovectomy, thorough debridement, and meticulous irrigation were performed to eradicate the infection. Antibiotic therapy was initiated, and the joint was stabilized. The patient's condition improved postoperatively with reduced infection, relieved bone pain, and restored elbow joint function.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and a severe infection affecting the extreme moving joint of the left wrist. A synovectomy, extensive debridement, and intensive irrigation were carried out to control the infection. The joint was stabilized, and appropriate antibiotic treatment was administered. The patient experienced improved symptoms postoperatively with reduced infection, diminished bone pain, and enhanced wrist joint mobility.

7. Surgical intervention was conducted with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and a severe infection involving the extreme moving joint of the right temporomandibular joint. A thorough synovectomy, meticulous debridement, and extensive irrigation were performed to eradicate the infection. The joint was stabilized, and systemic antibiotics were administered. The patient showed significant improvement with reduced infection, relieved bone pain, and improved jaw function after the surgery.

8. Urgent surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection affecting the extreme moving joint of the left hip. The surgical procedure involved a comprehensive synovectomy, thorough debridement, and extensive irrigation to control the infection. The joint was stabilized, and appropriate antibiotic therapy was initiated. The patient experienced improved symptoms postoperatively with reduced infection, relieved bone pain, and restored hip joint function.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection involving the extreme moving joint of the right knee

. A thorough synovectomy, meticulous debridement, and intensive irrigation were carried out to address the infection. The joint was stabilized, and systemic antibiotics were administered. The patient demonstrated significant improvement with reduced infection, relieved bone pain, and improved knee joint function postoperatively.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and a severe infection affecting the extreme moving joint of the left shoulder. A comprehensive synovectomy, meticulous debridement, and extensive irrigation were performed to control the infection. The joint was stabilized, and appropriate antibiotic treatment was administered. The patient showed notable improvement with reduced infection, relieved bone pain, and enhanced shoulder mobility after the surgery.

1. Urgent surgical intervention was performed under general anesthesia for severe synovial hypertrophy, extensive bone erosion, and intense inflammation in the extreme moving joint of the right knee. A thorough synovectomy, meticulous debridement, and anti-inflammatory measures were implemented to address the inflammation. The joint was stabilized, and the patient experienced a significant reduction in inflammation, relieved bone pain, and improved joint function postoperatively.

2. The patient underwent immediate surgical intervention with local anesthesia and sedation to manage synovial hypertrophy, significant bone erosion, and severe inflammation in the extreme moving joint of the left shoulder. A comprehensive synovectomy, aggressive debridement, and anti-inflammatory treatment were carried out to control the inflammation. Postoperatively, the patient showed remarkable improvement with reduced inflammation, diminished bone pain, and improved shoulder mobility.

3. Open joint surgery was conducted under spinal anesthesia to address synovial hypertrophy, severe bone erosion, and intense inflammation in the extreme moving joint of the right hip. The surgical intervention involved a thorough synovectomy, extensive debridement, and anti-inflammatory measures. The joint was stabilized, and appropriate anti-inflammatory medications were administered. The patient's condition improved postoperatively with reduced inflammation, relieved bone pain, and restored hip joint function.

4. Surgical intervention was performed with regional anesthesia for synovial hypertrophy, severe bone erosion, and severe inflammation affecting the extreme moving joint of the left ankle. A synovectomy, meticulous debridement, and anti-inflammatory interventions were carried out to address the inflammation. The joint was stabilized, and systemic anti-inflammatory treatment was initiated. The patient demonstrated a positive response, with reduced inflammation, alleviated bone pain, and improved mobility during the postoperative period.

5. The patient underwent urgent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and intense inflammation involving the extreme moving joint of the right elbow. A comprehensive synovectomy, thorough debridement, and anti-inflammatory measures were performed to control the inflammation. Anti-inflammatory medication was administered, and the joint was stabilized. The patient's condition improved postoperatively with reduced inflammation, relieved bone pain, and restored elbow joint function.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and intense inflammation affecting the extreme moving joint of the left wrist. A synovectomy, extensive debridement, and anti-inflammatory interventions were carried out to control the inflammation. The joint was stabilized, and appropriate anti-inflammatory therapy was administered. The patient experienced improved symptoms postoperatively with reduced inflammation, diminished bone pain, and enhanced wrist joint mobility.

7. Surgical intervention was conducted with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and severe inflammation involving the extreme moving joint of the right temporomandibular joint. A thorough synovectomy, meticulous debridement, and anti-inflammatory measures were performed to address the inflammation. The joint was stabilized, and systemic anti-inflammatory medications were administered. The patient showed significant improvement with reduced inflammation, relieved bone pain, and improved jaw function after the surgery.

8. Urgent surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and intense inflammation affecting the extreme moving joint of the left hip. The surgical procedure involved a comprehensive synovectomy, thorough debridement, and anti-inflammatory interventions to control the inflammation. The joint was stabilized, and appropriate anti-inflammatory therapy was initiated. The patient experienced improved symptoms postoperatively with reduced inflammation, relieved bone pain, and restored hip joint function.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and intense inflammation involving the extreme moving joint of the right knee. A

thorough synovectomy, meticulous debridement, and anti-inflammatory measures were implemented to address the inflammation. The joint was stabilized, and systemic anti-inflammatory medications were administered. The patient demonstrated significant improvement with reduced inflammation, relieved bone pain, and improved knee joint function postoperatively.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and severe inflammation affecting the extreme moving joint of the left shoulder. A comprehensive synovectomy, meticulous debridement, and anti-inflammatory interventions were performed to control the inflammation. The joint was stabilized, and appropriate anti-inflammatory treatment was administered. The patient showed notable improvement with reduced inflammation, relieved bone pain, and enhanced shoulder mobility after the surgery.

1. The patient's synovial hypertrophy and bone erosion were mild, requiring conservative management. Follow-up includes physical therapy, pain management, and regular monitoring of symptoms.

2. The severity of synovial hypertrophy and bone erosion warrants close follow-up with a rheumatologist and orthopedic specialist. Treatment plan includes a combination of medication, physical therapy, and periodic imaging to assess disease progression.

3. Given the moderate synovial hypertrophy and significant bone erosion, an aggressive treatment approach is necessary. Close follow-up includes regular appointments for joint injections, physical therapy, and frequent imaging to monitor response to treatment.

4. The patient's condition is critical due to severe synovial hypertrophy and extensive bone erosion. Immediate surgical intervention is required, followed by a comprehensive postoperative plan involving frequent follow-ups, specialized rehabilitation, and ongoing assessment for potential complications.

5. Due to the advanced stage of synovial hypertrophy and severe bone erosion, the patient requires intensive management. Follow-up includes a multidisciplinary approach involving rheumatology, orthopedics, and pain management to optimize treatment and minimize disease progression.

6. Given the early detection of synovial hypertrophy and minimal bone erosion, a conservative treatment approach will be followed. Regular follow-ups will focus on symptom assessment, lifestyle modifications, and medication adjustments as needed.

7. The patient's synovial hypertrophy is moderate, but bone erosion is minimal. Follow-up includes a combination of physical therapy, non-steroidal anti-inflammatory drugs (NSAIDs), and periodic imaging to monitor disease progression and response to conservative measures.

8. With severe synovial hypertrophy and moderate bone erosion, close follow-up is crucial. A treatment plan involving disease-modifying anti-rheumatic drugs (DMARDs), physical therapy, and regular assessments will be implemented to manage symptoms and prevent further joint damage.

9. The patient's condition is critical due to extensive synovial hypertrophy and severe bone erosion. Immediate surgical intervention is necessary, followed by an intensive postoperative follow-up plan involving regular check-ups, imaging studies, and rehabilitation to optimize functional outcomes.

10. In cases of mild synovial hypertrophy and minimal bone erosion, conservative management is recommended. Follow-up visits will focus on symptom evaluation, patient education, and lifestyle modifications to promote joint health and prevent disease progression.

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## M67.3 Transient synovitis

1. Patient presented with hip pain and limited range of motion. Clinical examination revealed signs consistent with transient synovitis. X-ray ruled out other pathology. No surgical intervention required. Prescribed rest and analgesics. Follow-up scheduled in two weeks.

2. Operative note: Arthrocentesis performed on patient with suspected transient synovitis. Clear synovial fluid obtained, ruling out septic arthritis. No signs of other joint pathology. Joint flushed with saline. Patient advised to rest and use pain medication. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Clear synovial fluid obtained, ruling out infection. No surgical intervention required. Patient advised to rest and use non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed on patient with suspected transient synovitis. No evidence of intra-articular pathology found. Joint irrigated with saline. Patient advised to rest and use pain medication. Follow-up in one week.

5. Patient presented with hip pain and limited range of motion. Clinical and imaging findings consistent with transient synovitis. No surgical intervention required. Prescribed rest, ice, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage performed on patient with transient synovitis. Effusion aspirated, and joint irrigated with saline. No signs of septic arthritis or other joint pathology observed. Patient instructed to rest and use analgesics. Follow-up in one week.

7. Patient underwent hip aspiration for suspected transient synovitis. Synovial fluid analysis showed no signs of infection or crystal deposition. Joint flushed with saline. Patient advised to rest, elevate the leg, and use pain medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic ultrasound-guided aspiration performed on patient with suspected transient synovitis. Synovial fluid analysis revealed no evidence of infection or other abnormalities. Joint flushed with saline. Patient instructed to rest and use anti-inflammatory medication. Follow-up in one week.

9. Patient presented with hip pain and decreased mobility. Clinical evaluation consistent with transient synovitis. No surgical intervention required. Prescribed rest, physical therapy, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage and aspiration performed on patient with transient synovitis. Synovial fluid analysis negative for infection. Joint flushed and irrigated. No other intra-articular abnormalities observed. Patient advised to rest, apply ice, and take pain medication. Follow-up in one week.

1. Patient presented with acute hip pain and limited range of motion. Diagnosis of transient synovitis confirmed based on clinical examination and exclusion of other pathologies. Non-surgical management initiated with rest, analgesics, and physical therapy. Follow-up scheduled in two weeks to monitor progress.

2. Operative note: Arthrocentesis performed on patient with suspected transient synovitis. Synovial fluid obtained was clear and showed no signs of infection. Joint lavage performed using saline solution. Patient instructed to rest and use pain medication. Follow-up in one week.

3. Patient underwent hip joint aspiration for suspected transient synovitis. Synovial fluid analysis revealed no signs of infection or inflammatory markers. Joint irrigated with saline. Non-surgical management advised, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed to assess hip joint in patient with suspected transient synovitis. No evidence of intra-articular abnormalities or pathology found. Joint lavage performed. Patient advised to rest and use pain relief medication. Follow-up in one week.

5. Patient presented with hip pain and reduced mobility. Clinical examination consistent with transient synovitis. No surgical intervention required. Prescribed rest, application of ice packs, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage performed on patient with transient synovitis. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Non-surgical management initiated with rest and pain medication. Follow-up in one week.

7. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Synovial fluid analysis revealed no signs of infection or crystals. Joint lavage performed with saline. Non-surgical management recommended, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic arthroscopy performed on patient with suspected transient synovitis. No abnormalities or intra-articular pathology observed. Joint lavage performed. Patient advised to rest, apply cold packs, and use pain relief medication. Follow-up in one week.

9. Patient presented with hip pain and restricted range of motion. Clinical evaluation consistent with transient synovitis. No surgical intervention required. Prescribed rest, elevation of the leg, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage and aspiration performed on patient with transient synovitis. Synovial fluid analysis showed no signs of infection or other abnormalities. Joint flushed and irrigated. Non-surgical management initiated with rest, ice application, and pain medication. Follow-up in one week.

1. Patient presented with hip pain and limited range of motion. Clinical examination and imaging findings consistent with transient synovitis. Non-surgical management initiated with rest, analgesics, and local anesthesia for pain relief. Follow-up scheduled in two weeks to assess progress.

2. Operative note: Arthrocentesis performed on patient with suspected transient synovitis under local anesthesia. Clear synovial fluid obtained, ruling out septic arthritis. Joint lavage performed using saline solution. Patient advised to rest and use pain medication. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis ruled out infection. Joint irrigated with saline. Non-surgical management prescribed, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed on patient with suspected transient synovitis under regional anesthesia. No intra-articular abnormalities or pathology observed. Joint lavage performed. Patient instructed to rest and use pain relief medication. Follow-up in one week.

5. Patient presented with acute hip pain and decreased mobility. Clinical evaluation and imaging consistent with transient synovitis. Non-surgical management initiated with rest, systemic analgesics, and local anesthesia for targeted pain relief. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage and aspiration performed on patient with transient synovitis under local anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Non-surgical management advised, including rest, pain medication, and physical therapy. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis under regional anesthesia. Synovial fluid analysis revealed no signs of infection or inflammatory markers. Joint lavage performed with saline. Non-surgical management recommended, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic arthroscopy performed to evaluate hip joint in patient with suspected transient synovitis under general anesthesia. No intra-articular abnormalities detected. Joint lavage performed. Patient advised to rest, use pain relief medication, and initiate physical therapy. Follow-up in one week.

9. Patient presented with hip pain and limited range of motion. Clinical examination consistent with transient synovitis. Non-surgical management initiated with rest, local anesthesia for pain control, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage performed on patient with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Non-surgical management initiated with rest, pain medication, and physical therapy. Follow-up in one week.

1. Patient presented with hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Non-surgical management initiated with rest, analgesics, and referral to orthopedic specialist for further evaluation and management. Follow-up scheduled in two weeks to monitor progression of bone erosion.

2. Operative note: Arthrocentesis performed on patient with transient synovitis and associated bone erosion. Synovial fluid analysis ruled out infection. Joint lavage performed using saline solution. Orthopedic consultation recommended for management of bone erosion. Patient advised to rest and use pain medication. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and bone erosion. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Joint irrigated with saline. Orthopedic referral made for management of bone erosion. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed on patient with transient synovitis and evidence of bone erosion under general anesthesia. No additional intra-articular abnormalities detected. Joint lavage performed. Orthopedic consultation arranged for management of bone erosion. Patient instructed to rest and use pain relief medication. Follow-up in one week.

5. Patient presented with hip pain, limited range of motion, and significant bone erosion on imaging studies. Orthopedic consultation obtained for further evaluation and management. Non-surgical management initiated with rest, systemic analgesics, and referral to physical therapy. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage and aspiration performed on patient with transient synovitis and bone erosion under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Orthopedic specialist consulted for management of bone erosion. Non-surgical management prescribed, including rest, pain medication, and physical therapy. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and bone erosion under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Orthopedic referral made for management of bone erosion. Non-surgical management advised, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic arthroscopy performed on patient with transient synovitis and bone erosion under general anesthesia. No additional intra-articular abnormalities observed. Joint lavage performed. Orthopedic consultation arranged for management of bone erosion. Patient instructed to rest, use pain relief medication, and initiate physical therapy. Follow-up in one week.

9. Patient presented with hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Orthopedic specialist consulted for further evaluation and management. Non-surgical management initiated with rest, local anesthesia for pain control, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage performed on patient with transient synovitis and bone erosion under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Orthopedic referral made for management of bone erosion. Non-surgical management initiated with rest, pain medication, and physical therapy. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of severe bone pain associated with transient synovitis. Urgent orthopedic consultation obtained for further evaluation and management. Non-surgical management initiated with rest, high-dose analgesics, and referral to pain management specialist. Follow-up scheduled in one week to assess response to pain management interventions.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Joint lavage performed using saline solution. Pain management team consulted for optimized pain control. Patient advised to rest and use high-dose analgesics. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Joint irrigated with saline. Referral made to pain management specialist for optimized pain control. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. No additional intra-articular abnormalities detected. Joint lavage performed. Pain management team consulted for optimized pain control. Patient instructed to rest and use high-dose pain relief medication. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Urgent orthopedic consultation obtained for further evaluation and management of pain. Non-surgical management initiated with rest, systemic analgesics, and referral to pain management specialist for advanced pain control interventions. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Pain management team involved for optimized pain control. Non-surgical management prescribed, including rest, high-dose pain medication, and physical therapy. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Referral made to pain management specialist for optimized pain control. Non-surgical management advised, including rest and anti-inflammatory medication. Follow-up scheduled in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. No additional intra-articular abnormalities observed. Joint lavage performed. Pain management team consulted for optimized pain control. Patient instructed to rest, use high-dose pain relief medication, and initiate physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Urgent orthopedic consultation obtained for evaluation and management of pain. Non-surgical management initiated with rest, local anesthesia for pain control, and referral to pain management specialist for advanced pain management strategies. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Referral made to pain management specialist for optimized pain control. Non-surgical management initiated with rest, high-dose pain medication, and physical therapy. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Surgical intervention in the form of arthroscopic synovectomy was performed to address the underlying pathology. Post-operative management included rest, pain medication, and physical therapy. Follow-up scheduled in two weeks to monitor recovery.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Surgical intervention in the form of synovectomy planned to address persistent symptoms. Follow-up in one week to discuss surgical options.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Surgical intervention in the form of open synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon arranged. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular findings revealed extensive synovial proliferation and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Surgical intervention in the form of joint debridement and synovectomy recommended to address bone erosion. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Surgical intervention in the form of open synovectomy planned to address persistent symptoms. Consultation with orthopedic surgeon arranged. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Surgical intervention in the form of arthroscopic synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon scheduled. Follow-up in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and joint debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Surgical intervention in the form of open synovectomy planned to address bone erosion and alleviate symptoms. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Surgical intervention in the form of open synovectomy recommended to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Surgical intervention in the form of arthroscopic synovectomy was performed to address the underlying pathology. Post-operative management included rest, pain medication, and physical therapy. Follow-up scheduled in two weeks to monitor recovery.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Surgical intervention in the form of synovectomy planned to address persistent symptoms. Follow-up in one week to discuss surgical options.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Surgical intervention in the form of open synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon arranged. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular findings revealed extensive synovial proliferation and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Surgical intervention in the form of joint debridement and synovectomy recommended to address bone erosion. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Surgical intervention in the form of open synovectomy planned to address persistent symptoms. Consultation with orthopedic surgeon arranged. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Surgical intervention in the form of arthroscopic synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon scheduled. Follow-up in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and joint debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Surgical intervention in the form of open synovectomy planned to address bone erosion and alleviate symptoms. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Surgical intervention in the form of open synovectomy recommended to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Surgical intervention in the form of core decompression performed to alleviate pain and promote healing. Post-operative management included rest, weight-bearing restrictions, and physical therapy. Follow-up scheduled in two weeks to monitor recovery.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Surgical intervention in the form of joint realignment planned to address persistent symptoms and bone erosion. Follow-up in one week to discuss surgical options.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Surgical intervention in the form of joint realignment and bone grafting recommended to address bone erosion. Consultation with orthopedic surgeon arranged. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular findings revealed extensive synovial proliferation and bone erosion. Surgical intervention in the form of arthroscopic joint debridement and bone grafting performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Surgical intervention in the form of joint realignment and bone grafting recommended to address bone erosion and improve joint stability. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Surgical intervention in the form of joint realignment and bone grafting planned to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Surgical intervention in the form of arthroscopic joint realignment and bone grafting recommended to address bone erosion. Consultation with orthopedic surgeon scheduled. Follow-up in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and bone erosion. Surgical intervention in the form of arthroscopic joint realignment and bone grafting performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Surgical intervention in the form of joint realignment and bone grafting planned to address bone erosion and restore joint function. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Surgical intervention in the form of joint realignment and bone grafting recommended to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

1. Patient presented with severe hip pain, restricted range of motion, and signs of a severe infection involving the hip joint due to transient synovitis. Urgent surgical intervention in the form of open joint debridement and irrigation performed to address the infection. Intravenous antibiotics initiated post-operatively. Close monitoring and infectious disease consultation arranged. Follow-up in one week to assess response to treatment.

2. Operative note: Arthrocentesis performed on patient with severe infection involving the hip joint caused by transient synovitis. Synovial fluid analysis confirmed the presence of bacterial infection. Surgical intervention in the form of open joint debridement and extensive irrigation conducted to remove infected tissues. Intravenous antibiotics initiated. Infectious disease specialist consulted for further management. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of the infected hip joint associated with transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis revealed the presence of bacterial infection. Urgent surgical intervention in the form of open joint debridement and thorough irrigation performed. Intravenous antibiotics initiated. Infectious disease consultation obtained. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe infection involving the hip joint due to transient synovitis under general anesthesia. Intra-articular findings showed significant inflammation and signs of infection. Surgical intervention in the form of arthroscopic joint debridement and irrigation performed. Intravenous antibiotics initiated post-operatively. Infectious disease specialist involved in management. Follow-up in one week.

5. Patient presented with severe hip pain, restricted range of motion, and radiographic evidence of bone erosion associated with an extreme joint infection caused by transient synovitis. Urgent surgical intervention in the form of open joint debridement and extensive irrigation conducted to address the infection. Intravenous antibiotics initiated post-operatively. Close monitoring and infectious disease consultation arranged. Follow-up in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe infection involving the extreme moving joint due to transient synovitis under regional anesthesia. Synovial fluid analysis confirmed the presence of bacterial infection. Surgical intervention in the form of open joint debridement and thorough irrigation performed. Intravenous antibiotics initiated. Infectious disease specialist consulted for further management. Follow-up in one week.

7. Patient underwent joint aspiration for suspected transient synovitis and severe infection involving the extreme moving joint under local anesthesia. Synovial fluid analysis revealed the presence of bacterial infection. Joint lavage performed with saline. Urgent surgical intervention in the form of open joint debridement and thorough irrigation planned to address the infection. Infectious disease consultation obtained. Follow-up scheduled in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe infection involving the extreme moving joint due to transient synovitis under general anesthesia. Intra-articular examination showed severe inflammation and signs of infection. Surgical intervention in the form of arthroscopic joint debridement and irrigation performed. Intravenous antibiotics initiated post-operatively. Infectious disease specialist involved in management. Follow-up in one week.

9. Patient presented with severe hip pain, restricted range of motion, and radiographic evidence of bone erosion associated with an extreme joint infection caused by transient synovitis. Urgent surgical intervention in the form of open joint debridement and thorough irrigation conducted to address the infection. Intravenous antibiotics initiated post-operatively. Close monitoring and infectious disease consultation arranged. Follow-up in one week.

10. Operative note: Joint lavage performed on patient with severe infection involving the extreme moving joint due to transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. Bacterial infection confirmed. Surgical intervention in

the form of open joint debridement and thorough irrigation recommended to address the infection. Intravenous antibiotics initiated. Infectious disease consultation obtained. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of intense inflammation associated with transient synovitis. Non-surgical management initiated with rest, non-steroidal anti-inflammatory drugs (NSAIDs), and physical therapy. Close monitoring of inflammatory markers planned. Follow-up in two weeks to assess response to conservative treatment.

2. Operative note: Arthrocentesis performed on patient with severe inflammation due to transient synovitis. Synovial fluid analysis showed elevated inflammatory markers. Intra-articular corticosteroid injection administered for immediate relief. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe inflammation. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis revealed increased inflammatory markers. Non-surgical management initiated, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe inflammation associated with transient synovitis under general anesthesia. Intra-articular examination showed marked synovial hypertrophy and intense inflammation. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant inflammation related to transient synovitis. Non-surgical management initiated with rest, systemic corticosteroids, and referral to rheumatology specialist for advanced inflammatory control interventions. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe inflammation associated with transient synovitis under regional anesthesia. Synovial fluid analysis revealed elevated inflammatory markers. Joint flushed and irrigated using saline solution. Non-surgical management prescribed, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe inflammation under local anesthesia. Synovial fluid analysis showed increased inflammatory markers. Joint lavage performed with saline. Non-surgical management initiated, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up scheduled in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe inflammation associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and intense inflammation. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of inflammation associated with transient synovitis. Non-surgical management initiated with rest, local corticosteroid injection for inflammation control, and referral to rheumatology specialist. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe inflammation associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. Elevated inflammatory markers detected. Non-surgical management prescribed, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up in one week.

1. Patient presented with moderate hip pain, limited range of motion, and radiographic evidence of transient synovitis. Non-surgical management initiated with rest, pain medication, and physical therapy. Follow-up scheduled in four weeks to assess response to conservative treatment and determine the need for further intervention.

2. Operative note: Arthrocentesis performed on patient with severe hip pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in two weeks to evaluate response and adjust treatment plan accordingly.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Non-surgical management initiated, including rest, NSAIDs, and physical therapy. Follow-up scheduled in six weeks to assess progress and consider additional interventions if necessary.

4. Operative note: Diagnostic arthroscopy performed on patient with severe hip pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed significant synovial hypertrophy. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in four weeks to evaluate response and determine further steps.

5. Patient presented with mild hip pain, limited range of motion, and radiographic evidence of transient synovitis. Non-surgical management initiated with rest, activity modification, and pain medication as needed. Follow-up scheduled in six weeks to assess progress and determine if further intervention is required.

6. Operative note: Joint lavage and aspiration performed on patient with moderate hip pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis revealed no signs of infection. Joint flushed and irrigated using saline solution. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in eight weeks to evaluate response and adjust treatment plan as necessary.

7. Patient underwent hip joint aspiration for suspected transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis ruled out infection. Non-surgical management initiated, including rest, NSAIDs, and physical therapy. Follow-up scheduled in four weeks to assess progress and determine the need for further intervention.

8. Operative note: Diagnostic arthroscopy performed on patient with mild hip pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed mild synovial hypertrophy. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in six weeks to evaluate response and determine if additional steps are necessary.

9. Patient presented with moderate hip pain, limited range of motion, and radiographic evidence of transient synovitis. Non-surgical management initiated with rest, pain medication, and referral for physical therapy. Follow-up scheduled in two weeks to assess response to conservative treatment and decide on the need for further intervention.

10. Operative note: Joint lavage performed on patient with mild hip pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in four weeks to evaluate response and adjust treatment plan accordingly.

## M67.4 Ganglion

1. Procedure: Ganglion Excision

Operative Note:

A ganglion excision was performed on the dorsal aspect of the patient's wrist. A longitudinal incision was made over the ganglion, and dissection was carried down to expose the ganglion sac. The sac was carefully dissected and excised completely. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were noted.

2. Procedure: Ganglion Aspiration

Operative Note:

Ganglion aspiration was performed on the patient's volar wrist. Using sterile technique, a 22-gauge needle was inserted into the ganglion under ultrasound guidance. The cystic fluid was aspirated, and the ganglion collapsed. No evidence of infection or malignancy was noted. The patient experienced immediate relief of symptoms, and the area was dressed with a sterile dressing.

3. Procedure: Ganglion Decompression

Operative Note:

Ganglion decompression surgery was performed on the patient's ankle. A transverse incision was made over the ganglion, and the underlying tissues were dissected. The ganglion stalk was identified and released, relieving pressure within the cyst. The incision was closed, and the patient was placed in a compression bandage. Postoperatively, the patient was advised to limit weight-bearing activities.

4. Procedure: Ganglion Biopsy

Operative Note:

A ganglion biopsy was performed on the patient's hand. Under local anesthesia, an incision was made over the ganglion. The cystic fluid was aspirated, and a portion of the ganglion wall was excised for pathological examination. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were encountered.

5. Procedure: Ganglion Resection

Operative Note:

Ganglion resection was performed on the patient's foot. An incision was made over the ganglion, and dissection was carried down to expose the cyst. The ganglion and its stalk were carefully dissected and excised. Hemostasis was achieved, and the wound was closed in layers. The patient experienced immediate relief of symptoms, and postoperative instructions were given for wound care and follow-up.

6. Procedure: Ganglion Bursectomy

Operative Note:

A ganglion bursectomy was performed on the patient's knee. An arthroscopic approach was used. The ganglion was visualized and found to be originating from the joint capsule. The ganglion and the associated bursa were excised using arthroscopic instruments. Hemostasis was achieved, and the joint was irrigated. The patient tolerated the procedure well, and postoperative rehabilitation was initiated.

7. Procedure: Ganglion Coagulation

Operative Note:

Ganglion coagulation was performed on the patient's finger. A small incision was made over the ganglion, and the cystic fluid was aspirated. Electrocautery was used to cauterize the inner lining of the ganglion. Hemostasis was achieved, and the wound was closed with a sterile dressing. The patient reported immediate improvement in symptoms, and postoperative instructions were given for wound care.

8. Procedure: Ganglion Recurrence Excision

Operative Note:

The patient presented with a recurrent ganglion on the dorsal aspect of the wrist. An incision was made over the ganglion, and the cyst was carefully dissected and excised. The previous surgical site was explored, and no residual ganglion tissue was found. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and appropriate postoperative follow-up was planned.

9. Procedure: Ganglion Marsup

ialization

Operative Note:

Ganglion marsupialization was performed on the patient's ankle. An incision was made over the ganglion, and the cyst was dissected and opened. The edges of the cyst were sutured to the surrounding skin, creating a permanent opening. The cyst was thoroughly irrigated, and the wound was closed with sutures. The patient experienced immediate relief of symptoms, and postoperative care instructions were provided.

10. Procedure: Ganglion Ligament Resection

Operative Note:

The patient presented with a ganglion arising from the scapholunate ligament. An incision was made over the ganglion, and dissection was carried down to expose the ligament. The ganglion was excised, and a portion of the involved ligament was resected. Hemostasis was achieved, and the wound was closed in layers. The patient was placed in a splint postoperatively and referred for hand therapy.

1. Procedure: Ganglion Cryotherapy

Operative Note:

Ganglion cryotherapy was performed on the patient's knee. A small incision was made over the ganglion, and a cryoprobe was inserted into the cyst under ultrasound guidance. The ganglion was frozen using liquid nitrogen, destroying the cystic tissue. The cryoprobe was then removed, and the incision was closed with sutures. The patient tolerated the procedure well, and postoperative instructions were given for pain management and rehabilitation.

2. Procedure: Ganglion Capsulotomy

Operative Note:

Ganglion capsulotomy was performed on the patient's shoulder. An arthroscopic approach was used to access the joint. The ganglion, originating from the joint capsule, was visualized and carefully dissected. A capsulotomy was performed to release the ganglion and relieve joint compression. Hemostasis was achieved, and the joint was irrigated. The patient's shoulder stability was assessed, and postoperative rehabilitation was initiated.

3. Procedure: Ganglion Drainage

Operative Note:

Ganglion drainage was performed on the patient's foot. Under local anesthesia, a small incision was made over the ganglion, and the cystic fluid was drained using a syringe. Gentle pressure was applied to evacuate the cyst completely. The wound was dressed with a sterile dressing, and the patient was advised to keep the area clean and dry. Postoperative follow-up was scheduled.

4. Procedure: Ganglion Repair with Graft

Operative Note:

The patient presented with a large ganglion on the volar aspect of the wrist. An incision was made over the ganglion, and the cyst was carefully dissected and excised. To prevent recurrence, a graft was harvested from the patient's palmaris longus tendon and used to reinforce the defect. Hemostasis was achieved, and the wound was closed in layers. Postoperative immobilization and hand therapy were initiated.

5. Procedure: Ganglion Sclerotherapy

Operative Note:

Ganglion sclerotherapy was performed on the patient's hand. Following sterile preparation, a needle was inserted into the ganglion under ultrasound guidance. A sclerosing agent was injected into the cyst to induce fibrosis and collapse. The needle was removed, and a compression dressing was applied. The patient was advised to limit hand use and keep the area elevated for optimal results.

6. Procedure: Ganglion Neurolysis

Operative Note:

Ganglion neurolysis was performed on the patient's sciatic nerve. The ganglion was visualized using intraoperative imaging. Adhesions around the nerve were carefully dissected and released, allowing for improved nerve mobility. The ganglion was preserved during the procedure. Hemostasis was achieved, and the wound was closed. Postoperatively, the patient was monitored for neurological improvement and provided with pain management instructions.

7. Procedure: Ganglion Radiofrequency Ablation

Operative Note:

Ganglion radiofrequency ablation was performed on the patient's lumbar facet joint. Under fluoroscopic guidance, a radiofrequency needle was placed near the ganglion. Radiofrequency energy was delivered to create a thermal lesion, interrupting the ganglion's pain signals. The needle was removed, and the patient reported immediate pain relief. Postoperative instructions included activity modification and follow-up evaluation.

8. Procedure: Ganglion Endoscopic Resection

Operative Note:

Ganglion endoscopic resection was performed on the patient's elbow. Two small incisions were made, and an endoscope and instruments were inserted. The ganglion was visualized, dissected, and excised using endoscopic techniques. Hemostasis was achieved, and the incisions were closed with sutures. The patient experienced improvement in

range of motion and was advised on postoperative care and rehabilitation exercises.

9. Procedure: Ganglion Laser Ablation

Operative Note:

Ganglion laser ablation was performed on the patient's spine. Under fluoroscopic guidance, a laser fiber was inserted into the ganglion. Laser energy was delivered to heat and destroy the ganglion tissue. The fiber was removed, and hemostasis was achieved. The patient reported immediate pain reduction. Postoperative instructions included post-procedural care and follow-up evaluation.

10. Procedure: Ganglion Arthrotomy

Operative Note:

Ganglion arthrotomy was performed on the patient's hip joint. A surgical approach was used to expose the joint. The ganglion, arising from the synovium, was identified and carefully dissected. An arthrotomy was performed to excise the ganglion and evaluate the joint for any underlying pathology. Hemostasis was achieved, and the wound was closed in layers. The patient was started on a postoperative rehabilitation program.

1. Procedure: Ganglion Excision

Operative Note:

A ganglion excision was performed on the patient's dorsal wrist under local anesthesia with 1% lidocaine. A longitudinal incision was made over the ganglion, and dissection was carried down to expose the ganglion sac. The sac was carefully dissected and excised completely. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were noted.

2. Procedure: Ganglion Aspiration

Operative Note:

Ganglion aspiration was performed on the patient's volar wrist under local anesthesia with 2% lidocaine. Using sterile technique, a 22-gauge needle was inserted into the ganglion under ultrasound guidance. The cystic fluid was aspirated, and the ganglion collapsed. No evidence of infection or malignancy was noted. The patient experienced immediate relief of symptoms, and the area was dressed with a sterile dressing.

3. Procedure: Ganglion Decompression

Operative Note:

Ganglion decompression surgery was performed on the patient's ankle under regional anesthesia with a popliteal nerve block. A transverse incision was made over the ganglion, and the underlying tissues were dissected. The ganglion stalk was identified and released, relieving pressure within the cyst. The incision was closed, and the patient was placed in a compression bandage. Postoperatively, the patient was advised to limit weight-bearing activities.

4. Procedure: Ganglion Biopsy

Operative Note:

A ganglion biopsy was performed on the patient's hand under general anesthesia with endotracheal intubation. An incision was made over the ganglion, and the cystic fluid was aspirated. A portion of the ganglion wall was excised for pathological examination. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were encountered.

5. Procedure: Ganglion Resection

Operative Note:

Ganglion resection was performed on the patient's foot under regional anesthesia with an ankle block. An incision was made over the ganglion, and dissection was carried down to expose the cyst. The ganglion and its stalk were carefully dissected and excised. Hemostasis was achieved, and the wound was closed in layers. The patient experienced immediate relief of symptoms, and postoperative instructions were given for wound care and follow-up.

6. Procedure: Ganglion Bursectomy

Operative Note:

A ganglion bursectomy was performed on the patient's knee under spinal anesthesia. An arthroscopic approach was used. The ganglion was visualized and found to be originating from the joint capsule. The ganglion and the associated bursa were excised using arthroscopic instruments. Hemostasis was achieved, and the joint was irrigated. The patient tolerated the procedure well, and postoperative rehabilitation was initiated.

7. Procedure: Ganglion Coagulation

Operative Note:

Ganglion coagulation was performed on the patient's finger under local anesthesia with 0.5% bupivacaine. A small incision was made over the ganglion, and the cystic fluid was aspirated. Electrocautery was used to cauterize the inner lining of the ganglion. Hemostasis was achieved, and the wound was closed with a sterile dressing. The patient reported immediate improvement in symptoms, and postoperative instructions were given for wound care.

8. Procedure: Ganglion Recurrence Excision

Operative Note:

The patient presented with a recurrent ganglion on the dorsal aspect of the wrist. An incision was made over the ganglion, and the cyst was carefully dissected

and excised. The previous surgical site was explored, and no residual ganglion tissue was found. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, which was performed under conscious sedation with intravenous midazolam and fentanyl.

9. Procedure: Ganglion Marsupialization

Operative Note:

Ganglion marsupialization was performed on the patient's ankle under local anesthesia with 1% lidocaine. An incision was made over the ganglion, and the cyst was dissected and opened. The edges of the cyst were sutured to the surrounding skin, creating a permanent opening. The cyst was thoroughly irrigated, and the wound was closed with sutures. The patient experienced immediate relief of symptoms, and postoperative care instructions were provided.

10. Procedure: Ganglion Ligament Resection

Operative Note:

The patient presented with a ganglion arising from the scapholunate ligament. An incision was made over the ganglion, and dissection was carried down to expose the ligament. The ganglion was excised, and a portion of the involved ligament was resected. Hemostasis was achieved, and the wound was closed in layers. The patient was placed under general anesthesia with a laryngeal mask airway for the procedure. Postoperatively, immobilization and hand therapy were initiated.

1. Procedure: Ganglion Excision with Bone Erosion

Operative Note:

A ganglion excision with bone erosion was performed on the patient's wrist. An incision was made over the ganglion, and dissection revealed erosion of the underlying bone due to chronic pressure. The ganglion sac was carefully dissected and excised, and the eroded bone was debrided. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and postoperative instructions were given for immobilization and bone healing.

2. Procedure: Ganglion Aspiration with Bone Erosion

Operative Note:

Ganglion aspiration with bone erosion was performed on the patient's ankle. Using sterile technique, a 22-gauge needle was inserted into the ganglion under ultrasound guidance, revealing bone erosion adjacent to the cyst. The cystic fluid was aspirated, and the ganglion collapsed. The eroded bone was debrided, and thorough irrigation was performed. The patient experienced immediate relief of symptoms, and postoperative instructions were given for bone healing and rehabilitation.

3. Procedure: Ganglion Decompression with Bone Erosion

Operative Note:

Ganglion decompression surgery with bone erosion was performed on the patient's knee. A transverse incision was made over the ganglion, exposing the cyst and underlying bone erosion. The ganglion stalk was released, and meticulous debridement of the eroded bone was performed. The incision was closed, and the patient was placed in a compression bandage. Postoperatively, weight-bearing activities were restricted to promote bone healing.

4. Procedure: Ganglion Biopsy with Bone Erosion

Operative Note:

A ganglion biopsy with bone erosion was performed on the patient's hand. An incision was made over the ganglion, revealing bone erosion upon dissection. A portion of the ganglion wall and the eroded bone were excised for pathological examination. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and appropriate postoperative follow-up was planned for bone healing assessment.

5. Procedure: Ganglion Resection with Bone Erosion

Operative Note:

Ganglion resection with bone erosion was performed on the patient's foot. An incision was made over the ganglion, exposing the cyst and adjacent bone erosion. The ganglion and its stalk were meticulously dissected and excised. The eroded bone was debrided, and thorough irrigation was performed. Hemostasis was achieved, and the wound was closed in layers. Postoperatively, the patient was instructed for immobilization and bone healing.

6. Procedure: Ganglion Bursectomy with Bone Erosion

Operative Note:

A ganglion bursectomy with bone erosion was performed on the patient's knee. An arthroscopic approach was used to visualize the ganglion, which revealed bone erosion within the joint. The ganglion and the associated bursa were excised using arthroscopic instruments. The eroded bone was debrided, and the joint was irrigated. Hemostasis was achieved, and the patient tolerated the procedure well. Postoperatively, rehabilitation and bone healing protocols were initiated.

7. Procedure: Ganglion Coagulation with Bone Erosion

Operative Note:

Ganglion coagulation with bone erosion was performed on the patient's finger. A small incision was made over the ganglion, exposing bone erosion adjacent to the cyst. The cystic fluid was aspirated, and the inner lining of the ganglion was cauterized using electrocautery. The eroded bone was debrided, and meticulous hemostasis was achieved. The wound was closed with a sterile

dressing, and the patient was provided with postoperative instructions for bone healing.

8. Procedure: Ganglion Recurrence Excision with Bone Erosion

Operative Note:

The patient presented with a recurrent ganglion with underlying bone erosion on the dorsal aspect of the wrist. An incision was made over the ganglion, revealing the cyst and adjacent bone erosion. The ganglion was carefully dissected and excised, and the eroded bone was debrided. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and appropriate follow-up was planned for bone healing assessment.

9. Procedure: Ganglion Marsupialization with Bone Erosion

Operative Note:

Ganglion marsupialization with bone erosion was performed on the patient's ankle. An incision was made over the ganglion, exposing the cyst and adjacent bone erosion. The cystic lining was carefully dissected and sutured to the surrounding skin, creating a permanent opening. The eroded bone was debrided, and thorough irrigation was performed. The wound was closed, and postoperative instructions were given for bone healing and rehabilitation.

10. Procedure: Ganglion Ligament Resection with Bone Erosion

Operative Note:

The patient presented with a ganglion arising from the scapholunate ligament, with evidence of bone erosion. An incision was made over the ganglion, exposing the ligament and eroded bone. The ganglion was excised, and a portion of the involved ligament and eroded bone were resected. Hemostasis was achieved, and the wound was closed in layers. The patient was placed under general anesthesia, and postoperatively, immobilization and bone healing protocols were initiated.

1. Procedure: Ganglion Excision with Severe Bone Pain

Operative Note:

A ganglion excision was performed on the patient's wrist under regional anesthesia. The patient presented with severe bone pain associated with the ganglion. An incision was made over the ganglion, and dissection was carried out carefully to avoid exacerbating the pain. The ganglion sac was completely excised, and meticulous hemostasis was achieved. The wound was closed in layers. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up evaluation.

2. Procedure: Ganglion Aspiration with Severe Bone Pain

Operative Note:

Ganglion aspiration was performed on the patient's ankle under local anesthesia. The patient reported severe bone pain associated with the ganglion. Using sterile technique, the cystic fluid was aspirated from the ganglion, providing temporary relief of symptoms. The patient's pain level was closely monitored throughout the procedure. Postoperatively, pain management measures were implemented, and the patient was scheduled for further evaluation and treatment if needed.

3. Procedure: Ganglion Decompression with Severe Bone Pain

Operative Note:

Ganglion decompression surgery was performed on the patient's knee under spinal anesthesia. The patient experienced severe bone pain related to the ganglion. The ganglion stalk was carefully released to alleviate pressure and decompress the affected area. The procedure was performed with utmost care to minimize pain. Postoperatively, pain control measures were initiated, and the patient was advised on rehabilitation protocols to manage the underlying bone pain.

4. Procedure: Ganglion Biopsy with Severe Bone Pain

Operative Note:

A ganglion biopsy was performed on the patient's hand under general anesthesia. The patient presented with severe bone pain associated with the ganglion. An incision was made over the ganglion, and a portion of the ganglion wall was excised for pathological examination. Special attention was given to managing the patient's pain during the procedure. Postoperatively, pain management strategies were employed, and the patient was scheduled for further evaluation based on biopsy results.

5. Procedure: Ganglion Resection with Severe Bone Pain

Operative Note:

Ganglion resection was performed on the patient's foot under regional anesthesia. The patient reported severe bone pain associated with the ganglion. An incision was made over the ganglion, and the cyst and underlying eroded bone were meticulously resected. Pain control measures were carefully implemented throughout the procedure. Postoperatively, the patient was provided with pain management instructions and scheduled for follow-up evaluation.

6. Procedure: Ganglion Bursectomy with Severe Bone Pain

Operative Note:

A ganglion bursectomy was performed on the patient's knee under general anesthesia. The patient experienced severe bone pain related to the ganglion. The ganglion and associated bursa were excised meticulously to relieve the pressure and alleviate pain. Pain management strategies were employed intraoperatively and continued postoperatively. The patient was instructed on pain control measures and rehabilitation exercises to manage the severe bone pain.

7. Procedure: Ganglion Coagulation with Severe Bone Pain

Operative Note:

Ganglion coagulation was performed on the patient's finger under local anesthesia. The patient reported severe bone pain associated with the ganglion. The ganglion sac was cauterized using electrocautery to achieve coagulation. Pain management measures were implemented during the procedure to alleviate the patient's pain. Postoperatively, pain control strategies were employed, and the patient was scheduled for follow-up evaluation.

8. Procedure: Ganglion Recurrence Excision with Severe Bone Pain

Operative Note:

The patient presented with a recurrent ganglion on the dorsal aspect of the wrist, accompanied by severe bone pain.

An incision was made over the ganglion, and complete excision was performed, paying special attention to managing the patient's pain. The wound was closed meticulously. Postoperatively, pain management techniques were employed, and the patient was scheduled for further evaluation to address the severe bone pain.

9. Procedure: Ganglion Marsupialization with Severe Bone Pain

Operative Note:

Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The patient experienced severe bone pain associated with the ganglion. The cystic lining was sutured to the surrounding skin to create a permanent opening, relieving pressure and reducing pain. Intraoperative pain management strategies were employed. Postoperatively, pain control measures were initiated, and the patient was scheduled for follow-up evaluation.

10. Procedure: Ganglion Ligament Resection with Severe Bone Pain

Operative Note:

The patient presented with a ganglion arising from the scapholunate ligament, causing severe bone pain. An incision was made over the ganglion, and meticulous dissection was performed to minimize pain. The ganglion and involved ligament were resected carefully. Special attention was given to managing the patient's pain during the procedure. Postoperatively, pain control measures were implemented, and the patient was instructed on rehabilitation protocols to address the severe bone pain.

1. Procedure: Ganglion Excision with Surgical Intervention

Operative Note:

A ganglion excision was performed on the patient's wrist under local anesthesia. The ganglion was carefully dissected and excised, and the surrounding tissues were thoroughly inspected. During the procedure, a surgical intervention was required to repair a small tendon tear that was identified. The tear was repaired using sutures, and the wound was closed. Postoperatively, the patient was instructed on tendon rehabilitation protocols and scheduled for follow-up evaluation.

2. Procedure: Ganglion Aspiration with Surgical Intervention

Operative Note:

Ganglion aspiration was performed on the patient's ankle under conscious sedation. The cystic fluid was successfully aspirated from the ganglion, providing symptomatic relief. However, during the procedure, a surgical intervention was necessary to address a small articular cartilage defect adjacent to the ganglion. The defect was debrided and treated accordingly. The patient tolerated the procedure well, and postoperative care instructions were provided.

3. Procedure: Ganglion Decompression with Surgical Intervention

Operative Note:

Ganglion decompression surgery was performed on the patient's knee under general anesthesia. The ganglion stalk was released to alleviate pressure and decompress the affected area. Additionally, a surgical intervention was performed to address a meniscal tear that was discovered during the procedure. The torn meniscus was trimmed and repaired. The patient was immobilized postoperatively and instructed on rehabilitation protocols for optimal recovery.

4. Procedure: Ganglion Biopsy with Surgical Intervention

Operative Note:

A ganglion biopsy was performed on the patient's hand under regional anesthesia. The ganglion wall was excised for pathological examination. Additionally, a surgical intervention was necessary to address a small bone spur that was identified adjacent to the ganglion. The bone spur was carefully removed. The patient tolerated the procedure well, and postoperative instructions were given for wound care and follow-up evaluation.

5. Procedure: Ganglion Resection with Surgical Intervention

Operative Note:

Ganglion resection was performed on the patient's foot under general anesthesia. The ganglion and underlying tissues were meticulously dissected and excised. Furthermore, a surgical intervention was required to repair a small ligament tear that was discovered during the procedure. The torn ligament was repaired using sutures, and appropriate tension was restored. The patient was placed in a compression bandage postoperatively, and rehabilitation protocols were initiated.

6. Procedure: Ganglion Bursectomy with Surgical Intervention

Operative Note:

A ganglion bursectomy was performed on the patient's knee under spinal anesthesia. The ganglion and associated bursa were carefully excised. Additionally, a surgical intervention was necessary to address a small meniscal tear that was identified during the procedure. The torn meniscus was trimmed and repaired. The patient tolerated the procedure well, and postoperative instructions were provided for pain management and rehabilitation.

7. Procedure: Ganglion Coagulation with Surgical Intervention

Operative Note:

Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery to achieve coagulation. Moreover, a surgical intervention was required to address a small nerve entrapment that was observed during the procedure. The entrapped nerve was released, providing relief to the patient. Postoperatively, the patient was instructed on wound care and given pain management guidelines.

8. Procedure: Ganglion Recurrence Excision with Surgical Intervention

Operative Note:

The patient presented with a recurrent ganglion on the dorsal aspect of the wrist. A repeat excision was performed, removing the ganglion completely. Additionally, a surgical intervention was necessary to address a small tendon adhesion that was discovered during the procedure. The adhesion

was carefully released, restoring normal tendon function. The wound was closed, and the patient was advised on postoperative care and follow-up evaluation.

9. Procedure: Ganglion Marsupialization with Surgical Intervention

Operative Note:

Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin, creating a permanent opening. Moreover, a surgical intervention was required to address a small joint capsule contracture that was identified during the procedure. The contracture was released, restoring normal joint range of motion. The patient was provided with postoperative instructions for wound care and rehabilitation.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention

Operative Note:

The patient presented with a ganglion arising from the scapholunate ligament. The ganglion and associated ligament were meticulously resected. Furthermore, a surgical intervention was necessary to address a small bone erosion that was discovered adjacent to the ganglion. The eroded bone was debrided and treated accordingly. The patient tolerated the procedure well, and postoperative care instructions were given for wound healing and rehabilitation.

1. Procedure: Ganglion Excision with Extensive Surgical Intervention

Operative Note:

A ganglion excision was performed on the patient's wrist under general anesthesia. The ganglion was carefully dissected and completely excised. Additionally, extensive surgical intervention was required to address a complex tendon injury and bone erosion associated with the ganglion. Tendon repair, bone grafting, and fixation were performed to restore function and stability. The wound was closed meticulously, and the patient was placed in a splint for immobilization and scheduled for postoperative rehabilitation.

2. Procedure: Ganglion Aspiration with Surgical Intervention for Joint Instability

Operative Note:

Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated from the ganglion, providing symptomatic relief. Moreover, a surgical intervention was necessary to address concurrent joint instability identified during the procedure. Ligament reconstruction and stabilization procedures were performed to restore joint integrity. Postoperatively, the patient was instructed on weight-bearing restrictions and referred for physical therapy.

3. Procedure: Ganglion Decompression with Surgical Intervention for Nerve Entrapment

Operative Note:

Ganglion decompression surgery was performed on the patient's hand under local anesthesia. The ganglion stalk was released to alleviate pressure and decompress the affected area. Additionally, a surgical intervention was required to address nerve entrapment caused by the ganglion. The entrapped nerve was meticulously released, providing relief to the patient. The wound was closed, and the patient was instructed on hand therapy exercises for nerve regeneration.

4. Procedure: Ganglion Biopsy with Surgical Intervention for Bone Fracture

Operative Note:

A ganglion biopsy was performed on the patient's foot under general anesthesia. The ganglion wall was excised for pathological examination. Furthermore, a surgical intervention was necessary to address an underlying bone fracture associated with the ganglion. The fracture was anatomically reduced and stabilized using internal fixation. The patient was immobilized postoperatively and instructed on weight-bearing restrictions for optimal fracture healing.

5. Procedure: Ganglion Resection with Surgical Intervention for Vascular Impingement

Operative Note:

Ganglion resection was performed on the patient's elbow under regional anesthesia. The ganglion and adjacent tissues were meticulously excised. Additionally, a surgical intervention was required to address vascular impingement caused by the ganglion. Vascular repair and reconstruction procedures were performed to restore blood flow. The wound was closed, and the patient was monitored closely for vascular compromise postoperatively.

6. Procedure: Ganglion Bursectomy with Surgical Intervention for Tendon Adhesion

Operative Note:

A ganglion bursectomy was performed on the patient's knee under spinal anesthesia. The ganglion and associated bursa were meticulously excised. Moreover, a surgical intervention was necessary to address a tendon adhesion caused by the ganglion. The adhesion was carefully released, allowing for normal tendon movement. The patient was provided with postoperative instructions for wound care and referred for physical therapy.

7. Procedure: Ganglion Coagulation with Surgical Intervention for Joint Contracture

Operative Note:

Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. Additionally, a surgical intervention was required to address a joint contracture associated with the ganglion. The contracture was released through capsular release and tenolysis procedures. The patient was instructed on postoperative hand therapy exercises to regain full joint range of motion.

8. Procedure: Ganglion Recurrence Excision with Surgical Intervention for Ligament Tear

Operative Note:

The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. Moreover

, a surgical intervention was necessary to address a ligament tear identified during the procedure. Ligament repair or reconstruction was performed to restore stability and function. The wound was closed meticulously, and the patient was placed in a splint for immobilization.

9. Procedure: Ganglion Marsupialization with Surgical Intervention for Tendon Rupture

Operative Note:

Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin to create a permanent opening. Furthermore, a surgical intervention was required to address a tendon rupture associated with the ganglion. Tendon repair or reconstruction was performed to restore normal function. The patient was instructed on postoperative weight-bearing restrictions and referred for physical therapy.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention for Joint Instability

Operative Note:

The patient presented with a ganglion arising from the wrist ligament. The ganglion and associated ligament were meticulously resected. Additionally, a surgical intervention was necessary to address joint instability caused by ligament laxity. Ligament reconstruction or stabilization procedures were performed to restore joint stability. Postoperatively, the patient was instructed on immobilization and referred for rehabilitation to regain full wrist function.

1. Procedure: Ganglion Excision with Surgical Intervention for Severe Joint Infection

Operative Note:

A ganglion excision was performed on the patient's elbow under general anesthesia. The ganglion and surrounding tissues were meticulously excised. Additionally, due to the presence of severe infection involving the extreme moving joint, a surgical intervention was necessary. Joint debridement, irrigation, and thorough cleansing were performed to eradicate the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for resolution of the infection.

2. Procedure: Ganglion Aspiration with Surgical Intervention for Septic Joint

Operative Note:

Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated, providing symptomatic relief. However, a surgical intervention was required due to the presence of a septic joint caused by the severe infection. Joint washout and debridement were performed to remove infected tissue and debris. Postoperatively, appropriate antibiotic therapy was initiated, and the patient was monitored closely for infection control.

3. Procedure: Ganglion Decompression with Surgical Intervention for Infected Joint

Operative Note:

Ganglion decompression surgery was performed on the patient's shoulder under general anesthesia. The ganglion stalk was released to alleviate pressure. Additionally, a surgical intervention was necessary to address the infected joint. Joint exploration, debridement, and irrigation were performed to remove infected tissues and promote healing. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for resolution of the joint infection.

4. Procedure: Ganglion Biopsy with Surgical Intervention for Extreme Joint Infection

Operative Note:

A ganglion biopsy was performed on the patient's ankle under regional anesthesia. The ganglion wall was excised for pathological examination. Furthermore, a surgical intervention was required to address an extreme joint infection. Joint debridement, thorough irrigation, and abscess drainage were performed to control the infection. Postoperatively, appropriate antibiotic therapy was initiated, and the patient was monitored for signs of infection resolution.

5. Procedure: Ganglion Resection with Surgical Intervention for Septic Arthritic Joint

Operative Note:

Ganglion resection was performed on the patient's hip under general anesthesia. The ganglion and surrounding tissues were meticulously resected. Additionally, a surgical intervention was necessary to address a septic arthritic joint caused by the severe infection. Joint debridement, synovectomy, and irrigation were performed to eradicate the infection and alleviate arthritic symptoms. Postoperatively, the patient was started on intravenous antibiotics and scheduled for close follow-up.

6. Procedure: Ganglion Bursectomy with Surgical Intervention for Infected Bursa and Joint

Operative Note:

A ganglion bursectomy was performed on the patient's knee under regional anesthesia. The ganglion and associated bursa were meticulously excised. Furthermore, a surgical intervention was required to address the presence of an infected bursa and joint. Bursal and joint debridement, thorough irrigation, and drainage were performed to control the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for infection resolution.

7. Procedure: Ganglion Coagulation with Surgical Intervention for Septic Extreme Joint

Operative Note:

Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. Additionally, a surgical intervention was required to address a septic extreme joint caused by the severe infection. Joint debridement, irrigation, and abscess drainage were performed to control the infection. Postoperatively, appropriate antibiotic therapy was initiated, and the patient was closely monitored for joint infection resolution.

8. Procedure: Gang

lion Recurrence Excision with Surgical Intervention for Infected Extreme Joint

Operative Note:

The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. Moreover, a surgical intervention was necessary to address the presence of an infected extreme joint. Joint exploration, debridement, and thorough irrigation were performed to control the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for joint infection resolution.

9. Procedure: Ganglion Marsupialization with Surgical Intervention for Septic Moving Joint

Operative Note:

Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin, creating a permanent opening. Additionally, a surgical intervention was necessary to address the septic moving joint caused by the severe infection. Joint debridement, irrigation, and abscess drainage were performed to control the infection. The patient was started on intravenous antibiotics and scheduled for close follow-up.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention for Infected Extreme Joint

Operative Note:

The patient presented with a ganglion arising from the knee ligament. The ganglion and associated ligament were meticulously resected. Furthermore, a surgical intervention was necessary to address the presence of an infected extreme joint. Joint debridement, synovectomy, and thorough irrigation were performed to control the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for joint infection resolution.

1. Procedure: Ganglion Excision with Surgical Intervention for Inflamed Joint

Operative Note:

A ganglion excision was performed on the patient's wrist under general anesthesia. The ganglion and surrounding tissues were meticulously excised. Additionally, a surgical intervention was necessary due to the presence of an inflamed joint. Joint debridement and irrigation were performed to alleviate inflammation and promote healing. Postoperatively, the patient was prescribed anti-inflammatory medications and instructed on proper joint immobilization.

2. Procedure: Ganglion Aspiration with Surgical Intervention for Acutely Inflamed Joint

Operative Note:

Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated, providing immediate relief. However, a surgical intervention was required due to acute inflammation in the joint. Joint debridement and irrigation were performed to reduce inflammation and improve joint function. Postoperatively, the patient was advised on pain management strategies and referred for physical therapy.

3. Procedure: Ganglion Decompression with Surgical Intervention for Chronically Inflamed Joint

Operative Note:

Ganglion decompression surgery was performed on the patient's shoulder under general anesthesia. The ganglion stalk was released to relieve pressure and compression. Additionally, a surgical intervention was necessary to address chronic inflammation in the joint. Synovectomy and joint debridement were performed to alleviate inflammation and improve joint mobility. Postoperatively, the patient was prescribed anti-inflammatory medications and instructed on rehabilitation exercises.

4. Procedure: Ganglion Biopsy with Surgical Intervention for Inflamed Bursa and Joint

Operative Note:

A ganglion biopsy was performed on the patient's ankle under regional anesthesia. The ganglion wall was excised for pathological examination. Furthermore, a surgical intervention was required to address inflammation in the bursa and joint. Bursal and joint debridement, irrigation, and synovectomy were performed to reduce inflammation and promote healing. Postoperatively, the patient was prescribed anti-inflammatory medications and advised on joint protection measures.

5. Procedure: Ganglion Resection with Surgical Intervention for Inflamed Arthritic Joint

Operative Note:

Ganglion resection was performed on the patient's hip under general anesthesia. The ganglion and surrounding tissues were meticulously resected. Additionally, a surgical intervention was necessary to address inflammation in the arthritic joint. Joint debridement, synovectomy, and irrigation were performed to reduce inflammation and alleviate arthritic symptoms. Postoperatively, the patient was prescribed anti-inflammatory medications and referred for rehabilitation.

6. Procedure: Ganglion Bursectomy with Surgical Intervention for Inflamed Bursa and Joint Capsule

Operative Note:

A ganglion bursectomy was performed on the patient's knee under regional anesthesia. The ganglion and associated bursa were meticulously excised. Furthermore, a surgical intervention was required to address inflammation in the bursa and joint capsule. Bursal and joint capsule debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint function. Postoperatively, the patient was prescribed anti-inflammatory medications and advised on activity modification.

7. Procedure: Ganglion Coagulation with Surgical Intervention for Inflamed Extreme Joint

Operative Note:

Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. Additionally, a surgical intervention was necessary to address inflammation in the extreme joint. Joint debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint mobility. Postoperatively, the patient was prescribed anti-inflammatory medications and instructed on joint protection techniques.

8. Procedure: Ganglion Recurrence Excision with Surgical Intervention for Inflamed Joint

Operative

Note:

The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. Moreover, a surgical intervention was necessary to address inflammation in the joint. Joint debridement, irrigation, and synovectomy were performed to alleviate inflammation and promote healing. Postoperatively, the patient was prescribed anti-inflammatory medications and referred for occupational therapy.

9. Procedure: Ganglion Marsupialization with Surgical Intervention for Inflamed Moving Joint

Operative Note:

Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin to create a permanent opening. Additionally, a surgical intervention was necessary to address inflammation in the moving joint. Joint debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint mobility. The patient was prescribed anti-inflammatory medications and instructed on joint protection measures.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention for Inflamed Extreme Joint

Operative Note:

The patient presented with a ganglion arising from the knee ligament. The ganglion and associated ligament were meticulously resected. Furthermore, a surgical intervention was necessary to address inflammation in the extreme joint. Joint debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint function. Postoperatively, the patient was prescribed anti-inflammatory medications and scheduled for follow-up evaluation.

1. Procedure: Ganglion Excision for Diagnosis of Benign Cyst

Operative Note:

Ganglion excision was performed on the patient's wrist under local anesthesia. The ganglion and surrounding tissues were meticulously excised. The diagnosis confirmed a benign cyst. Postoperatively, the patient was instructed to monitor the surgical site for signs of infection or recurrence. Follow-up evaluation was scheduled in six weeks unless any concerning symptoms arise.

2. Procedure: Ganglion Aspiration for Diagnosis of Ganglion Cyst

Operative Note:

Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated, confirming the diagnosis of a ganglion cyst. The patient experienced immediate relief. Postoperatively, the patient was advised to observe for any recurrence or worsening of symptoms. A follow-up appointment was scheduled in four weeks to monitor progress.

3. Procedure: Ganglion Decompression for Diagnosis of Ganglion Impingement

Operative Note:

Ganglion decompression surgery was performed on the patient's shoulder under general anesthesia. The ganglion stalk was released to alleviate impingement symptoms. The diagnosis confirmed ganglion impingement. Postoperatively, the patient was prescribed pain medication and advised to follow up in two weeks for a postoperative evaluation and assessment of symptoms.

4. Procedure: Ganglion Biopsy for Diagnostic Evaluation of Mass

Operative Note:

A ganglion biopsy was performed on the patient's ankle under regional anesthesia. The ganglion wall was excised for pathological examination to determine the nature of the mass. Postoperatively, the patient was instructed to rest and elevate the affected limb. The follow-up plan depended on the biopsy results, with a consultation scheduled in one week to discuss the findings and further treatment options.

5. Procedure: Ganglion Resection for Diagnosis of Ganglion Tumor

Operative Note:

Ganglion resection was performed on the patient's hip under general anesthesia. The ganglion and surrounding tissues were meticulously resected. The pathological evaluation confirmed the presence of a ganglion tumor. Postoperatively, the patient was referred to an oncology specialist for further evaluation and treatment. A follow-up appointment was scheduled to coordinate the ongoing care.

6. Procedure: Ganglion Bursectomy for Diagnosis of Bursal Inflammation

Operative Note:

A ganglion bursectomy was performed on the patient's knee under regional anesthesia. The ganglion and associated inflamed bursa were meticulously excised. The diagnosis revealed bursal inflammation. Postoperatively, the patient was prescribed anti-inflammatory medications and advised on activity modification. A follow-up appointment was scheduled in four weeks to assess the response to treatment.

7. Procedure: Ganglion Coagulation for Diagnosis of Ganglion Cystic Degeneration

Operative Note:

Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. The diagnosis confirmed ganglion cystic degeneration. Postoperatively, the patient was instructed on wound care and advised to monitor for any signs of infection or recurrence. A follow-up appointment was scheduled in six weeks unless any concerns arise.

8. Procedure: Ganglion Recurrence Excision for Diagnosis of Recurrent Ganglion Cyst

Operative Note:

The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. The diagnosis confirmed a recurrent ganglion cyst. Postoperatively, the patient was advised on activity restrictions and instructed to observe for any recurrence or persistent symptoms. A follow-up appointment was scheduled in two weeks for a wound check and assessment of symptoms.

9. Procedure: Ganglion Marsupialization for Diagnosis of Symptomatic Ganglion Cyst

Operative

Note:

Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin, creating a permanent opening. The diagnosis confirmed a symptomatic ganglion cyst. Postoperatively, the patient was prescribed pain medication and advised on self-care measures. A follow-up appointment was scheduled in four weeks to assess symptom improvement and wound healing.

10. Procedure: Ganglion Ligament Resection for Diagnosis of Ganglion-Associated Ligament Tear

Operative Note:

The patient presented with a ganglion arising from the knee ligament. The ganglion and associated ligament were meticulously resected. The diagnosis revealed a ganglion-associated ligament tear. Postoperatively, the patient was referred to physical therapy for rehabilitation and instructed to follow up in six weeks for a comprehensive evaluation of joint stability and functional recovery.

## M67.8 Other specified disorders of synovium and tendon

1. Operative Note: Patient presented with other specified disorder of synovium and tendon. A medial incision was made, allowing access to the affected area. Careful dissection revealed synovial thickening and tendon involvement. Debridement was performed, removing abnormal tissue. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including immobilization and physical therapy.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. A dorsal approach was utilized to access the affected site. Intraoperatively, synovial hypertrophy and tendon inflammation were observed. Partial synovectomy and tenotomy were performed to alleviate symptoms. Hemostasis was ensured, and the incision was closed. Postoperatively, the patient was advised on pain management and rehabilitation exercises.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. A lateral approach was chosen, providing optimal exposure. Intraoperative findings included synovial proliferation and tendon adhesions. The affected synovium was excised, and tenolysis was performed to restore tendon function. Hemostasis was confirmed, and the wound was sutured. The patient was instructed on postoperative care, including wound care and activity restrictions.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A volar approach was utilized to access the affected area. Intraoperatively, synovial thickening and tendon nodules were observed. Complete synovectomy and tenolysis were performed, followed by meticulous hemostasis. The wound was closed, and the patient received postoperative instructions for pain management and rehabilitation exercises.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon. An arthroscopic approach was employed, allowing visualization of the joint. Arthroscopy revealed synovial hypertrophy and tendon impingement. Synovectomy and tendon release were performed using specialized instruments. The joint was irrigated, and hemostasis was achieved. The incisions were closed, and the patient was educated on postoperative care, including physical therapy.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A mini-open approach was employed, providing access to the affected region. Intraoperative assessment revealed synovial inflammation and tendon thickening. Partial synovectomy and tendon debridement were performed, followed by meticulous hemostasis. The incision was closed, and the patient received postoperative instructions for wound care and gradual mobilization.

7. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. An endoscopic approach was chosen to minimize invasiveness. Endoscopy revealed synovial proliferation and tendon entrapment. Synovectomy and tenotomy were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient was counseled on postoperative care, including pain management and gradual return to normal activities.

8. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A posterior approach was employed, providing direct access to the affected site. Intraoperatively, synovial hyperplasia and tendon degeneration were observed. Synovectomy and tendon repair were performed, ensuring adequate hemostasis. The wound was closed, and the patient received postoperative instructions for immobilization and rehabilitation exercises.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon. An ultrasound-guided approach was employed for precise localization. Ultrasonography revealed synovial thickening and tendon adhesions. Synovectomy and tenolysis were performed

under ultrasound guidance. Hemostasis was ensured, and the wound was closed. The patient was educated on postoperative care, including pain management and gradual return to normal activities.

10. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. A transverse incision was made, providing exposure to the affected region. Intraoperatively, synovial inflammation and tendon contracture were noted. Synovectomy and tendon release were performed, followed by meticulous hemostasis. The incision was closed, and the patient was provided with postoperative instructions for wound care and physical therapy.

Certainly! Here are 10 additional synthetic operative notes pertaining to other specified disorders of synovium and tendon:

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. A subcutaneous approach was employed, allowing access to the affected area. Intraoperatively, synovial proliferation and tendon thickening were observed. Synovectomy and tenotomy were performed, followed by thorough hemostasis. The wound was closed, and postoperative instructions were provided, including immobilization and gradual range-of-motion exercises.

2. Operative Note: Patient presented with other specified disorder of synovium and tendon. An open approach was chosen to visualize the affected site. Intraoperative findings revealed synovial hypertrophy and tendon entrapment. Complete synovectomy and tendon release were performed, ensuring meticulous hemostasis. The incision was closed, and the patient received postoperative instructions for pain management and physical therapy.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A medial parapatellar approach was utilized, providing excellent exposure. Intraoperative assessment demonstrated synovial thickening and tendon degeneration. Partial synovectomy and tenodesis were performed, followed by appropriate hemostasis. The incision was closed, and the patient was educated on postoperative care, including wound care and gradual mobilization.

4. Operative Note: The patient underwent arthroscopic surgery for other specified disorder of synovium and tendon. Multiple portals were created, allowing thorough joint inspection. Arthroscopy revealed synovial hyperplasia and tendon adhesions. Extensive synovectomy and tenolysis were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions for pain management and rehabilitation exercises.

5. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A lateral transposition approach was employed, providing direct access to the affected region. Intraoperatively, synovial inflammation and tendon contracture were noted. Synovectomy and tendon repositioning were performed, ensuring adequate hemostasis. The incision was closed, and the patient was provided with postoperative instructions for wound care and gradual return to normal activities.

6. Operative Note: Patient presented with other specified disorder of synovium and tendon. An endoscopic-assisted approach was chosen, combining visualization techniques. Intraoperative assessment revealed synovial thickening and tendon impingement. Endoscopic synovectomy and tendon decompression were performed, followed by meticulous hemostasis. The incisions were closed, and the patient was educated on postoperative care, including pain management and physical therapy.

7. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. A mini-open approach was employed, allowing access to the affected area. Intraoperatively, synovial proliferation and tendon inflammation were observed. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for wound care and gradual rehabilitation.

8. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. A percutaneous approach was utilized, minimizing tissue trauma. Intraoperative findings included synovial hypertrophy and tendon thickening. Percutaneous synovectomy and tenolysis were performed, followed by meticulous hemostasis. The access points were closed, and the patient was counseled on postoperative care, including pain management and progressive mobilization.

9. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. An anterol

ateral approach was employed, providing excellent exposure to the affected site. Intraoperative assessment revealed synovial thickening and tendon degeneration. Complete synovectomy and tendon repair were performed, ensuring adequate hemostasis. The incision was closed, and the patient received postoperative instructions for wound care and gradual return to normal activities.

10. Operative Note: Patient presented with other specified disorder of synovium and tendon. An ultrasonography-guided approach was utilized to precisely target the pathology. Ultrasonographic findings revealed synovial hyperplasia and tendon adhesions. Synovectomy and tenolysis were performed under ultrasound guidance, with meticulous hemostasis achieved. The incision was closed, and the patient was provided with postoperative instructions for pain management and a tailored rehabilitation program.

Certainly! Here are 10 additional synthetic operative notes pertaining to other specified disorders of synovium and tendon, with variations in anesthesia dosage:

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under general anesthesia. A dorsal approach was utilized, providing access to the affected area. Intraoperatively, synovial thickening and tendon involvement were observed. Debridement was performed while maintaining a moderate level of anesthesia. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including immobilization and physical therapy.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. The procedure was performed under regional anesthesia, with a peripheral nerve block targeting the affected area. A lateral approach was chosen, allowing visualization of the pathology. Intraoperative findings revealed synovial hypertrophy and tendon adhesions. Partial synovectomy and tenotomy were performed while maintaining an appropriate level of anesthesia. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for pain management and rehabilitation exercises.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under local anesthesia with conscious sedation. An arthroscopic approach was employed, providing visualization of the joint. Arthroscopy revealed synovial proliferation and tendon impingement. Synovectomy and tendon release were performed while closely monitoring the patient's sedation level. The joint was irrigated, and hemostasis was achieved. The incisions were closed, and the patient was educated on postoperative care, including pain management and gradual return to normal activities.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. The procedure was performed under monitored anesthesia care (MAC) with deep sedation. A volar approach was chosen, allowing access to the affected region. Intraoperative findings included synovial thickening and tendon nodules. Complete synovectomy and tenolysis were performed while closely monitoring the patient's sedation depth. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided for pain management and rehabilitation.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon. The surgery was performed under general anesthesia with neuromuscular blockade. An endoscopic approach was employed, providing excellent visualization. Intraoperative assessment revealed synovial hyperplasia and tendon entrapment. Synovectomy and tenotomy were performed while maintaining appropriate muscle relaxation. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions for pain management and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The procedure was performed under regional anesthesia with intravenous sedation. A mini-open approach was employed, providing access to the affected area. Intraoperative assessment revealed synovial inflammation and tendon thickening. Partial synovectomy and tendon debridement were performed while maintaining a moderate level of sedation. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for wound care and gradual mobilization.

7. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under local anesthesia. An ultrasound-guided approach was employed for precise localization. Ultrasonography revealed synovial thickening and tendon adhesions. Synovectomy and tenolysis were performed under local anesthesia, with the patient remaining awake and comfortable throughout the procedure. Hemostasis was achieved, and the wound was closed. The patient was educated on postoperative care, including pain management and gradual return to normal activities.

8. Oper

ative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. The procedure was performed under general anesthesia with balanced anesthesia technique. A posterior approach was employed, providing direct access to the affected site. Intraoperative findings revealed synovial hyperplasia and tendon degeneration. Synovectomy and tendon repair were performed while carefully monitoring the patient's anesthetic depth. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for immobilization and rehabilitation exercises.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon. The surgery was performed under regional anesthesia with light sedation. An open approach was chosen to visualize the affected site. Intraoperative findings included synovial proliferation and tendon inflammation. Complete synovectomy and tenodesis were performed while maintaining a light level of sedation. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions for wound care and gradual return to normal activities.

10. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under general anesthesia with controlled hypotension. A subcutaneous approach was employed, allowing access to the affected area. Intraoperatively, synovial proliferation and tendon degeneration were observed. Partial synovectomy and tenolysis were performed while maintaining controlled hypotension to minimize bleeding. Hemostasis was ensured, and the wound was closed. The patient was provided with postoperative instructions for pain management and a tailored rehabilitation program.

Certainly! Here are 10 additional synthetic operative notes pertaining to other specified disorders of synovium and tendon, with bone erosion included:

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon with associated bone erosion. A medial incision was made, allowing access to the affected area. Intraoperatively, synovial thickening, tendon involvement, and bone erosion were observed. Debridement was performed to remove abnormal tissue, including the eroded bone fragments. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including immobilization, physical therapy, and appropriate measures to address bone healing.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon, complicated by bone erosion. A dorsal approach was utilized, providing access to the affected region. Intraoperative findings included synovial hypertrophy, tendon adhesions, and bone erosion. Synovectomy, tenolysis, and bone debridement were performed to address the pathology. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided, emphasizing the importance of bone healing and rehabilitation exercises.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, with significant bone erosion. An arthroscopic approach was employed to visualize the joint and associated pathology. Arthroscopy revealed synovial proliferation, tendon impingement, and bone erosion. Synovectomy, tendon release, and bone debridement were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including bone healing support and rehabilitation to restore joint function.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by extensive bone erosion. A lateral approach was chosen to address the pathology. Intraoperative assessment revealed synovial thickening, tendon contracture, and bone erosion. Complete synovectomy, tenodesis, and bone grafting were performed to restore joint stability and address the bone erosion. Hemostasis was achieved, and the incision was closed. Postoperative instructions were provided for bone healing, physical therapy, and gradual return to normal activities.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon, with significant bone erosion. An open approach was employed to address the pathology comprehensively. Intraoperatively, synovial hyperplasia, tendon thickening, and bone erosion were observed. Partial synovectomy, tenotomy, and bone debridement were performed to remove the diseased tissues. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, including bone healing support, wound care, and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon, complicated by extensive bone erosion. A volar approach was chosen to access the affected area. Intraoperative findings included synovial inflammation, tendon nodules, and bone erosion. Complete synovectomy, tenolysis, and bone repair were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided, emphasizing bone healing, immobilization, and gradual restoration of joint function.

7. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, with significant bone erosion. An endoscopic approach was employed, combining visualization techniques to address the pathology. Intraoperative assessment revealed synovial proliferation, tendon entrapment, and bone erosion. Endoscopic synovectomy, tendon release, and bone debridement were performed to restore joint integrity. Hemostasis

was achieved, and the incisions were closed. The patient received postoperative instructions, including bone healing support, pain management, and rehabilitation exercises.

8. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by severe bone erosion. The procedure was performed under general anesthesia, and a posterior approach was employed to access the affected site. Intraoperative findings included synovial hypertrophy, tendon inflammation, and extensive bone erosion. Complete synovectomy, tenodesis, and bone grafting were performed to address the pathology comprehensively. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions, including bone healing support, physical therapy, and gradual return to normal activities.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon, with significant bone erosion. The surgery was performed under regional anesthesia, with a peripheral nerve block targeting the affected area. A mini-open approach was chosen to visualize the pathology. Intraoperative findings revealed synovial thickening, tendon degeneration, and bone erosion. Partial synovectomy, tenolysis, and bone debridement were performed while closely monitoring the patient's comfort and addressing the bone erosion. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for bone healing support, wound care, and rehabilitation exercises.

10. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, complicated by significant bone erosion. The procedure was performed under general anesthesia, with controlled hypotension to minimize bleeding from the eroded bone. An anterolateral approach was employed, providing direct access to the affected region. Intraoperative assessment revealed synovial hyperplasia, tendon adhesions, and bone erosion. Complete synovectomy, tenodesis, and bone repair were performed while maintaining controlled hypotension. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions for bone healing support, pain management, and a tailored rehabilitation program.

Certainly! Here are 10 additional synthetic operative notes pertaining to other specified disorders of synovium and tendon, with the inclusion of severe bone pain:

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, complicated by severe bone pain. A medial approach was utilized, providing access to the affected area. Intraoperatively, synovial thickening, tendon involvement, and significant bone erosion were observed. Debridement was performed to remove the diseased tissue, including the eroded bone fragments. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including pain management strategies, immobilization, and rehabilitation exercises.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon, with associated severe bone pain. A dorsal approach was employed, allowing visualization of the affected region. Intraoperative findings included synovial hypertrophy, tendon adhesions, and bone erosion. Synovectomy, tenolysis, and bone debridement were performed to address the pathology and alleviate the severe bone pain. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided, emphasizing pain control measures, bone healing support, and rehabilitation.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, with severe bone pain. An arthroscopic approach was employed, providing excellent visualization of the joint and associated pathology. Arthroscopy revealed synovial proliferation, tendon impingement, and significant bone erosion contributing to the severe bone pain. Synovectomy, tendon release, and bone debridement were performed to alleviate the pain and address the underlying pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies and tailored rehabilitation exercises.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by severe bone pain. A lateral approach was chosen to address the pathology and alleviate the pain. Intraoperative assessment revealed synovial thickening, tendon contracture, and severe bone erosion causing significant pain. Complete synovectomy, tenodesis, bone grafting, and nerve decompression were performed to relieve the severe bone pain and restore joint stability. Hemostasis was achieved, and the incision was closed. Postoperative instructions were provided, focusing on pain management, bone healing, and rehabilitation.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon, accompanied by severe bone pain. An open approach was employed to address the pathology and alleviate the pain comprehensively. Intraoperative findings included synovial hyperplasia, tendon thickening, and severe bone erosion contributing to the severe bone pain. Partial synovectomy, tenotomy, bone debridement, and nerve decompression were performed to alleviate the severe bone pain and restore function. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing pain management strategies, wound care, and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon, complicated by severe bone pain. A volar approach was chosen to address the pathology and alleviate the pain effectively. Intraoperative findings included synovial inflammation, tendon nodules, and severe bone erosion contributing to the severe bone pain. Complete synovectomy, tenolysis, bone repair, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided, focusing on pain management, bone healing support, and rehabilitation exercises.

7. Operative Note: The patient underwent

surgery for other specified disorder of synovium and tendon, with severe bone pain. An endoscopic approach was employed, combining visualization techniques to address the pathology and alleviate the pain. Intraoperative assessment revealed synovial proliferation, tendon entrapment, and severe bone erosion contributing to the severe bone pain. Endoscopic synovectomy, tendon release, bone debridement, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was achieved, and the incisions were closed. The patient received postoperative instructions, including pain management strategies, bone healing support, and tailored rehabilitation program.

8. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by severe bone pain. The procedure was performed under general anesthesia, with controlled hypotension to minimize intraoperative pain. A posterior approach was employed to access the affected site and alleviate the severe bone pain. Intraoperative findings included synovial hypertrophy, tendon inflammation, and severe bone erosion contributing to the severe bone pain. Complete synovectomy, tenodesis, bone grafting, and nerve decompression were performed to alleviate the severe bone pain and restore joint stability. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions, emphasizing pain management strategies, bone healing support, and a tailored rehabilitation program.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon, accompanied by severe bone pain. The surgery was performed under regional anesthesia, with intravenous analgesia to ensure pain control throughout the procedure. A mini-open approach was chosen to visualize the pathology and alleviate the severe bone pain. Intraoperative findings revealed synovial thickening, tendon degeneration, and severe bone erosion contributing to the severe bone pain. Partial synovectomy, tenolysis, bone debridement, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, focusing on pain management strategies, bone healing support, and rehabilitation exercises.

10. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, complicated by severe bone pain. The procedure was performed under general anesthesia, with adequate analgesia to alleviate the severe bone pain during the operation. An anterolateral approach was employed to access the affected region and address the severe bone pain effectively. Intraoperative assessment revealed synovial hyperplasia, tendon adhesions, and severe bone erosion contributing to the severe bone pain. Complete synovectomy, tenodesis, bone repair, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing pain management strategies, bone healing support, and a tailored rehabilitation program.

Certainly! Here are 10 additional synthetic operative notes pertaining to other specified disorders of synovium and tendon, with surgical intervention mentioned:

1. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. A posterior approach was chosen to access the affected area. Intraoperative findings included synovial hypertrophy and tendon degeneration. Complete synovectomy and tendon repair were performed to address the pathology. Hemostasis was achieved, and the wound was closed. The patient received postoperative instructions for immobilization and rehabilitation exercises.

2. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. An open approach was employed, providing direct access to the affected site. Intraoperative findings revealed synovial proliferation and tendon inflammation. Synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the incision was closed. The patient received postoperative instructions for wound care and gradual return to normal activities.

3. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening and tendon impingement. Synovectomy and tendon release were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including immobilization, physical therapy, and gradual return to normal activities.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A lateral approach was chosen to address the pathology. Intraoperative assessment revealed synovial hyperplasia and tendon contracture. Complete synovectomy and tenolysis were performed to remove the diseased tissues. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided for pain management and a tailored rehabilitation program.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon, requiring surgical intervention. An open approach was employed to comprehensively address the pathology. Intraoperative findings included synovial inflammation and tendon nodules. Partial synovectomy and tenotomy were performed to remove the diseased tissues. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, including wound care and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A volar approach was chosen to access the affected area. Intraoperative findings included synovial hyperplasia and tendon adhesions. Complete synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided for pain management and a tailored rehabilitation program.

7. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative assessment revealed synovial proliferation and tendon entrapment. Endoscopic synovectomy and tendon release were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies and rehabilitation exercises.

8. Operative Note: Other specified disorder of synovium and tendon required surgical intervention. The procedure was performed under general anesthesia. A posterior approach was employed, providing direct access to the affected region. Intraoperative findings included synovial hypertrophy and tendon inflammation. Synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for wound care and rehabilitation exercises.

9. Operative Note:

Patient presented with other specified disorder of synovium and tendon, necessitating surgical intervention. An open approach was chosen to access the affected area. Intraoperative findings revealed synovial thickening and tendon degeneration. Partial synovectomy and tendon repair were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for immobilization and gradual return to normal activities.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An arthroscopic approach was employed, providing excellent visualization of the joint and associated pathology. Arthroscopy revealed synovial proliferation and tendon impingement. Synovectomy and tendon release were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies, immobilization, and rehabilitation exercises.

Certainly! Here are 10 more synthetic operative notes pertaining to other specified disorders of synovium and tendon:

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. A medial approach was chosen to access the affected area. Intraoperative findings included synovial hypertrophy and tendon inflammation. Complete synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given for pain management, immobilization, and gradual return to normal activities.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. A dorsal approach was employed to access the affected region. Intraoperative findings revealed synovial thickening and tendon adhesions. Synovectomy and tenolysis were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for wound care, pain management, and a tailored rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. An endoscopic approach was utilized to visualize the joint and associated pathology. Intraoperative findings included synovial hyperplasia and tendon degeneration. Endoscopic synovectomy and tenotomy were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies, immobilization, and rehabilitation exercises.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An anterolateral approach was chosen to access the affected site. Intraoperative assessment revealed synovial inflammation and tendon nodules. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. Postoperative instructions were provided for pain management, wound care, and a tailored rehabilitation program.

5. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A volar approach was employed to access the affected area. Intraoperative findings included synovial proliferation and tendon contracture. Complete synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the wound was closed. The patient received postoperative instructions for pain management, immobilization, and a tailored rehabilitation program.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An open approach was chosen to address the pathology. Intraoperative findings revealed synovial hyperplasia and tendon entrapment. Partial synovectomy and tendon release were performed to address the pathology. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided for pain management, wound care, and rehabilitation exercises.

7. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The procedure was performed under general anesthesia. A lateral approach was employed to access the affected region. Intraoperative findings included synovial hypertrophy and tendon inflammation. Synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for immobilization, pain management, and gradual return to normal activities.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening and tendon impingement. Synovectomy and tendon repair were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received post

operative instructions, including pain management strategies, immobilization, and tailored rehabilitation exercises.

9. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial proliferation and tendon adhesions. Endoscopic synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing pain management, immobilization, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. A posterior approach was chosen to access the affected area. Intraoperative findings revealed synovial inflammation and tendon degeneration. Complete synovectomy and tenotomy were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for pain management, wound care, and a tailored rehabilitation program.

Certainly! Here are 10 synthetic operative notes pertaining to other specified disorders of synovium and tendon with a severe infection on the extreme moving joint:

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. The procedure was performed under general anesthesia. An open approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy, tendon inflammation, and evidence of severe infection. Extensive synovectomy, tendon debridement, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was achieved, and the wound was closed. Postoperative instructions included antibiotics, wound care, and a tailored rehabilitation program.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, tendon adhesions, and evidence of severe infection. Arthroscopic synovectomy, tenolysis, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including antibiotics, immobilization, and a rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. A medial approach was chosen to access the affected area. Intraoperative findings included synovial hyperplasia, tendon degeneration, and evidence of severe infection. Complete synovectomy, tendon repair, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing antibiotics, wound care, and a tailored rehabilitation program.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial proliferation, tendon entrapment, and evidence of severe infection. Endoscopic synovectomy, tendon release, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including antibiotics, pain management, and rehabilitation exercises.

5. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. The procedure was performed under general anesthesia. A posterior approach was employed to access the affected region. Intraoperative findings included synovial inflammation, tendon nodules, and evidence of severe infection. Partial synovectomy, tenodesis, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was confirmed, and the wound was closed. Postoperative instructions included antibiotics, wound care, and immobilization.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An open approach was chosen to comprehensively address the pathology and control the infection. Intraoperative findings included synovial hyperplasia, tendon contracture, and evidence of severe infection. Complete synovectomy, tenolysis, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing antibiotics, wound care, and a tailored rehabilitation program.

7. Operative Note:

Surgical intervention was necessary for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An anterolateral approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy, tendon inflammation, and evidence of severe infection. Partial synovectomy, tenodesis, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, including antibiotics, pain management, and a tailored rehabilitation program.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, tendon impingement, and evidence of severe infection. Arthroscopic synovectomy, tendon repair, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing antibiotics, wound care, and a tailored rehabilitation program.

9. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. A volar approach was employed to access the affected area. Intraoperative findings included synovial proliferation, tendon adhesions, and evidence of severe infection. Complete synovectomy, tenolysis, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was ensured, and the wound was closed. The patient received postoperative instructions, including antibiotics, pain management, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An open approach was chosen to address the pathology and control the infection. Intraoperative findings included synovial hyperplasia, tendon degeneration, and evidence of severe infection. Partial synovectomy, tendon debridement, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the wound was closed. Postoperative instructions included antibiotics, wound care, pain management, and a tailored rehabilitation program.

Certainly! Here are 10 synthetic operative notes pertaining to other specified disorders of synovium and tendon with variation in inflammation:

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with severe inflammation. An open approach was employed to access the affected area. Intraoperative findings revealed marked synovial hypertrophy, tendon inflammation, and extensive inflammation of the surrounding tissues. Complete synovectomy, tendon repair, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions included anti-inflammatory medication, wound care, and a tailored rehabilitation program.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with moderate inflammation. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, mild tendon inflammation, and localized inflammation within the joint. Arthroscopic synovectomy, tenodesis, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including anti-inflammatory medication, wound care, and a tailored rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with minimal inflammation. A medial approach was chosen to access the affected area. Intraoperative findings included mild synovial hypertrophy, minimal tendon inflammation, and absence of significant inflammation in the surrounding tissues. Partial synovectomy, tenolysis, and irrigation were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing pain management, wound care, and a tailored rehabilitation program.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with severe inflammation. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings revealed extensive synovial hyperplasia, severe tendon inflammation, and significant inflammation within the joint capsule. Endoscopic synovectomy, tendon release, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including anti-inflammatory medication, pain management, and rehabilitation exercises.

5. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with moderate inflammation. The procedure was performed under general anesthesia. A posterior approach was employed to access the affected region. Intraoperative findings included moderate synovial inflammation, tendon nodules, and localized inflammation within the joint. Partial synovectomy, tenodesis, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. Postoperative instructions included anti-inflammatory medication, wound care, and immobilization.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with minimal inflammation. An open approach was chosen to comprehensively address the pathology. Intraoperative findings revealed mild synovial hypertrophy, minimal tendon inflammation, and absence of significant inflammation in the surrounding tissues. Complete synovectomy, tenolysis, and irrigation were performed to address the pathology. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing pain management, wound care, and a tailored rehabilitation program.

7. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with severe inflammation. An anterolateral approach was employed to access the affected area. Intraoperative findings included marked synovial hyperplasia, severe tendon inflammation, and diffuse inflammation within the joint. Partial synovectomy,

tenodesis, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, including anti-inflammatory medication, pain management, and a tailored rehabilitation program.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with moderate inflammation. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, moderate tendon inflammation, and localized inflammation within the joint. Arthroscopic synovectomy, tendon repair, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including anti-inflammatory medication, wound care, and a tailored rehabilitation program.

9. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with minimal inflammation. A volar approach was employed to access the affected area. Intraoperative findings included mild synovial proliferation, minimal tendon inflammation, and absence of significant inflammation in the surrounding tissues. Complete synovectomy, tenolysis, and irrigation were performed to address the pathology. Hemostasis was ensured, and the wound was closed. The patient received postoperative instructions, emphasizing pain management, wound care, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with severe inflammation. An open approach was chosen to address the pathology. Intraoperative findings included marked synovial hypertrophy, severe tendon inflammation, and extensive inflammation of the surrounding tissues. Partial synovectomy, tendon debridement, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions included anti-inflammatory medication, wound care, pain management, and a tailored rehabilitation program.

Certainly! Here are 10 synthetic operative notes pertaining to other specified disorders of synovium and tendon, where the follow-up depends on the severity of the diagnosis:

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. The severity of the diagnosis necessitates close follow-up with the patient. An open approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy and tendon degeneration. Complete synovectomy and tenotomy were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions included regular follow-up visits, pain management, and a tailored rehabilitation program.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Due to the severity of the diagnosis, frequent follow-up appointments are essential. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening and tendon adhesions. Arthroscopic synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, and a tailored rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The severity of the diagnosis warrants an intensive follow-up plan. A medial approach was chosen to access the affected area. Intraoperative findings included synovial proliferation and tendon inflammation. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing close monitoring with regular follow-up visits, pain management, and a tailored rehabilitation program.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Given the severity of the diagnosis, a comprehensive follow-up strategy is crucial. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial hyperplasia and tendon degeneration. Endoscopic synovectomy and tenotomy were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing frequent follow-up visits, pain management, and a tailored rehabilitation program.

5. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. The severity of the diagnosis necessitates a diligent follow-up plan. An open approach was chosen to comprehensively address the pathology. Intraoperative findings included synovial hyperplasia and tendon contracture. Complete synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. Postoperative instructions included regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Given the severity of the diagnosis, a structured follow-up protocol is crucial. An anterolateral approach was employed to access the affected area. Intraoperative findings included synovial inflammation and tendon entrapment. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

7. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The severity of the diagnosis requires frequent follow-up assessments. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thick

ening and tendon inflammation. Arthroscopic synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Due to the severity of the diagnosis, a strict follow-up schedule is imperative. A volar approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy and tendon degeneration. Complete synovectomy and tenotomy were performed to address the pathology. Hemostasis was ensured, and the wound was closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

9. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. The severity of the diagnosis mandates close monitoring through regular follow-up visits. An open approach was chosen to comprehensively address the pathology. Intraoperative findings included synovial hyperplasia and tendon adhesions. Partial synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. Postoperative instructions included regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Given the severity of the diagnosis, a meticulous follow-up plan is essential. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial proliferation and tendon inflammation. Endoscopic synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

## M67.9 Disorder of synovium and tendon, unspecified

1. Operative Note: Patient underwent a synovectomy and tendon repair for synovium and tendon disorder. The synovium was excised using arthroscopic techniques, followed by meticulous debridement of the affected tendon. Tendon repair was performed using sutures to restore its integrity. The procedure was successful, and the patient was advised postoperative rehabilitation for optimal recovery.

2. Operative Note: A patient presented with a disorder of the synovium and tendon, necessitating surgical intervention. An open synovectomy was performed, with careful excision of the diseased synovial tissue. Concurrently, the affected tendon was repaired using suture techniques. Intraoperative findings revealed synovial hypertrophy and tendon inflammation. The procedure concluded without complications, and the patient was referred for postoperative physical therapy.

3. Operative Note: This operative intervention addressed a synovium and tendon disorder. Through arthroscopic means, the synovial tissue was meticulously resected, alleviating the inflammatory process. Additionally, the affected tendon was repaired with sutures, aiming to restore its function. The patient tolerated the procedure well, and follow-up consultations were scheduled to assess their progress and implement a suitable rehabilitation program.

4. Operative Note: Surgical management was pursued to address a synovium and tendon disorder in the patient. An open synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, the involved tendon underwent meticulous debridement and repair with sutures. Intraoperatively, evidence of synovial hyperplasia and tendon degeneration was noted. The patient's postoperative course was uneventful, and they were referred for physiotherapy to optimize their recovery.

5. Operative Note: A synovectomy and tendon repair were conducted to address the patient's synovium and tendon disorder. Utilizing arthroscopic techniques, the diseased synovium was meticulously excised, alleviating the inflammation. Simultaneously, the damaged tendon underwent thorough debridement and repair using sutures. Intraoperative findings confirmed synovial proliferation and tendon degeneration. The patient was discharged with appropriate postoperative care instructions and scheduled for follow-up visits.

6. Operative Note: The patient underwent surgical intervention for a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided, followed by repair using sutures. Intraoperative examination revealed synovial hypertrophy and tendon degeneration. The patient's postoperative recovery was uneventful, and a comprehensive rehabilitation program was recommended to optimize functional outcomes.

7. Operative Note: This operative procedure addressed the patient's disorder of the synovium and tendon. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon was meticulously debrided and repaired using sutures. Intraoperatively, synovial proliferation and tendon inflammation were noted. The patient tolerated the surgery well, and postoperative physical therapy was initiated to facilitate their recovery.

8. Operative Note: The patient underwent surgery to address a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed to excise the hypertrophic synovial tissue. Concurrently, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient was discharged with appropriate postoperative instructions and advised to follow up for rehabilitation and further evaluation of their condition.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting the synovium and tendon. An open synovectomy was performed, meticulously removing the hypertrophic synovial

tissue. Concurrently, the damaged tendon underwent debridement and repair utilizing sutures. Intraoperative examination revealed synovial hyperplasia and tendon inflammation. The patient recovered well postoperatively and was referred for physical therapy to optimize their functional recovery.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures. Intraoperatively, synovial hypertrophy and tendon degeneration were noted. The patient's postoperative course was uncomplicated, and they were advised to participate in a rehabilitation program for improved outcomes.

1. Operative Note: The patient underwent surgical intervention for a synovium and tendon disorder. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, the affected tendon was meticulously debrided and repaired using suture techniques. Intraoperative findings revealed synovial inflammation and tendon degeneration. The patient tolerated the procedure well, and postoperative rehabilitation was recommended for optimal recovery.

2. Operative Note: A synovium and tendon disorder in the patient necessitated surgical management. An open synovectomy was performed, excising the pathologic synovial tissue. The damaged tendon underwent meticulous debridement and repair using sutures. Intraoperative examination confirmed synovial proliferation and tendon inflammation. The patient's postoperative course was uneventful, and they were advised to follow up for further evaluation and rehabilitation.

3. Operative Note: This operative intervention addressed a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed to remove the hypertrophic synovial tissue, reducing inflammation. Concurrently, the affected tendon was meticulously debrided and repaired with sutures. Intraoperatively, evidence of synovial hypertrophy and tendon degeneration was observed. The patient's recovery was satisfactory, and a comprehensive rehabilitation program was recommended.

4. Operative Note: Surgical management was pursued to address a synovium and tendon disorder in the patient. An open synovectomy was performed, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's postoperative course was smooth, and they were referred for physiotherapy to optimize their recovery.

5. Operative Note: A synovectomy and tendon repair were conducted to address the patient's synovium and tendon disorder. Utilizing arthroscopic techniques, the diseased synovium was meticulously excised, alleviating the inflammation. Simultaneously, the damaged tendon underwent thorough debridement and repair using sutures. Intraoperative findings confirmed synovial proliferation and tendon degeneration. The patient's postoperative recovery was satisfactory, and they were advised on postoperative care measures.

6. Operative Note: The patient underwent surgical intervention for a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided, followed by repair using sutures. Intraoperative examination revealed synovial hypertrophy and tendon degeneration. The patient's postoperative recovery was uneventful, and a comprehensive rehabilitation program was recommended to optimize functional outcomes.

7. Operative Note: This operative procedure addressed the patient's disorder of the synovium and tendon. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon was meticulously debrided and repaired using sutures. Intraoperatively, synovial proliferation and tendon inflammation were noted. The patient tolerated the surgery well, and postoperative physical therapy was initiated to facilitate their recovery.

8. Operative Note: The patient underwent surgery to address a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed to excise the hypertrophic synovial tissue. Concurrently, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's postoperative course was unremarkable, and they were discharged with instructions for postoperative rehabilitation.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting the synovium and tendon. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue. Concurrently, the damaged tendon underwent debridement and repair utilizing sutures. Intraoperative examination revealed synovial hyperplasia and tendon inflammation. The patient's postoperative recovery was smooth, and they were advised to follow up for rehabilitation and further evaluation of their condition.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures. Intraoperatively, synovial hypertrophy and tendon degeneration were noted. The patient's postoperative course was satisfactory, and they were recommended to participate in a structured rehabilitation program for optimal outcomes.

1. Operative Note: The patient underwent surgical intervention for a synovium and tendon disorder under general anesthesia. Arthroscopic synovectomy was performed with appropriate anesthesia dosage, excising the hypertrophic synovial tissue. Concurrently, the affected tendon was meticulously debrided and repaired using sutures. Intraoperative findings revealed synovial inflammation and tendon degeneration. The patient's vital signs remained stable throughout the procedure, and postoperative pain control was achieved using a suitable analgesic regimen.

2. Operative Note: A synovium and tendon disorder in the patient necessitated surgical management under regional anesthesia. An open synovectomy was performed, with the anesthesia dosage tailored to the patient's needs, excising the pathologic synovial tissue. The damaged tendon underwent meticulous debridement and repair using sutures. Intraoperative examination confirmed synovial proliferation and tendon inflammation. The patient's anesthesia experience was uneventful, and they were referred for postoperative pain management.

3. Operative Note: This operative intervention addressed a disorder involving the synovium and tendon under local anesthesia. Arthroscopic synovectomy was performed using an appropriate anesthesia dosage, excising the hypertrophic synovial tissue and reducing inflammation. Concurrently, the affected tendon was meticulously debrided and repaired with sutures. Intraoperatively, evidence of synovial hypertrophy and tendon degeneration was observed. The patient remained comfortable throughout the procedure, and postoperative pain control measures were implemented.

4. Operative Note: Surgical management was pursued to address a synovium and tendon disorder in the patient under conscious sedation. An open synovectomy was performed with a carefully titrated anesthesia dosage, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's sedation level was appropriately maintained, ensuring their comfort and cooperation during the procedure.

5. Operative Note: A synovectomy and tendon repair were conducted to address the patient's synovium and tendon disorder under general anesthesia. Utilizing arthroscopic techniques with the appropriate anesthesia dosage, the diseased synovium was meticulously excised, alleviating inflammation. Simultaneously, the damaged tendon underwent thorough debridement and repair using sutures. Intraoperative findings confirmed synovial proliferation and tendon degeneration. The patient's anesthesia was well-managed, and postoperative pain control measures were implemented.

6. Operative Note: The patient underwent surgical intervention for a disorder involving the synovium and tendon under regional anesthesia. Arthroscopic synovectomy was performed, with the anesthesia dosage tailored to the patient's needs, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided and repaired using sutures. Intraoperative examination revealed synovial hypertrophy and tendon degeneration. The patient remained comfortable and cooperative throughout the procedure, and appropriate postoperative pain management was provided.

7. Operative Note: This operative procedure addressed the patient's disorder of the synovium and tendon under local anesthesia with monitored anesthesia care. An open synovectomy was performed using a carefully titrated anesthesia dosage, removing the pathologic synovial tissue. The involved tendon was meticulously debrided and repaired with sutures. Intraoperatively, synovial proliferation and tendon inflammation were noted. The patient was awake and responsive during the surgery, and postoperative pain control measures were implemented.

8. Operative Note: The patient underwent surgery to address a disorder involving the synovium

and tendon under general anesthesia with controlled depth. Arthroscopic synovectomy was performed with the appropriate anesthesia dosage, excising the hypertrophic synovial tissue. Concurrently, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's anesthesia was well-maintained throughout the procedure, and postoperative pain management was initiated.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting the synovium and tendon under local anesthesia with sedation. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue, with the anesthesia dosage adjusted to maintain patient comfort. Concurrently, the damaged tendon underwent debridement and repair utilizing sutures. Intraoperative examination revealed synovial hyperplasia and tendon inflammation. The patient remained relaxed and pain-free during the procedure, and suitable postoperative pain control measures were implemented.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving the synovium and tendon under general anesthesia with an emphasis on minimizing dosage. Arthroscopic synovectomy was performed, excising the pathological synovial tissue while closely monitoring the patient's anesthesia depth. The affected tendon underwent meticulous debridement and repair using sutures. Intraoperatively, synovial hypertrophy and tendon degeneration were noted. The patient's anesthesia was carefully managed to ensure their well-being, and appropriate postoperative pain management was initiated.

1. Operative Note: The patient underwent surgical intervention for a synovium, tendon, and bone erosion disorder. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, meticulous debridement and repair of the affected tendon were conducted using sutures. Additionally, bone erosion was addressed through bone grafting and stabilization. Intraoperative findings revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with appropriate rehabilitation and follow-up imaging planned.

2. Operative Note: A synovium, tendon, and bone erosion disorder in the patient necessitated surgical management. An open synovectomy was performed, excising the pathologic synovial tissue. The damaged tendon underwent meticulous debridement and repair using sutures, with concurrent bone grafting and stabilization to address bone erosion. Intraoperative examination confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative recovery was closely monitored, and appropriate measures were taken to ensure bone healing and functional restoration.

3. Operative Note: This operative intervention addressed a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, meticulously excising the hypertrophic synovial tissue. Concurrently, the affected tendon was debrided and repaired using sutures, while bone erosion was addressed through bone grafting and stabilization. Intraoperative findings revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing and rehabilitation to optimize outcomes.

4. Operative Note: Surgical management was pursued to address a synovium, tendon, and bone erosion disorder in the patient. An open synovectomy was performed, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures, with concurrent bone grafting and stabilization to address bone erosion. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was carefully monitored, with appropriate measures taken to promote bone healing and functional recovery.

5. Operative Note: A synovectomy, tendon repair, and bone erosion management were conducted to address the patient's synovium, tendon, and bone erosion disorder. Utilizing arthroscopic techniques, the hypertrophic synovial tissue was meticulously excised, alleviating inflammation. Concurrently, the damaged tendon was debrided and repaired using sutures, while bone erosion was addressed through bone grafting and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative recovery was closely monitored, with appropriate rehabilitation and bone healing strategies implemented.

6. Operative Note: The patient underwent surgical intervention for a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hypertrophy, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with specific emphasis on bone healing and functional rehabilitation.

7. Operative Note: This operative procedure addressed the patient's disorder of synovium, tendon, and bone erosion. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon underwent meticulous

debridement and repair with sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperatively, extensive synovial proliferation, tendon degeneration, and significant bone erosion were observed. The patient's postoperative course was closely monitored, with emphasis on bone healing, functional restoration, and rehabilitation.

8. Operative Note: The patient underwent surgery to address a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, the affected tendon was meticulously debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was carefully monitored, with emphasis on bone healing and comprehensive rehabilitation.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, and bone erosion. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue. Concurrently, the damaged tendon was debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing, functional recovery, and rehabilitation.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperatively, extensive synovial hypertrophy, tendon degeneration, and significant bone erosion were noted. The patient's postoperative course was closely monitored, with comprehensive rehabilitation and regular imaging planned to assess bone healing and functional outcomes.

1. Operative Note: The patient underwent surgical intervention for a synovium, tendon, and bone erosion disorder. A comprehensive procedure was performed, including arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative course will involve close monitoring, rehabilitation, and regular imaging to assess healing and functional recovery.

2. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, and bone erosion. The procedure involved an open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was well-executed, and the patient's postoperative management will focus on pain control, rehabilitation, and monitoring for bone healing and functional restoration.

3. Operative Note: This operative intervention aimed to address a challenging synovium, tendon, and bone erosion disorder. The surgical approach included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will involve pain management, physical therapy, and regular follow-up for assessing bone healing and functional recovery.

4. Operative Note: A surgical intervention was performed to address the patient's synovium, tendon, and bone erosion disorder. The comprehensive procedure included open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was meticulously executed, and the patient's postoperative management will focus on pain control, rehabilitation, and close monitoring for bone healing and functional restoration.

5. Operative Note: The patient underwent surgical intervention for a complex synovium, tendon, and bone erosion disorder. The procedure involved arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will include pain management, physiotherapy, and regular imaging to assess bone healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a challenging synovium, tendon, and bone erosion disorder. The procedure encompassed open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative management will involve pain control, rehabilitation, and close follow-up to evaluate bone healing and functional outcomes.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, and bone erosion disorder. The comprehensive procedure involved arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will focus on pain management, physical therapy, and regular monitoring for bone healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address

the complex synovium, tendon, and bone erosion disorder in the patient. The procedure encompassed open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative management will involve pain control, rehabilitation, and close follow-up to assess bone healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a challenging synovium, tendon, and bone erosion disorder. The procedure involved arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will include pain management, physiotherapy, and regular imaging to evaluate bone healing and functional recovery.

10. Operative Note: Surgical intervention was performed to address the patient's synovium, tendon, and bone erosion disorder. The procedure included open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was executed with precision, and the patient's postoperative management will involve pain control, rehabilitation, and close monitoring for bone healing and functional restoration.

1. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, and bone erosion. The procedure included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative management will focus on pain control, rehabilitation, and close monitoring for bone healing and functional restoration.

2. Operative Note: The patient underwent surgical intervention for a challenging synovium, tendon, and bone erosion disorder. The comprehensive procedure included open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative care will involve pain management, rehabilitation, and close monitoring for bone healing and functional recovery.

3. Operative Note: This operative procedure aimed to alleviate the patient's disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperatively, extensive synovial hypertrophy, tendon degeneration, and significant bone erosion were noted. The patient's postoperative course was closely monitored, with comprehensive rehabilitation and regular imaging planned to assess bone healing and functional outcomes.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, and bone erosion. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue. Concurrently, the damaged tendon was debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing, functional recovery, and rehabilitation.

5. Operative Note: The patient underwent surgical intervention for a complex synovium, tendon, and bone erosion disorder. The procedure included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was meticulously executed, and the patient's postoperative management will involve pain control, rehabilitation, and regular follow-up to assess bone healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, and bone erosion. An open synovectomy was performed, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures, with concurrent bone grafting and stabilization to address bone erosion. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with appropriate measures taken to promote bone healing and functional recovery.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, and bone erosion disorder. The comprehensive procedure included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's post

operative care will focus on pain management, physical therapy, and regular monitoring for bone healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address a challenging synovium, tendon, and bone erosion disorder. The procedure encompassed open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative management will involve pain control, rehabilitation, and close follow-up to evaluate bone healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided and repaired using sutures, while bone erosion was addressed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing and functional rehabilitation.

10. Operative Note: Surgical management was pursued to address a synovium, tendon, and bone erosion disorder in the patient. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon underwent meticulous debridement and repair with sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with specific emphasis on bone healing, functional recovery, and rehabilitation.

1. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent fluid. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will include antibiotic therapy, wound care, rehabilitation, and close monitoring for healing and functional recovery.

2. Operative Note: The patient underwent surgical intervention for a challenging disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and purulent fluid collection. The surgical intervention was carefully executed to address the infection, and the patient's postoperative care will involve intravenous antibiotics, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

3. Operative Note: This operative procedure aimed to address the patient's disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The surgery included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was successful in eradicating the infection, and the patient's postoperative management will focus on antibiotic therapy, wound care, physical therapy, and close monitoring for healing and functional recovery.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure involved thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and purulent fluid accumulation. The surgical intervention was carefully performed to control the infection, and the patient's postoperative care will include intravenous antibiotics, wound management, rehabilitation, and regular follow-up for assessing healing and functional outcomes.

5. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will involve antibiotic therapy, wound care, physical therapy, and close monitoring for healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and purulent fluid collection. The surgical intervention was carefully executed to address the infection, and the patient's postoperative care will involve

intravenous antibiotics, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and purulent fluid accumulation. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will focus on antibiotic therapy, wound care, physical therapy, and regular monitoring for healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address a challenging disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure encompassed thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was skillfully executed to control the infection, and the patient's postoperative management will include intravenous antibiotics, wound care, rehabilitation, and close follow-up for assessing healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was meticulously executed to control the infection, and the patient's postoperative care will involve antibiotic therapy, wound management, physical therapy, and regular follow-up to assess healing and functional recovery.

10. Operative Note: Surgical intervention was performed to address the patient's disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The comprehensive procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will focus on antibiotic therapy, wound care, physical therapy, and close monitoring for healing and functional restoration.

1. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, bone erosion, severe infection, and intense inflammation on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and marked inflammatory changes. The surgical intervention was carefully executed to control the infection and alleviate the inflammation. The patient's postoperative management will include antibiotic therapy, anti-inflammatory medication, wound care, rehabilitation, and close monitoring for healing and functional recovery.

2. Operative Note: The patient underwent surgical intervention for a challenging disorder involving synovium, tendon, bone erosion, severe infection, and heightened inflammation on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and intense inflammatory response. The surgical intervention was skillfully executed to address the infection and mitigate the inflammation. The patient's postoperative care will involve antibiotic therapy, anti-inflammatory medication, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

3. Operative Note: This operative procedure aimed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and severe inflammation on the extreme moving joint. The surgery included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and intense inflammatory changes. The surgical intervention was successful in controlling the infection and reducing inflammation. The patient's postoperative management will focus on antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and close monitoring for healing and functional recovery.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, bone erosion, severe infection, and pronounced inflammation on the extreme moving joint. The procedure involved thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and marked inflammatory response. The surgical intervention was carefully performed to control the infection and manage the inflammation. The patient's postoperative care will include antibiotic therapy, anti-inflammatory medication, wound management, rehabilitation, and regular follow-up for assessing healing and functional outcomes.

5. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, severe infection, and significant inflammation on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and prominent inflammatory changes. The surgical intervention was successful in controlling the infection and managing the inflammation. The patient's postoperative management will involve antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and close monitoring for healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, severe infection, and elevated inflammation on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive

synovial hyperplasia, tendon degeneration, significant bone erosion, and heightened inflammatory response. The surgical intervention was carefully executed to control the infection and manage the inflammation. The patient's postoperative care will include antibiotic therapy, anti-inflammatory medication, wound care, rehabilitation, and regular follow-up to assess healing and functional recovery.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, bone erosion, severe infection, and inflammatory changes on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and notable inflammatory response. The surgical intervention was successful in controlling the infection and addressing the inflammation. The patient's postoperative management will involve antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and regular monitoring for healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address a challenging disorder involving synovium, tendon, bone erosion, severe infection, and inflammatory changes on the extreme moving joint. The procedure encompassed thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and marked inflammatory response. The surgical intervention was skillfully executed to control the infection and manage the inflammation. The patient's postoperative management will include antibiotic therapy, anti-inflammatory medication, wound care, rehabilitation, and close follow-up for assessing healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, severe infection, and intense inflammation on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and heightened inflammatory response. The surgical intervention was carefully executed to address the infection and alleviate the inflammation. The patient's postoperative care will involve antibiotic therapy, anti-inflammatory medication, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

10. Operative Note: Surgical intervention was performed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and severe inflammation on the extreme moving joint. The comprehensive procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and intense inflammatory response. The surgical intervention was successful in controlling the infection and reducing inflammation. The patient's postoperative management will focus on antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and close monitoring for healing and functional restoration.

1. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a severe pathological condition. The surgical intervention was carefully executed to address the diagnosis. The patient's postoperative management will involve regular follow-ups with imaging, functional assessments, and consultations with specialists to determine the appropriate treatment plan.

2. Operative Note: The patient underwent surgical intervention for a challenging disorder involving synovium, tendon, bone erosion, severe infection, and a moderate diagnosis. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a moderate pathological condition. The surgical intervention was skillfully executed to address the diagnosis. The patient's postoperative care will involve regular follow-ups with the primary care physician and specialist consultations to monitor the progression of the condition and determine the need for additional interventions.

3. Operative Note: This operative procedure aimed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and a mild diagnosis. The surgery included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a mild pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician to assess the response to treatment and adjust the management plan as necessary.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure involved thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a severe pathological condition. The surgical intervention was carefully performed to address the diagnosis. The patient's postoperative care will involve frequent follow-ups with the primary care physician, regular imaging and laboratory tests, and consultations with specialists to monitor the progression of the condition and determine further treatment options.

5. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, severe infection, and a moderate diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a moderate pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician and specialist evaluations to monitor the response to treatment and adjust the management plan accordingly.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a severe pathological condition. The

surgical intervention was skillfully executed to address the diagnosis. The patient's postoperative care will involve frequent follow-ups with the primary care physician, regular imaging and laboratory tests, and consultations with specialists to closely monitor the progression of the condition and determine the need for additional interventions.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, bone erosion, severe infection, and a mild diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a mild pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician to monitor the response to treatment and make adjustments to the management plan as required.

8. Operative Note: A surgical intervention was performed to address a challenging disorder involving synovium, tendon, bone erosion, severe infection, and a moderate diagnosis. The procedure encompassed thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a moderate pathological condition. The surgical intervention was skillfully executed to address the diagnosis. The patient's postoperative care will involve periodic follow-ups with the primary care physician and specialist consultations to assess the treatment response and determine the need for further interventions.

9. Operative Note: The patient underwent surgical intervention for a disorder involving synovium, tendon, bone erosion, severe infection, and a mild diagnosis. The comprehensive procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a mild pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician to monitor the treatment response and make adjustments to the management plan as necessary.

10. Operative Note: Surgical intervention was performed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a severe pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative care will involve frequent follow-ups with the primary care physician, regular imaging and laboratory tests, and consultations with specialists to closely monitor the progression of the condition and determine further treatment options.

## M68.0 Synovitis and tenosynovitis in bacterial diseases classified elsewhere

Operative Note 1: Synovitis and Tenosynovitis Excision

Procedure: The patient underwent a surgical excision of synovitis and tenosynovitis in the right knee joint. A midline incision was made, and the affected synovial and tenosynovial tissues were meticulously dissected and excised. The surgical site was irrigated with saline, and hemostasis was achieved. Closure was performed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 2: Drainage of Septic Tenosynovitis

Procedure: The patient presented with septic tenosynovitis in the left hand. Under sterile conditions, a longitudinal incision was made over the affected tendon sheath. Pus was evacuated, and the tendon sheath was thoroughly irrigated with saline solution. A drain was placed to ensure adequate drainage. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 3: Arthroscopic Synovectomy for Infectious Synovitis

Procedure: The patient underwent arthroscopic synovectomy for infectious synovitis in the right shoulder joint. Arthroscopy was performed, and the inflamed synovial tissue was visualized. Using arthroscopic instruments, synovectomy was carried out to remove the infected synovium. The joint was thoroughly irrigated, and hemostasis was achieved. The arthroscope was removed, and the portals were closed with sutures. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 4: Debridement of Infected Tenosynovitis

Procedure: The patient underwent debridement of infected tenosynovitis in the left ankle. A curvilinear incision was made, and the infected tenosynovial tissues were carefully debrided. Necrotic tissue and purulent material were thoroughly removed. The wound was irrigated with a sterile solution and left open for secondary healing. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 5: Tenolysis with Synovectomy for Bacterial Tenosynovitis

Procedure: The patient underwent tenolysis with synovectomy for bacterial tenosynovitis in the right hand. A longitudinal incision was made, and the affected tendon sheath was carefully opened. Adhesions were released, and the infected synovium was excised. The tendon was freed from the surrounding scar tissue. The wound was irrigated and closed in layers. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 6: Drainage and Lavage of Pyogenic Synovitis

Procedure: The patient presented with pyogenic synovitis in the left hip joint. A sterile approach was used, and a capsular incision was made. Purulent material was drained, and the joint was lavaged with copious amounts of sterile saline solution. A drain was placed, and the wound was closed in layers. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 7: Synovectomy and Joint Debridement for Reactive Synovitis

Procedure: The patient underwent synovectomy and joint debridement for reactive synovitis in the right elbow joint. A posterior incision was made, and the inflamed synovium was visualized. Synovectomy was performed to remove the hypertrophic synovial tissue. Joint debridement was carried out to remove loose bodies and inflammatory debris. The wound was closed, and a

sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 8: Tenosynovectomy for Infectious Tenosynovitis

Procedure: The patient underwent tenosynovectomy for infectious tenosynovitis in the left wrist. A longitudinal incision was made over the affected tendon sheath. The infected tenosynovium was carefully excised, and the tendon was freed from the diseased tissue. The wound was irrigated and closed in layers. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 9: Joint Aspiration and Injection for Septic Arthritis with Synovitis

Procedure: The patient presented with septic arthritis and synovitis in the right knee joint. A sterile technique was used to perform joint aspiration, and purulent fluid was aspirated. The joint was then injected with an appropriate antibiotic solution. The procedure was performed under ultrasound guidance to ensure accurate needle placement. The patient tolerated the procedure well, and there were no complications.

Operative Note 10: Arthroscopic Debridement of Infected Synovitis

Procedure: The patient underwent arthroscopic debridement of infected synovitis in the left ankle joint. Arthroscopy was performed, and infected synovial tissue was identified and removed using arthroscopic instruments. The joint was thoroughly irrigated with saline solution. The arthroscope was removed, and the portals were closed with sutures. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 11: Synovial Biopsy for Suspected Bacterial Synovitis

Procedure: The patient underwent a synovial biopsy to investigate suspected bacterial synovitis in the right hip joint. Under sterile conditions, a small incision was made, and a biopsy sample of the synovial tissue was obtained. Hemostasis was achieved, and the wound was closed with sutures. The sample was sent for histopathological examination and microbial culture. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 12: Tenorrhaphy for Tenosynovitis-Induced Tendon Rupture

Procedure: The patient presented with tendon rupture due to tenosynovitis in the right index finger. A dorsal incision was made over the affected tendon, and the ruptured ends were identified. The tendon was repaired using absorbable sutures in a figure-eight fashion. The tenosynovial tissue was excised, and the wound was closed with interrupted sutures. The patient's finger was immobilized with a splint postoperatively, and there were no complications.

Operative Note 13: Joint Lavage and Synovectomy for Chronic Bacterial Synovitis

Procedure: The patient underwent joint lavage and synovectomy for chronic bacterial synovitis in the left shoulder joint. An arthrotomy was performed, and the joint was lavaged with sterile saline to remove inflammatory debris. Synovectomy was then carried out to excise the hypertrophic synovial tissue. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 14: Tendon Sheath Irrigation and Debridement for Pyogenic Tenosynovitis

Procedure: The patient presented with pyogenic tenosynovitis in the right thumb. A longitudinal incision was made over the affected tendon sheath, and the sheath was opened. The tendon and sheath were thoroughly irrigated with sterile saline to remove pus and debris. Debridement was performed to excise necrotic tissue. The wound was closed in layers, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 15: Synovial Cyst Excision in Tenosynovitis

Procedure: The patient underwent surgical excision of a synovial cyst associated with tenosynovitis in the right wrist. A dorsal incision was made, and the cyst was identified and carefully dissected from the surrounding tissues. The inflamed tenosynovial tissue was excised, and the wound was closed with sutures. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 16: Joint Arthroscopy and Synovial Biopsy for Infectious Synovitis

Procedure: The patient underwent joint arthroscopy and synovial biopsy for infectious synovitis in the left knee joint. Arthroscopy was performed, and the joint was thoroughly inspected. Multiple synovial biopsy samples were obtained using arthroscopic instruments. Hemostasis was achieved, and the portals were closed with sutures. The biopsy samples were sent for pathological and microbiological analysis. The patient tolerated the procedure well, and there were no complications.

Operative Note 17: Drainage of Subcutaneous Abscess Associated with Tenosynovitis

Procedure: The patient presented with a subcutaneous abscess associated with tenosynovitis in the left forearm. Under sterile conditions, an incision was made over the abscess, and purulent material was drained. The infected tenosynovial tissue was debrided

, and the wound was irrigated. A drain was placed to facilitate continued drainage. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 18: Open Synovectomy for Recurrent Bacterial Synovitis

Procedure: The patient underwent an open synovectomy for recurrent bacterial synovitis in the right hip joint. A curvilinear incision was made, and the hypertrophic synovial tissue was excised meticulously. The joint was irrigated, and hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 19: Tenolysis for Adhesive Tenosynovitis in Bacterial Disease

Procedure: The patient underwent tenolysis for adhesive tenosynovitis in the right hand due to bacterial infection. A longitudinal incision was made over the affected tendon sheath, and adhesions were carefully released. The tenosynovial tissue was inspected and debrided as needed. The wound was irrigated and closed with sutures. The patient's range of motion improved postoperatively, and there were no complications.

Operative Note 20: Synovial Fluid Drainage and Joint Injection for Septic Arthritis with Synovitis

Procedure: The patient presented with septic arthritis and synovitis in the left ankle joint. Under aseptic conditions, synovial fluid was aspirated from the joint using a sterile needle. The joint was then injected with an appropriate antibiotic solution. The procedure was performed under fluoroscopic guidance to ensure accurate needle placement. The patient tolerated the procedure well, and there were no complications.

Operative Note 21: Arthroscopic Synovectomy with General Anesthesia for Bacterial Synovitis

Procedure: The patient underwent arthroscopic synovectomy for bacterial synovitis in the right knee joint under general anesthesia. The patient was placed in a supine position, and general anesthesia was induced. Arthroscopy was performed, and the infected synovial tissue was visualized. Synovectomy was carried out using arthroscopic instruments. The joint was thoroughly irrigated, and hemostasis was achieved. The arthroscope was removed, and the portals were closed with sutures. The patient recovered smoothly from anesthesia, and there were no intraoperative complications.

Operative Note 22: Drainage of Infected Tenosynovitis with Local Anesthesia

Procedure: The patient presented with infected tenosynovitis in the left thumb. A digital nerve block with local anesthesia was administered for pain control. A longitudinal incision was made over the affected tendon sheath, and pus was drained. The tenosynovial tissue was irrigated with saline solution. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no complications.

Operative Note 23: Open Synovectomy with Regional Anesthesia for Chronic Bacterial Synovitis

Procedure: The patient underwent open synovectomy for chronic bacterial synovitis in the right elbow joint under regional anesthesia. The patient received a brachial plexus block for anesthesia. A posterior incision was made, and the hypertrophic synovial tissue was excised meticulously. The joint was irrigated, and hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient remained comfortable throughout the procedure, and there were no intraoperative complications.

Operative Note 24: Debridement of Infected Tenosynovitis with Conscious Sedation

Procedure: The patient presented with infected tenosynovitis in the right hand. Conscious sedation was administered for procedural comfort. A longitudinal incision was made over the affected tendon sheath, and the infected tenosynovial tissue was carefully debrided. The wound was irrigated with a sterile solution and closed with interrupted sutures. The patient remained stable and responsive during the procedure, and there were no complications.

Operative Note 25: Arthroscopic Synovial Biopsy with Moderate Sedation for Suspected Bacterial Synovitis

Procedure: The patient underwent arthroscopic synovial biopsy for suspected bacterial synovitis in the left shoulder joint under moderate sedation. The patient was positioned comfortably, and moderate sedation was administered for pain and anxiety control. Arthroscopy was performed, and multiple synovial biopsy samples were obtained using arthroscopic instruments. The joint was irrigated, and the portals were closed with sutures. The patient had a smooth recovery from sedation, and there were no intraoperative complications.

Operative Note 26: Tenolysis with Local Anesthesia and Sedation for Tenosynovitis-Induced Tendon Adhesions

Procedure: The patient underwent tenolysis for tendon adhesions caused by tenosynovitis in the right wrist. Local anesthesia was administered at the operative site, and conscious sedation was provided for patient comfort. A dorsal incision was made, and adhesions were carefully released. The tenosynovial tissue was inspected and debrided as needed. The wound was irrigated and closed with sutures. The patient remained calm and pain-free throughout the procedure, and there were no complications.

Operative Note 27: Joint Lavage and Synovectomy with Spinal Anesthesia for Acute Bacterial Synov

itis

Procedure: The patient underwent joint lavage and synovectomy for acute bacterial synovitis in the left hip joint under spinal anesthesia. The patient was positioned appropriately, and spinal anesthesia was administered for surgical anesthesia. An arthrotomy was performed, and the joint was lavaged with sterile saline to remove inflammatory debris. Synovectomy was then carried out to excise the hypertrophic synovial tissue. The wound was closed in layers, and a sterile dressing was applied. The patient remained hemodynamically stable throughout the procedure, and there were no complications.

Operative Note 28: Drainage of Subcutaneous Abscess with Local Anesthesia and Sedation in Tenosynovitis

Procedure: The patient presented with a subcutaneous abscess associated with tenosynovitis in the left forearm. Local anesthesia with sedation was administered for pain control and patient comfort. An incision was made over the abscess, and purulent material was drained. The infected tenosynovial tissue was debrided, and the wound was irrigated. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient remained relaxed and pain-free throughout the procedure, and there were no complications.

Operative Note 29: Open Synovectomy with General Anesthesia and Intubation for Chronic Bacterial Synovitis

Procedure: The patient underwent open synovectomy for chronic bacterial synovitis in the right knee joint under general anesthesia with endotracheal intubation. The patient was positioned appropriately, and general anesthesia was induced. A midline incision was made, and the hypertrophic synovial tissue was excised meticulously. The joint was irrigated, and hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient was extubated successfully postoperatively, and there were no intraoperative complications.

Operative Note 30: Tenorrhaphy with Local Anesthesia and Sedation for Tenosynovitis-Induced Tendon Rupture

Procedure: The patient presented with tendon rupture due to tenosynovitis in the right Achilles tendon. Local anesthesia with sedation was administered for pain control and patient comfort. A longitudinal incision was made over the affected tendon, and the ruptured ends were identified. The tendon was repaired using absorbable sutures in a figure-eight fashion. The tenosynovial tissue was excised, and the wound was closed with interrupted sutures. The patient remained relaxed and pain-free throughout the procedure, and there were no complications.

Operative Note 31: Joint Debridement, Synovectomy, and Bone Grafting for Bacterial Synovitis with Bone Erosion

Procedure: The patient underwent joint debridement, synovectomy, and bone grafting for bacterial synovitis with bone erosion in the right ankle joint. A medial approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the joint was debrided to remove necrotic bone. Bone grafting was performed to reconstruct the eroded bone surfaces. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 32: Arthroscopic Debridement, Synovectomy, and Bone Lavage for Bacterial Synovitis with Bone Erosion

Procedure: The patient underwent arthroscopic debridement, synovectomy, and bone lavage for bacterial synovitis with bone erosion in the left knee joint. Arthroscopy was performed, and the joint was visualized. The infected synovial tissue was debrided, and bone lavage was carried out to remove debris and bacteria from the eroded bone surfaces. The joint was thoroughly irrigated, and the arthroscope was removed. The portals were closed with sutures. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 33: Open Synovectomy, Bone Debridement, and Stabilization for Chronic Bacterial Synovitis with Extensive Bone Erosion

Procedure: The patient underwent open synovectomy, bone debridement, and stabilization for chronic bacterial synovitis with extensive bone erosion in the right shoulder joint. A deltopectoral approach was used to access the joint. The hypertrophic synovial tissue was excised, and extensive bone debridement was performed to remove necrotic bone and sequestra. The joint was stabilized using plates and screws. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 34: Joint Arthrodesis with Bone Grafting for Bacterial Synovitis and Severe Bone Erosion

Procedure: The patient underwent joint arthrodesis with bone grafting for bacterial synovitis and severe bone erosion in the left wrist joint. A dorsal approach was used, and the joint surfaces were prepared for fusion. The infected synovial tissue was excised, and the eroded bone surfaces were debrided meticulously. Bone grafts were placed to promote fusion and stability. The wound was closed with sutures, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 35: Bone Biopsy and Joint Lavage for Bacterial Synovitis with Suspicion of Bone Erosion

Procedure: The patient underwent bone biopsy and joint lavage for bacterial synovitis with suspicion of bone erosion in the right hip joint. A surgical approach was used to access the joint. A bone biopsy sample was obtained for histopathological examination and microbial culture. The joint was thoroughly lavaged with sterile saline to remove inflammatory debris. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 36: Joint Fusion with Bone Grafting and Debridement for Bacterial Synovitis and Extensive Bone Erosion

Procedure: The patient underwent joint fusion with bone grafting and debridement for bacterial synovitis and extensive bone erosion in the right ankle joint. A medial approach was used,

and the joint was exposed. The hypertrophic synovial tissue was excised, and the eroded bone surfaces were debrided meticulously. Bone grafts were placed to promote fusion. The wound was closed in layers, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 37: Arthroscopic Bone Erosion Debridement and Synovectomy for Bacterial Synovitis

Procedure: The patient underwent arthroscopic bone erosion debridement and synovectomy for bacterial synovitis in the right shoulder joint. Arthroscopy was performed, and the joint was visualized. The eroded bone surfaces were debrided using arthroscopic instruments. The infected synovial tissue was excised meticulously. The joint was thoroughly irrigated, and the arthroscope was removed. The portals were closed with sutures. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 38: Open Bone Grafting and Synovectomy for Chronic Bacterial Synovitis with Bone Erosion

Procedure: The patient underwent open bone grafting and synovectomy for chronic bacterial synovitis with bone erosion in the left elbow joint. A posterior approach was used, and the joint was exposed. The eroded bone surfaces were debrided, and bone grafts were placed to promote healing and stability. The hypertrophic synovial tissue was excised meticulously. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 39: Joint Reconstruction with Bone Grafting and Synovectomy for Bacterial Synovitis and Bone Erosion

Procedure: The patient underwent joint reconstruction with bone grafting and synovectomy for bacterial synovitis and bone erosion in the right knee joint. A medial approach was used, and the joint was exposed. The infected synovial tissue was excised, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was thoroughly irrigated, and the wound was closed in layers. A sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 40: Bone Curettage, Synovectomy, and Joint Lavage for Bacterial Synovitis with Focal Bone Erosion

Procedure: The patient underwent bone curettage, synovectomy, and joint lavage for bacterial synovitis with focal bone erosion in the left hip joint. A surgical approach was used, and the joint was exposed. The eroded bone surfaces were curetted to remove necrotic bone and promote healing. The infected synovial tissue was excised meticulously. The joint was thoroughly lavaged with sterile saline. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 41: Joint Decompression and Synovectomy with Nerve Block for Bacterial Synovitis and Severe Bone Pain

Procedure: The patient underwent joint decompression and synovectomy with nerve block for bacterial synovitis and severe bone pain in the right knee joint. A surgical approach was used to access the joint. The hypertrophic synovial tissue was excised meticulously, and the joint was decompressed to alleviate pressure and relieve pain. A nerve block was administered for localized anesthesia and enhanced pain management. The wound was closed in layers, and a sterile dressing was applied. The patient experienced immediate relief from severe bone pain, and there were no complications.

Operative Note 42: Bone Biopsy, Synovectomy, and Joint Lavage for Bacterial Synovitis with Severe Bone Pain

Procedure: The patient underwent bone biopsy, synovectomy, and joint lavage for bacterial synovitis with severe bone pain in the left ankle joint. A surgical approach was used to access the joint. A bone biopsy sample was obtained for histopathological examination and microbial culture. The hypertrophic synovial tissue was excised meticulously, and the joint was thoroughly lavaged to remove inflammatory debris. The wound was closed in layers, and a sterile dressing was applied. The patient's severe bone pain significantly improved postoperatively, and there were no complications.

Operative Note 43: Joint Fusion and Bone Grafting for Bacterial Synovitis with Severe Bone Pain and Instability

Procedure: The patient underwent joint fusion and bone grafting for bacterial synovitis with severe bone pain and instability in the right wrist joint. A dorsal approach was used, and the joint surfaces were prepared for fusion. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote fusion and stability. The wound was closed with sutures, and a sterile dressing was applied. The patient experienced immediate relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 44: Arthroscopic Bone Erosion Debridement, Synovectomy, and Pain Control Measures for Bacterial Synovitis

Procedure: The patient underwent arthroscopic bone erosion debridement, synovectomy, and pain control measures for bacterial synovitis in the left shoulder joint. Arthroscopy was performed, and the joint was visualized. The eroded bone surfaces were debrided meticulously, and the infected synovial tissue was excised. Various pain control measures, including intra-articular analgesic injections and regional nerve blocks, were employed to alleviate severe bone pain. The joint was thoroughly irrigated, and the arthroscope was removed. The portals were closed with sutures. The patient experienced significant relief from severe bone pain, and there were no complications.

Operative Note 45: Joint Stabilization, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Instability

Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and instability in the left knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and the joint was stabilized using appropriate fixation devices. Bone grafts were placed to promote stability and alleviate bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced immediate relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 46: Joint Lavage, Synovectomy, and Nerve Block for Bacterial Synovitis with Severe Bone Pain and Neuropathy

Procedure: The patient underwent joint lavage, syn

ovectomy, and nerve block for bacterial synovitis with severe bone pain and neuropathy in the right hip joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the joint was thoroughly lavaged with sterile saline. A nerve block was administered to alleviate severe bone pain and manage neuropathic symptoms. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and improved neuropathic symptoms, and there were no complications.

Operative Note 47: Bone Debridement, Synovectomy, and Pain Control Measures for Bacterial Synovitis with Severe Bone Pain

Procedure: The patient underwent bone debridement, synovectomy, and pain control measures for bacterial synovitis with severe bone pain in the left elbow joint. A surgical approach was used, and the joint was exposed. The eroded bone surfaces were debrided meticulously, and the infected synovial tissue was excised. Various pain control measures, including local analgesic injections and systemic pain medications, were employed to alleviate severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain, and there were no complications.

Operative Note 48: Joint Reconstruction, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction

Procedure: The patient underwent joint reconstruction, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint dysfunction in the right ankle joint. A medial approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was stabilized to improve joint function and alleviate severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint functionality, and there were no complications.

Operative Note 49: Bone Curettage, Synovectomy, and Pain Management Measures for Bacterial Synovitis with Severe Bone Pain

Procedure: The patient underwent bone curettage, synovectomy, and pain management measures for bacterial synovitis with severe bone pain in the right hip joint. A surgical approach was used, and the joint was exposed. The eroded bone surfaces were curetted to remove necrotic bone and alleviate severe bone pain. The infected synovial tissue was excised meticulously. Various pain management measures, including local analgesic injections and systemic pain medications, were employed to control severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain, and there were no complications.

Operative Note 50: Joint Fusion, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability

Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint instability in the left shoulder joint. A posterior approach was used, and the joint surfaces were prepared for fusion. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote fusion and stability. The joint was stabilized to alleviate severe bone pain and restore joint integrity. The wound was closed with sutures, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 51: Joint Arthroplasty with Bone Grafting and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration

Procedure: The patient underwent joint arthroplasty with bone grafting and synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the right hip joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was replaced with a prosthetic implant to alleviate severe bone pain and restore joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain and improved joint mobility, and there were no complications.

Operative Note 52: Joint Resection and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Tumor Formation

Procedure: The patient underwent joint resection and synovectomy for bacterial synovitis with severe bone pain and tumor formation in the left knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue and the tumor were excised meticulously. The eroded bone surfaces were debrided, and the joint was thoroughly lavaged. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and the tumor was sent for pathological examination. There were no complications during the procedure.

Operative Note 53: Joint Exploration, Bone Debridement, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Infection

Procedure: The patient underwent joint exploration, bone debridement, and synovectomy for bacterial synovitis with severe bone pain and infection in the right ankle joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were debrided to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 54: Joint Reconstruction, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction

Procedure: The patient underwent joint reconstruction, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint dysfunction in the left shoulder joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was stabilized to improve joint function and alleviate severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint functionality, and there were no complications.

Operative Note 55: Joint Fusion, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability

Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint instability in the right knee joint. A surgical approach was used, and the joint surfaces were prepared for fusion. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote fusion and stability. The joint was stabilized to alleviate severe bone pain and restore joint integrity. The wound was closed with sutures, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, and there were no complications

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Operative Note 56: Joint Reconstruction with Arthroplasty, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration

Procedure: The patient underwent joint reconstruction with arthroplasty, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the left hip joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was replaced with a prosthetic implant to alleviate severe bone pain and restore joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain and improved joint mobility, and there were no complications.

Operative Note 57: Joint Debridement, Bone Curettage, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Septic Arthritis

Procedure: The patient underwent joint debridement, bone curettage, and synovectomy for bacterial synovitis with severe bone pain and septic arthritis in the right shoulder joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were curetted to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 58: Joint Stabilization, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability

Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint instability in the left elbow joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was stabilized using appropriate fixation devices. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 59: Joint Resection, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction

Procedure: The patient underwent joint resection, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint dysfunction in the right wrist joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was resected to address joint dysfunction. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and improved joint functionality, and there were no complications.

Operative Note 60: Joint Exploration, Bone Debridement, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Infection

Procedure: The patient underwent joint exploration, bone debridement, and synovectomy for bacterial synovitis with severe bone pain and infection in the left knee joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were debrided to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 61: Joint Reconstruction with Total Joint Replacement, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration

Procedure: The patient underwent joint reconstruction with total joint replacement, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the right knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was replaced with a total joint prosthesis to alleviate severe bone pain and restore joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain and improved joint mobility, and there were no complications.

Operative Note 62: Joint Debridement, Bone Curettage, and Synovectomy with Joint Lavage for Bacterial Synovitis with Severe Bone Pain and Septic Arthritis

Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with joint lavage for bacterial synovitis with severe bone pain and septic arthritis in the left hip joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were curetted to remove necrotic bone and infection. The joint was thoroughly lavaged with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 63: Joint Stabilization, Bone Grafting, and Synovectomy with Osteotomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability

Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with osteotomy for bacterial synovitis with severe bone pain and joint instability in the right ankle joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was stabilized using appropriate fixation devices, and an osteotomy was performed to correct joint alignment. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and joint stability improved, with no complications.

Operative Note 64: Joint Resection, Bone Grafting, and Synovectomy with Tendon Transfer for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction

Procedure: The patient underwent joint resection, bone grafting, and synovectomy with tendon transfer for bacterial synovitis with severe bone pain and joint dysfunction in the left shoulder joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. Joint resection was performed to address joint dysfunction, and a tendon transfer was conducted for improved joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint functionality, and there were no complications.

Operative Note 65: Joint Exploration, Bone Debridement, and Synovectomy with Antibiotic Spacer Placement for Bacterial Synovitis with Severe Bone Pain and Infection

Procedure: The patient underwent joint exploration, bone debridement, and synovectomy with antibiotic spacer placement for bacterial synovitis with severe bone pain and infection in the right elbow joint. A surgical approach was used, and the joint was exposed. The infected

synovial tissue was excised meticulously, and the eroded bone surfaces were debrided to remove necrotic bone and infection. An antibiotic spacer was placed to deliver local antimicrobial therapy. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 66: Joint Fusion, Bone Grafting, and Synovectomy with Internal Fixation for Bacterial Synovitis with Severe Bone Pain and Joint Instability

Procedure: The patient underwent joint fusion, bone grafting, and synovectomy with internal fixation for bacterial synovitis with severe bone pain and joint instability in the left wrist joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was fused using appropriate fixation devices. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, with no complications.

Operative Note 67: Joint Reconstruction with Arthroscopic Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration

Procedure: The patient underwent joint reconstruction with arthroscopic synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the right shoulder joint. Arthroscopic access was achieved, and the hypertrophic synovial tissue was meticulously excised. The eroded bone surfaces were addressed, and joint lavage was performed. The joint was stabilized using appropriate arthroscopic techniques. The wound was closed, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint mobility, and there were no complications.

Operative Note 68: Joint Debridement, Bone Curettage, and Synovectomy with External Fixation for Bacterial Synovitis with Severe Bone Pain and Septic Arthritis

Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with external fixation for bacterial synovitis with severe bone pain and septic arthritis in the left ankle joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were curetted to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. External fixation was applied to stabilize the joint and aid in the healing process. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 69: Joint Stabilization, Bone Grafting, and Synovectomy with Arthroscopic Cartilage Restoration for Bacterial Synovitis with Severe Bone Pain and Joint Instability

Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with arthroscopic cartilage restoration for bacterial synovitis with severe bone pain and joint instability in the right knee joint. Arthroscopic access was achieved, and the hypertrophic synovial tissue was excised meticulously. Bone grafts were placed to promote stability and alleviate severe bone pain. Arthroscopic cartilage restoration techniques were employed to address joint surface damage. The wound was closed, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint stability, and there were no complications.

Operative Note 70: Joint Resection, Bone Grafting, and Synovectomy with Ligament Repair for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction

Procedure: The patient underwent joint resection, bone grafting, and synovectomy with ligament repair for bacterial synovitis with severe bone pain and joint dysfunction in the left knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. Joint resection was performed to address joint dysfunction, and ligament repair was carried out to restore stability. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint functionality, and there were no complications.

Operative Note 71: Joint Exploration, Bone Debridement, and Synovectomy with Antibiotic Spacer Placement for Severe Infection and Synovitis in the Hip Joint

Procedure: The patient underwent joint exploration, bone debridement, and synovectomy with antibiotic spacer placement for severe infection and synovitis in the hip joint. A surgical approach was used, and the joint was exposed. Extensive infected synovial tissue was meticulously excised, and thorough bone debridement was performed to remove necrotic bone and infection. An antibiotic spacer was carefully placed to provide local antimicrobial therapy. The wound was closed in layers, and a sterile dressing was applied. The patient's severe infection and joint symptoms were successfully addressed, and there were no complications observed during the procedure.

Operative Note 72: Joint Debridement, Bone Curettage, and Synovectomy with Intravenous Antibiotic Infusion for Severe Infection and Synovitis in the Shoulder Joint

Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with intravenous antibiotic infusion for severe infection and synovitis in the shoulder joint. A surgical approach was employed, and the joint was exposed. Thorough debridement of infected synovial tissue and bone curettage were performed to eliminate the source of infection. Intravenous antibiotics were administered during the procedure to provide systemic antimicrobial therapy. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection was successfully managed, and there were no complications observed during the procedure.

Operative Note 73: Joint Stabilization, Bone Grafting, and Synovectomy with Extensive Irrigation for Severe Infection and Synovitis in the Ankle Joint

Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with extensive irrigation for severe infection and synovitis in the ankle joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and aid in the healing process. The joint was thoroughly irrigated with antimicrobial solutions to eliminate infection. The wound was closed in layers, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 74: Joint Resection, Bone Grafting, and Synovectomy with Drain Placement for Severe Infection and Synovitis in the Knee Joint

Procedure: The patient underwent joint resection, bone grafting, and synovectomy with drain placement for severe infection and synovitis in the knee joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and facilitate bone healing. A drain was inserted to assist in the drainage of excess fluids and reduce the risk of infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were successfully managed, and there were no complications observed during the procedure.

Operative Note 75: Joint Fusion, Bone Grafting, and Synovectomy with Intensive Antibiotic Therapy for Severe Infection and Synovitis in the Elbow Joint

Procedure: The patient underwent joint fusion, bone grafting, and synovectomy with intensive antibiotic therapy for severe infection and synovitis in the elbow joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and enhance bone healing. Intensive antibiotic therapy was administered throughout the procedure to combat the severe infection. The

wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 76: Joint Debridement, Bone Curettage, and Synovectomy with Antibiotic Impregnated Cement Spacer for Severe Infection and Synovitis in the Wrist Joint

Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with antibiotic impregnated cement spacer placement for severe infection and synovitis in the wrist joint. A surgical approach was utilized, and the joint was exposed. Thorough debridement of infected synovial tissue and bone curettage were performed to eradicate the infection. An antibiotic impregnated cement spacer was carefully placed to provide localized antimicrobial therapy. The wound was meticulously closed, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 77: Joint Exploration, Bone Debridement, and Synovectomy with Intravenous Antibiotic Infusion for Severe Infection and Synovitis in the Temporomandibular Joint

Procedure: The patient underwent joint exploration, bone debridement, and synovectomy with intravenous antibiotic infusion for severe infection and synovitis in the temporomandibular joint. A surgical approach was employed, and the joint was exposed. Extensive debridement of infected synovial tissue and bone was performed to eliminate the source of infection. Intravenous antibiotics were administered throughout the procedure to provide systemic antimicrobial therapy. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 78: Joint Stabilization, Bone Grafting, and Synovectomy with Extensive Irrigation for Severe Infection and Synovitis in the Sacroiliac Joint

Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with extensive irrigation for severe infection and synovitis in the sacroiliac joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and facilitate bone healing. The joint was thoroughly irrigated with antimicrobial solutions to eliminate the infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were successfully managed, and there were no complications observed during the procedure.

Operative Note 79: Joint Resection, Bone Grafting, and Synovectomy with Drain Placement for Severe Infection and Synovitis in the Temporomandibular Joint

Procedure: The patient underwent joint resection, bone grafting, and synovectomy with drain placement for severe infection and synovitis in the temporomandibular joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and facilitate bone healing. A drain was inserted to assist in the drainage of excess fluids and reduce the risk of infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 80: Joint Fusion, Bone Grafting, and Synovectomy with Intensive Antibiotic Therapy for Severe Infection and Synovitis in the Sternoclavicular Joint

Procedure: The patient underwent joint fusion, bone grafting, and synovectomy with intensive antibiotic therapy for severe infection and synovitis in the sternoclavicular joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and enhance bone healing. Intensive antibiotic therapy was administered throughout the procedure to combat the severe infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 81: Joint Debridement, Synovectomy, and Intra-articular Steroid Injection for Inflammatory Synovitis with Moderate Joint Effusion in the Knee Joint

Procedure: The patient underwent joint debridement, synovectomy, and intra-articular steroid injection for inflammatory synovitis with moderate joint effusion in the knee joint. A surgical approach was employed, and the joint was exposed. The inflamed synovial tissue was meticulously excised, and the joint was thoroughly irrigated. An intra-articular steroid injection was administered to reduce inflammation and manage joint effusion. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms were effectively addressed, and there were no complications observed during the procedure.

Operative Note 82: Joint Stabilization, Biologic Agent Injection, and Synovectomy for Inflammatory Synovitis with Persistent Joint Swelling in the Ankle Joint

Procedure: The patient underwent joint stabilization, biologic agent injection, and synovectomy for inflammatory synovitis with persistent joint swelling in the ankle joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the joint was stabilized using appropriate techniques. A biologic agent injection was administered to target and reduce inflammation. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms and persistent joint swelling were effectively managed, and there were no complications observed during the procedure.

Operative Note 83: Joint Resection, Tendon Release, and Synovectomy for Inflammatory Synovitis with Tenosynovitis and Joint Contracture in the Elbow Joint

Procedure: The patient underwent joint resection, tendon release, and synovectomy for inflammatory synovitis with tenosynovitis and joint contracture in the elbow joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the affected tendons were released to address tenosynovitis. Joint resection was performed to alleviate joint contracture. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, tenosynovitis, and joint contracture were effectively managed, and there were no complications observed during the procedure.

Operative Note 84: Joint Fusion, Bone Grafting, and Synovectomy for Inflammatory Synovitis with Bone Erosion and Joint Instability in the Shoulder Joint

Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for inflammatory synovitis with bone erosion and joint instability in the shoulder joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and address bone erosion. Joint fusion was performed to stabilize the joint. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, bone erosion, and joint instability were effectively managed, and there were no complications observed during the procedure.

Operative Note 85: Joint Debridement, Synovectomy, and Intra-articular Corticosteroid Injection for Inflammatory Synovitis with Recurrent Flares in the Hip Joint

Procedure: The patient underwent joint debridement, synovectomy, and intra-articular corticosteroid injection for inflammatory synovitis with recurrent flares in the hip joint. A surgical approach was utilized, and the joint was exposed. The inflamed synovial tissue was meticulously excised, and the joint was thoroughly irrigated. An intra-articular corticosteroid injection was administered to reduce inflammation

and manage recurrent flares. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms and recurrent flares were effectively addressed, and there were no complications observed during the procedure.

Operative Note 86: Joint Stabilization, Biologic Agent Injection, and Synovectomy for Inflammatory Synovitis with Joint Effusion and Cartilage Degeneration in the Wrist Joint

Procedure: The patient underwent joint stabilization, biologic agent injection, and synovectomy for inflammatory synovitis with joint effusion and cartilage degeneration in the wrist joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the joint was stabilized using appropriate techniques. A biologic agent injection was administered to target and reduce inflammation. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, joint effusion, and cartilage degeneration were effectively managed, and there were no complications observed during the procedure.

Operative Note 87: Joint Resection, Tendon Repair, and Synovectomy for Inflammatory Synovitis with Tenosynovitis and Joint Instability in the Finger Joint

Procedure: The patient underwent joint resection, tendon repair, and synovectomy for inflammatory synovitis with tenosynovitis and joint instability in the finger joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the affected tendons were repaired to address tenosynovitis. Joint resection was performed to alleviate joint instability. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, tenosynovitis, and joint instability were effectively managed, and there were no complications observed during the procedure.

Operative Note 88: Joint Fusion, Bone Grafting, and Synovectomy for Inflammatory Synovitis with Bone Erosion and Joint Deformity in the Hip Joint

Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for inflammatory synovitis with bone erosion and joint deformity in the hip joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to address bone erosion and promote stability. Joint fusion was performed to correct joint deformity. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, bone erosion, and joint deformity were effectively managed, and there were no complications observed during the procedure.

Operative Note 89: Joint Debridement, Synovectomy, and Intra-articular Corticosteroid Injection for Inflammatory Synovitis with Recurrent Flares in the Temporomandibular Joint

Procedure: The patient underwent joint debridement, synovectomy, and intra-articular corticosteroid injection for inflammatory synovitis with recurrent flares in the temporomandibular joint. A surgical approach was utilized, and the joint was exposed. The inflamed synovial tissue was meticulously excised, and the joint was thoroughly irrigated. An intra-articular corticosteroid injection was administered to reduce inflammation and manage recurrent flares. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms and recurrent flares were effectively addressed, and there were no complications observed during the procedure.

Operative Note 90: Joint Stabilization, Biologic Agent Injection, and Synovectomy for Inflammatory Synovitis with Joint Effusion and Cartilage Degeneration in the Temporomandibular Joint

Procedure: The patient underwent joint stabilization, biologic agent injection, and synov

ectomy for inflammatory synovitis with joint effusion and cartilage degeneration in the temporomandibular joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the joint was stabilized using appropriate techniques. A biologic agent injection was administered to target and reduce inflammation. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, joint effusion, and cartilage degeneration were effectively managed, and there were no complications observed during the procedure.

Operative Note 91: Joint Debridement, Synovectomy, and Postoperative Physical Therapy for Mild Synovitis and Tenosynovitis in the Wrist Joint

Procedure: The patient underwent joint debridement, synovectomy, and postoperative physical therapy for mild synovitis and tenosynovitis in the wrist joint. A surgical approach was employed, and the joint was exposed. The inflamed synovial tissue and tenosynovial sheaths were meticulously excised. The wound was closed meticulously, and a sterile dressing was applied. The patient will be scheduled for postoperative physical therapy sessions to optimize joint function and prevent recurrence.

Operative Note 92: Joint Stabilization, Biologic Agent Injection, and Close Follow-up for Moderate Synovitis and Tenosynovitis in the Ankle Joint

Procedure: The patient underwent joint stabilization, biologic agent injection, and close follow-up for moderate synovitis and tenosynovitis in the ankle joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will be closely monitored with regular follow-up appointments to assess the response to treatment and determine the need for additional interventions.

Operative Note 93: Joint Resection, Tendon Repair, and Long-term Rheumatology Consultation for Severe Synovitis, Tenosynovitis, and Joint Erosion in the Elbow Joint

Procedure: The patient underwent joint resection, tendon repair, and long-term rheumatology consultation for severe synovitis, tenosynovitis, and joint erosion in the elbow joint. A surgical approach was employed, and the hypertrophic synovial tissue, tenosynovial sheaths, and eroded joint surfaces were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will be referred to a rheumatologist for long-term management and follow-up to optimize disease control and preserve joint function.

Operative Note 94: Joint Fusion, Bone Grafting, and Postoperative Imaging for Advanced Synovitis, Bone Erosion, and Joint Instability in the Shoulder Joint

Procedure: The patient underwent joint fusion, bone grafting, and postoperative imaging for advanced synovitis, bone erosion, and joint instability in the shoulder joint. A surgical approach was employed, and the hypertrophic synovial tissue, eroded bone surfaces, and unstable joint components were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. Postoperative imaging, such as X-rays or MRI, will be scheduled to assess the fusion progress and joint stability.

Operative Note 95: Joint Debridement, Synovectomy, and Systemic Immunomodulatory Therapy for Recurrent Synovitis and Tenosynovitis in the Hip Joint

Procedure: The patient underwent joint debridement, synovectomy, and systemic immunomodulatory therapy for recurrent synovitis and tenosynovitis in the hip joint. A surgical approach was employed, and the inflamed synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate systemic immunomodulatory therapy following the procedure to control the recurrent inflammation, and close follow-up appointments will be scheduled to assess the response to treatment.

Operative Note 96: Joint Stabilization, Biologic Agent Injection, and Rehabilitation Program for Chronic Synovitis and Tenosynovitis

in the Knee Joint

Procedure: The patient underwent joint stabilization, biologic agent injection, and a tailored rehabilitation program for chronic synovitis and tenosynovitis in the knee joint. A surgical approach was utilized, and the hypertrophic synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate a structured rehabilitation program consisting of exercises, physical therapy, and functional training to improve joint function and alleviate symptoms in conjunction with biologic agent therapy.

Operative Note 97: Joint Resection, Tendon Reconstruction, and Long-term Rheumatology Management for Severe Synovitis, Tenosynovitis, and Joint Deformity in the Finger Joint

Procedure: The patient underwent joint resection, tendon reconstruction, and long-term rheumatology management for severe synovitis, tenosynovitis, and joint deformity in the finger joint. A surgical approach was employed, and the hypertrophic synovial tissue, tenosynovial sheaths, and deformed joint structures were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will be referred to a rheumatologist for ongoing management and follow-up to optimize disease control and prevent further joint deformity.

Operative Note 98: Joint Fusion, Bone Grafting, and Postoperative Physical Therapy for Extensive Synovitis, Bone Erosion, and Joint Dysfunction in the Temporomandibular Joint

Procedure: The patient underwent joint fusion, bone grafting, and postoperative physical therapy for extensive synovitis, bone erosion, and joint dysfunction in the temporomandibular joint. A surgical approach was employed, and the hypertrophic synovial tissue, eroded bone surfaces, and dysfunctional joint components were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will undergo postoperative physical therapy to optimize jaw function, restore range of motion, and alleviate pain following the joint fusion procedure.

Operative Note 99: Joint Debridement, Synovectomy, and Systemic Immunomodulatory Therapy for Persistent Synovitis and Tenosynovitis in the Sternoclavicular Joint

Procedure: The patient underwent joint debridement, synovectomy, and systemic immunomodulatory therapy for persistent synovitis and tenosynovitis in the sternoclavicular joint. A surgical approach was employed, and the inflamed synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate systemic immunomodulatory therapy following the procedure to control the persistent inflammation, and close follow-up appointments will be scheduled to assess the response to treatment.

Operative Note 100: Joint Stabilization, Biologic Agent Injection, and Rehabilitation Program for Aggressive Synovitis, Bone Erosion, and Joint Dysfunction in the Hip Joint

Procedure: The patient underwent joint stabilization, biologic agent injection, and a tailored rehabilitation program for aggressive synovitis, bone erosion, and joint dysfunction in the hip joint. A surgical approach was employed, and the hypertrophic synovial tissue, eroded bone surfaces, and dysfunctional joint components were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate a structured rehabilitation program consisting of exercises, physical therapy, and functional training in conjunction with biologic agent therapy to optimize joint function and restore mobility.

## M68.8 Other disorders of synovium and tendon in diseases classified elsewhere

1. Operative Note: Patient underwent arthroscopic debridement for synovial hypertrophy and tenosynovitis of the right wrist, secondary to rheumatoid arthritis. Synovium was excised, and tendon sheaths were thoroughly irrigated. The procedure was successful in alleviating pain and improving joint mobility.

2. Operative Note: Excision of nodular synovitis and tenosynovitis was performed on the left ankle due to underlying psoriatic arthritis. The inflamed synovium was excised, and the tendon sheaths were carefully cleaned. The patient tolerated the procedure well, and postoperative recovery is anticipated to be favorable.

3. Operative Note: In the setting of systemic lupus erythematosus, the patient underwent synovectomy and tendon repair for synovial hypertrophy and tendon rupture in the right knee. Synovium was excised, and the tendon was repaired using sutures. The procedure was uneventful, and the patient is expected to regain functional mobility.

4. Operative Note: The patient with gouty arthritis underwent surgical intervention for tophaceous synovitis and tenosynovitis in the left hand. Multiple tophi were excised from the synovium, and tendon sheaths were thoroughly cleaned. The patient tolerated the procedure well, and early postoperative outcomes appear promising.

5. Operative Note: Excision of synovial chondromatosis and tendon release was performed on the right shoulder of a patient with pigmented villonodular synovitis. The synovium was meticulously removed, and tendon release was accomplished successfully. The patient is expected to have improved range of motion and reduced pain postoperatively.

6. Operative Note: A patient with systemic sclerosis underwent synovectomy and tendon repair for synovial fibrosis and tendon adhesions in the fingers of the right hand. The fibrotic synovium was excised, and tendon adhesions were released. The procedure was well-tolerated, and the patient is anticipated to achieve improved hand function.

7. Operative Note: The patient with hemophilia A presented with recurrent synovial hemarthrosis and tenosynovitis in the left elbow. Arthroscopic synovectomy and tenolysis were performed, successfully removing the blood-filled synovium and releasing the tendon adhesions. The patient's pain is expected to be alleviated, and joint mobility should improve.

8. Operative Note: Synovial lipomatosis and tenosynovitis were addressed surgically in the right hip of a patient with primary synovial chondromatosis. Lipomatous synovium was excised, and the tendon sheaths were carefully cleaned. The patient tolerated the procedure well, and early rehabilitation efforts have begun.

9. Operative Note: A patient with Ehlers-Danlos syndrome underwent surgical intervention for synovial hyperplasia and tenosynovitis in the left shoulder. The hyperplastic synovium was excised, and tendon sheaths were released. The procedure was uneventful, and the patient is expected to experience reduced pain and improved joint stability.

10. Operative Note: Synovectomy and tendon repair were performed on the right foot of a patient with systemic amyloidosis. Synovial amyloid deposition and tendon rupture were addressed. The synovium was excised, and the tendon was repaired using appropriate techniques. The patient's postoperative course will be closely monitored for optimal outcomes.

1. Operative Note: Arthroscopic synovectomy and tenolysis were performed on the left knee of a patient with juvenile idiopathic arthritis. Synovial hypertrophy and tendon adhesions were addressed, allowing for improved joint mobility. The procedure was uncomplicated, and the patient is expected to have a smoother recovery.

2. Operative Note: The patient with systemic vasculitis underwent synovial biopsy and tenosynovectomy in the right ankle. The inflamed synovium was sampled for histopathological evaluation, and tendon sheaths were released. The procedure was well-tolerated, and postoperative care will focus on managing the underlying disease process.

3. Operative Note: A patient with sarcoidosis underwent synovectomy and tendon repair for synovial granuloma and tendon rupture in the left hand. The granulomatous synovium was excised, and tendon repair was achieved using appropriate sutures. The patient is expected to regain hand function and experience reduced pain.

4. Operative Note: Excision of synovial osteochondromatosis and tenosynovitis was performed on the right elbow of a patient with osteochondromatosis secondary to previous trauma. The osteochondromas were carefully removed from the synovium, and tendon sheaths were thoroughly cleaned. The patient's postoperative course is anticipated to be uneventful.

5. Operative Note: Synovectomy and tendon release were carried out on the left wrist of a patient with calcium pyrophosphate deposition disease. The calcific synovium was excised, and tendon release was accomplished successfully. The patient is expected to have improved wrist mobility and reduced pain.

6. Operative Note: A patient with systemic sclerosis underwent synovial debridement and tenolysis for synovial fibrosis and tendon adhesions in the right foot. The fibrotic synovium was meticulously removed, and tendon adhesions were released. The procedure was well-tolerated, and the patient is expected to experience improved foot function.

7. Operative Note: The patient with hemophilia B presented with recurrent synovial hemarthrosis and tenosynovitis in the right knee. Arthroscopic synovectomy and tenolysis were performed, successfully removing the blood-filled synovium and releasing the tendon adhesions. The patient's pain is expected to be alleviated, and joint mobility should improve.

8. Operative Note: Synovial lipoma and tenosynovitis were surgically addressed in the left shoulder of a patient with primary synovial chondromatosis. The lipomatous synovium was excised, and the tendon sheaths were carefully cleaned. The patient tolerated the procedure well, and early rehabilitation efforts have commenced.

9. Operative Note: A patient with Marfan syndrome underwent surgical intervention for synovial hyperplasia and tenosynovitis in the right wrist. The hyperplastic synovium was excised, and tendon sheaths were released. The procedure was uneventful, and the patient is expected to experience reduced pain and improved joint stability.

10. Operative Note: Synovectomy and tendon repair were performed on the left ankle of a patient with systemic lupus erythematosus. Synovial inflammation and tendon rupture were addressed. The synovium was excised, and the tendon was repaired using appropriate techniques. The patient's postoperative course will be closely monitored for optimal outcomes.

1. Operative Note: The patient underwent arthroscopic synovectomy and tenolysis of the right knee under general anesthesia with endotracheal intubation. Adequate anesthesia was achieved with a total of 100 mg of propofol and 50 mcg of fentanyl. The procedure was uneventful, and the patient tolerated it well. Postoperative pain was managed using a combination of oral analgesics and local anesthetic infiltration.

2. Operative Note: Excision of synovial osteochondromatosis and tenosynovitis in the left elbow was performed under regional anesthesia with ultrasound-guided nerve block. The patient received 20 ml of 0.5% bupivacaine with epinephrine for brachial plexus blockade. The procedure was completed without complications, and the patient reported minimal discomfort during the surgery.

3. Operative Note: A patient with systemic vasculitis underwent synovial biopsy and tenosynovectomy in the right ankle under monitored anesthesia care (MAC). The patient received 2 mg of midazolam and 50 mcg of fentanyl intravenously for sedation. Local anesthesia was achieved using 20 ml of 1% lidocaine with epinephrine. The procedure was well-tolerated, and the patient remained comfortable throughout.

4. Operative Note: Synovectomy and tendon repair of the right foot were performed on a patient with sarcoidosis under spinal anesthesia. The patient received 10 mg of hyperbaric bupivacaine intrathecally. The surgery proceeded smoothly, and the patient experienced complete sensory and motor blockade during the procedure. Postoperative pain control was managed using a combination of oral analgesics and intravenous patient-controlled analgesia (PCA).

5. Operative Note: The patient with hemophilia B underwent arthroscopic synovectomy and tenolysis in the right knee under general anesthesia. Anesthesia was induced with 150 mg of propofol and maintained using sevoflurane. A total of 100 mcg of fentanyl and 20 mg of rocuronium were administered for analgesia and muscle relaxation, respectively. The patient remained hemodynamically stable throughout the procedure.

6. Operative Note: Synovial lipoma excision and tenosynovectomy in the left shoulder were performed on a patient with primary synovial chondromatosis under local anesthesia with sedation. The shoulder was infiltrated with 20 ml of 1% lidocaine and 50 mcg of fentanyl was administered intravenously for conscious sedation. The procedure was well-tolerated, and the patient remained calm and comfortable throughout.

7. Operative Note: A patient with Marfan syndrome underwent synovial debridement and tenolysis in the right foot under general anesthesia with a laryngeal mask airway (LMA). Anesthesia was induced with 100 mg of propofol and maintained using desflurane. A total of 50 mcg of fentanyl and 10 mg of atracurium were administered for analgesia and muscle relaxation, respectively. The patient's vital signs remained stable throughout the procedure.

8. Operative Note: Excision of synovial hyperplasia and tenosynovitis in the right wrist was performed on a patient with Ehlers-Danlos syndrome under regional anesthesia with ultrasound-guided median nerve block. The patient received 10 ml of 1% lidocaine with epinephrine for local anesthesia. The procedure was well-tolerated, and the patient reported minimal discomfort during surgery. Postoperative pain was managed using a combination of oral analgesics and local an

esthetic infiltration.

9. Operative Note: Arthroscopic synovectomy and tenolysis were performed on the left knee of a patient with juvenile idiopathic arthritis under general anesthesia with balanced anesthesia technique. The patient received a total of 100 mg of propofol, 100 mcg of fentanyl, and 30 mg of rocuronium for induction and maintenance. An endotracheal tube was placed for airway management, and the patient remained stable throughout the procedure.

10. Operative Note: Synovectomy and tendon repair of the left ankle were performed on a patient with systemic lupus erythematosus under combined spinal-epidural anesthesia. The patient received 10 mg of hyperbaric bupivacaine intrathecally for spinal anesthesia and a continuous epidural infusion of 0.125% bupivacaine with fentanyl for postoperative pain control. The surgery was completed without complications, and the patient remained comfortable during the intraoperative period.

1. Operative Note: The patient with rheumatoid arthritis underwent synovectomy, tenolysis, and bone erosion repair in the right wrist. The procedure involved excision of hypertrophic synovium, release of tendon adhesions, and bone grafting to repair eroded areas. The bone graft was harvested from the iliac crest. The surgery was successful, and postoperative immobilization and rehabilitation will be crucial for optimal outcomes.

2. Operative Note: Excision of synovial hypertrophy, tenosynovitis, and bone erosion repair was performed on the left knee of a patient with psoriatic arthritis. The inflamed synovium was removed, tendon adhesions were released, and bone erosion sites were addressed using autologous bone grafts. The procedure was well-tolerated, and the patient's postoperative course will focus on pain management and rehabilitation.

3. Operative Note: A patient with systemic lupus erythematosus underwent synovectomy, tenolysis, and bone erosion repair in the right hip. The synovium was excised, tendon adhesions were released, and eroded bone areas were reconstructed using allograft materials. The surgery was completed successfully, and the patient's postoperative care will involve close monitoring of hip function and gradual rehabilitation.

4. Operative Note: Synovectomy, tendon repair, and bone erosion reconstruction were performed on the left shoulder of a patient with gouty arthritis. The procedure involved excision of tophaceous synovium, repair of tendon rupture, and grafting of eroded bone sites with synthetic bone substitutes. The patient tolerated the surgery well, and postoperative management will include pain control and early range of motion exercises.

5. Operative Note: The patient with systemic vasculitis underwent synovial biopsy, tenosynovectomy, and bone erosion repair in the right ankle. The synovial biopsy confirmed inflammatory changes, and subsequent surgery involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure was completed without complications, and the patient's postoperative course will focus on immobilization and rehabilitation.

6. Operative Note: A patient with sarcoidosis underwent synovial debridement, tenolysis, and bone erosion repair in the right hand. The procedure involved meticulous removal of granulomatous synovium, release of tendon adhesions, and grafting of eroded bone areas with autologous bone grafts. The surgery was successful, and the patient's postoperative care will involve hand therapy and gradual return to functional activities.

7. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right elbow of a patient with synovial osteochondromatosis. The procedure involved excision of osteochondromas, release of tendon adhesions, and reconstruction of eroded bone areas using bone grafts. The surgery was uneventful, and the patient's postoperative management will include pain control and early mobilization.

8. Operative Note: A patient with hemophilia A underwent synovial debridement, tenolysis, and bone erosion repair in the left knee. The procedure involved removal of blood-filled synovium, release of tendon adhesions, and grafting of eroded bone sites using bone substitutes. The surgery was successful in reducing pain and improving joint function, and the patient's postoperative care will focus on hemostasis and rehabilitation.

9. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right ankle of a patient with synovial lipomatosis. The lipomatous synovium

was excised, tendon adhesions were released, and eroded bone areas were addressed using bone graft substitutes. The procedure was completed without complications, and the patient's postoperative course will involve immobilization and gradual weight-bearing.

10. Operative Note: A patient with primary synovial chondromatosis underwent synovial debridement, tenosynovectomy, and bone erosion repair in the left shoulder. The procedure involved meticulous removal of chondromas, release of tendon adhesions, and reconstruction of eroded bone sites using autografts. The surgery was successful, and the patient's postoperative management will focus on pain control and early rehabilitation.

1. Operative Note: The patient with metastatic cancer underwent synovectomy, tenolysis, and bone erosion repair in the right knee. Severe bone pain was reported preoperatively due to tumor infiltration. The procedure involved excision of diseased synovium, release of tendon adhesions, and bone grafting to alleviate pain and stabilize eroded bone sites. The surgery was successful in providing pain relief, and the patient's postoperative care will involve palliative measures and close monitoring.

2. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left wrist of a patient with severe bone pain associated with rheumatoid arthritis. The inflamed synovium was excised, tendon adhesions were released, and bone grafting was performed to address erosion. The procedure aimed to alleviate pain and improve joint function. Postoperatively, pain management and rehabilitation will be critical for the patient's recovery.

3. Operative Note: A patient with osteomyelitis underwent synovial debridement, tenolysis, and bone erosion repair in the right foot. Severe bone pain was reported due to the underlying infection. The procedure involved meticulous removal of infected synovium, release of tendon adhesions, and bone grafting to promote healing and alleviate pain. The surgery was successful, and the patient's postoperative care will include antibiotic therapy and pain management.

4. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right shoulder of a patient with severe bone pain associated with ankylosing spondylitis. The procedure involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The surgery aimed to reduce pain and improve shoulder mobility. Postoperatively, pain control and physiotherapy will be essential for optimal outcomes.

5. Operative Note: The patient with sickle cell disease underwent synovial biopsy, tenolysis, and bone erosion repair in the left ankle. Severe bone pain was reported due to vaso-occlusive crises. The procedure involved sampling of synovium, release of tendon adhesions, and bone grafting to address erosion and provide pain relief. The surgery was successful, and the patient's postoperative care will involve pain management and close monitoring of sickle cell-related complications.

6. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left hip of a patient with severe bone pain associated with avascular necrosis. The procedure involved excision of necrotic synovium, release of tendon adhesions, and bone grafting to restore joint integrity and alleviate pain. The surgery was successful, and the patient's postoperative care will include pain control and gradual rehabilitation.

7. Operative Note: A patient with multiple myeloma underwent synovial debridement, tenolysis, and bone erosion repair in the right hand. Severe bone pain was reported due to myeloma-associated bone lesions. The procedure involved removal of diseased synovium, release of tendon adhesions, and bone grafting to stabilize eroded bone areas. The surgery aimed to reduce pain and improve hand function. Postoperatively, pain management and oncological treatment will be essential.

8. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right elbow of a patient with severe bone pain associated with psoriatic arthritis. The procedure involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The surgery aimed to alleviate pain and restore elbow mobility. Postoperatively

, pain control and rehabilitation exercises will be crucial for optimal recovery.

9. Operative Note: A patient with fibrous dysplasia underwent synovial debridement, tenolysis, and bone erosion repair in the left knee. Severe bone pain was reported due to the underlying bone disorder. The procedure involved meticulous removal of abnormal synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The surgery aimed to alleviate pain and improve knee function. Postoperatively, pain management and close monitoring of the bone condition will be necessary.

10. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left shoulder of a patient with severe bone pain associated with rotator cuff tear arthropathy. The procedure involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion and alleviate pain. The surgery aimed to restore shoulder function and reduce pain. Postoperatively, pain control and physical therapy will be crucial for the patient's recovery.

1. Operative Note: The patient with septic arthritis underwent arthroscopic synovectomy, tenolysis, and bone erosion repair in the right knee. The procedure involved thorough debridement of infected synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to eradicate the infection, relieve pain, and restore joint function. Postoperatively, the patient will receive appropriate antibiotics and undergo rehabilitation for optimal recovery.

2. Operative Note: Excision of synovial plica, tenosynovectomy, and bone erosion repair were performed on the left elbow of a patient with severe bone pain associated with synovial plica syndrome. The procedure involved meticulous removal of the inflamed plica, release of tendon adhesions, and bone grafting to stabilize eroded bone areas. The surgical intervention aimed to alleviate pain and restore elbow function. Postoperatively, pain management and physical therapy will be crucial for recovery.

3. Operative Note: A patient with calcium pyrophosphate crystal deposition disease underwent synovial debridement, tenolysis, and bone erosion repair in the right wrist. The procedure involved excision of calcified synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to alleviate pain, improve joint function, and reduce the progression of the disease. Postoperatively, the patient will receive appropriate medications and undergo rehabilitation for optimal outcomes.

4. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right ankle of a patient with severe bone pain associated with rheumatoid arthritis. The procedure involved excision of hypertrophic synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to relieve pain, restore joint stability, and prevent further joint damage. Postoperatively, the patient will receive appropriate medications and undergo rehabilitation for optimal recovery.

5. Operative Note: The patient with pigmented villonodular synovitis (PVNS) underwent open synovectomy, tenolysis, and bone erosion repair in the left hip. The procedure involved meticulous excision of the abnormal synovium, release of tendon adhesions, and bone grafting to stabilize eroded bone sites. The surgical intervention aimed to alleviate pain, improve hip function, and prevent disease recurrence. Postoperatively, the patient will be closely monitored for any signs of PVNS recurrence.

6. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right shoulder of a patient with severe bone pain associated with adhesive capsulitis (frozen shoulder). The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to relieve pain, improve shoulder mobility, and restore function. Postoperatively, pain management and physical therapy will be crucial for optimal recovery.

7. Operative Note: A patient with diffuse idiopathic skeletal hyperostosis (DISH) underwent synovial debridement, tenolysis, and bone erosion repair in the thoracic spine. The procedure involved meticulous removal of ossified synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to alleviate severe bone pain, improve spinal stability, and prevent further complications. Postoperatively, the patient will be closely monitored for any signs of disease progression.

8. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left knee of a patient with severe bone pain associated with Hoffa's disease (infrapatellar fat pad impingement).

The surgical intervention involved excision of hypertrophic synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, restore knee function, and prevent further damage. Postoperatively, pain management and physical therapy will be essential for optimal recovery.

9. Operative Note: A patient with Ehlers-Danlos syndrome underwent synovial debridement, tenolysis, and bone erosion repair in the right hand. The procedure involved meticulous removal of hypermobile synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to alleviate severe bone pain, improve hand stability, and restore function. Postoperatively, the patient will receive appropriate rehabilitation and support to manage the underlying connective tissue disorder.

10. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right ankle of a patient with severe bone pain associated with reflex sympathetic dystrophy (complex regional pain syndrome). The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, improve ankle function, and interrupt the abnormal sympathetic response. Postoperatively, pain management and multidisciplinary rehabilitation will be crucial for optimal recovery.

1. Operative Note: The patient with osteoarthritis underwent arthroscopic synovectomy, tenolysis, and bone erosion repair in the right knee. Severe bone pain and joint dysfunction were reported preoperatively. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve knee function, and delay the progression of osteoarthritis. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

2. Operative Note: Excision of synovial hemangioma, tenosynovectomy, and bone erosion repair were performed on the left wrist of a patient with severe bone pain associated with synovial hemangioma syndrome. The surgical intervention involved meticulous removal of the vascularized synovium, release of tendon adhesions, and bone grafting to stabilize eroded bone areas. The procedure aimed to alleviate pain, improve wrist function, and prevent further complications. Postoperatively, the patient will receive appropriate rehabilitation and follow-up.

3. Operative Note: A patient with Behçet's disease underwent synovial debridement, tenolysis, and bone erosion repair in the right ankle. Severe bone pain and joint instability were reported preoperatively. The surgical intervention involved removal of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, restore ankle stability, and improve functional outcomes. Postoperatively, the patient will receive appropriate immunosuppressive therapy and rehabilitation.

4. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right shoulder of a patient with severe bone pain associated with calcific tendinitis. The surgical intervention involved excision of calcified synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, improve shoulder mobility, and prevent recurrence. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

5. Operative Note: The patient with systemic sclerosis underwent synovial debridement, tenolysis, and bone erosion repair in the left hand. Severe bone pain and joint contractures were reported preoperatively. The surgical intervention involved meticulous removal of fibrotic synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve hand function, and prevent further joint deformity. Postoperatively, the patient will receive appropriate hand therapy and follow-up care.

6. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right knee of a patient with severe bone pain associated with pigmented villonodular synovitis (PVNS). The surgical intervention involved excision of abnormal synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, improve knee function, and prevent disease recurrence. Postoperatively, the patient will receive appropriate rehabilitation and be closely monitored for any signs of PVNS recurrence.

7. Operative Note: A patient with systemic lupus erythematosus (SLE) underwent synovial debridement, tenolysis, and bone erosion repair in the right hip. Severe bone pain and joint dysfunction were reported preoperatively. The surgical intervention involved meticulous removal of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve hip stability, and prevent further damage. Postoperatively, the patient will receive appropriate immunosuppressive therapy

and undergo rehabilitation.

8. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left shoulder of a patient with severe bone pain associated with rotator cuff tear. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, restore shoulder function, and promote rotator cuff healing. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

9. Operative Note: A patient with gouty arthritis underwent arthroscopic synovectomy, tenolysis, and bone erosion repair in the right foot. Severe bone pain and joint deformity were reported preoperatively. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve foot function, and prevent recurrent gout attacks. Postoperatively, the patient will receive appropriate medication and undergo rehabilitation.

10. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right elbow of a patient with severe bone pain associated with bursitis and osteochondritis dissecans. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve elbow function, and promote healing of the osteochondral defect. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

1. Operative Note: The patient with septic arthritis and severe infection in the hip joint underwent urgent surgical intervention. An extensive synovectomy, tenolysis, and bone erosion repair were performed. The procedure involved thorough debridement of infected synovium, release of tendon adhesions, and bone grafting to address erosion. The aim was to eradicate the infection, alleviate pain, and restore joint function. Postoperatively, the patient will receive intravenous antibiotics, close monitoring, and intensive rehabilitation.

2. Operative Note: A patient presented with a severe infection in the shoulder joint due to septic bursitis. Surgical intervention involved a thorough synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to eradicate the infection, alleviate severe pain, and restore shoulder mobility. Postoperatively, the patient will receive appropriate antibiotics, wound care, and rehabilitation.

3. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the knee joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore knee function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and intensive rehabilitation.

4. Operative Note: The patient presented with septic arthritis and a severe infection in the ankle joint. Urgent surgical intervention was performed, including a thorough synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to eradicate the infection, alleviate severe pain, and restore ankle mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive physical therapy.

5. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the elbow joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore elbow function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and rehabilitative exercises.

6. Operative Note: A patient with septic arthritis and a severe infection in the wrist joint underwent urgent surgical intervention. The procedure included a comprehensive synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to eradicate the infection, alleviate severe pain, and restore wrist mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive rehabilitation.

7. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the hip joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore hip function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and rehabilitative exercises.

8. Operative Note

: A patient with septic arthritis and a severe infection in the shoulder joint underwent urgent surgical intervention. The procedure involved a comprehensive synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to eradicate the infection, alleviate severe pain, and restore shoulder mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive rehabilitation.

9. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the knee joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore knee function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and rehabilitative exercises.

10. Operative Note: A patient presented with septic arthritis and a severe infection in the ankle joint. Urgent surgical intervention was performed, including a thorough synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to eradicate the infection, alleviate severe pain, and restore ankle mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive physical therapy.

1. Operative Note: The patient presented with chronic inflammation and severe infection in the hip joint. Surgical intervention involved synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The procedure aimed to alleviate severe pain, eradicate infection, and restore hip function. Postoperatively, the patient will receive appropriate anti-inflammatory medication and undergo rehabilitative therapy.

2. Operative Note: A patient with recurrent inflammation and a severe infection in the shoulder joint underwent surgical intervention. Synovial debridement, tenolysis, and bone erosion repair were performed. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to alleviate pain, eliminate infection, and restore shoulder mobility. Postoperatively, the patient will receive anti-inflammatory medication and participate in a comprehensive rehabilitation program.

3. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the knee joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to alleviate severe pain, eradicate infection, and restore knee function. Postoperatively, the patient will receive anti-inflammatory medication, undergo joint immobilization, and engage in rehabilitative exercises.

4. Operative Note: A patient with chronic inflammatory disease and severe infection in the ankle joint underwent surgical intervention. The procedure involved synovial debridement, tenolysis, and bone erosion repair. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The goal was to alleviate severe pain, eradicate infection, and restore ankle mobility. Postoperatively, the patient will receive anti-inflammatory medication and undergo intensive rehabilitative therapy.

5. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the elbow joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The objective was to alleviate severe pain, eliminate infection, and restore elbow function. Postoperatively, the patient will receive anti-inflammatory medication, joint immobilization, and rehabilitative exercises.

6. Operative Note: A patient with chronic inflammation and severe infection in the wrist joint underwent surgical intervention. Synovial debridement, tenolysis, and bone erosion repair were performed. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to alleviate severe pain, eradicate infection, and restore wrist mobility. Postoperatively, the patient will receive anti-inflammatory medication and engage in intensive rehabilitative therapy.

7. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the hip joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to alleviate severe pain, eliminate infection, and restore hip function. Postoperatively, the patient will receive anti-inflammatory medication, joint immobilization, and rehabilitative exercises.

8. Operative Note: A patient with chronic inflammation and severe infection in the shoulder joint underwent surgical intervention. The procedure involved synovial debridement, tenol

ysis, and bone erosion repair. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to alleviate severe pain, eradicate infection, and restore shoulder mobility. Postoperatively, the patient will receive anti-inflammatory medication and participate in a comprehensive rehabilitation program.

9. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the knee joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The objective was to alleviate severe pain, eliminate infection, and restore knee function. Postoperatively, the patient will receive anti-inflammatory medication, joint immobilization, and engage in rehabilitative exercises.

10. Operative Note: A patient with chronic inflammatory disease and severe infection in the ankle joint underwent surgical intervention. The procedure involved synovial debridement, tenolysis, and bone erosion repair. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The goal was to alleviate severe pain, eradicate infection, and restore ankle mobility. Postoperatively, the patient will receive anti-inflammatory medication and undergo intensive rehabilitative therapy.

1. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved synovectomy, tenosynovectomy, and bone erosion repair. The severity of the diagnosis necessitated close postoperative monitoring and follow-up appointments to assess the response to treatment. The patient will receive appropriate pain management and rehabilitation based on the severity of symptoms and disease progression.

2. Operative Note: Urgent surgical intervention was performed on a patient with a moderate diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. The surgical procedure included synovial debridement, tenolysis, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be scheduled based on the severity of symptoms and the response to treatment. The patient will receive appropriate medication, physiotherapy, and further interventions as required.

3. Operative Note: A patient with a mild diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere underwent surgical intervention. Synovectomy, tenosynovectomy, and bone erosion repair were performed. The patient's follow-up appointments will be scheduled to monitor the response to treatment and adjust the management plan accordingly. The patient will receive appropriate pain management, rehabilitation, and ongoing evaluation based on the severity of symptoms and disease progression.

4. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved an extensive synovial debridement, tenolysis, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be frequent and closely monitored due to the severity of the diagnosis. The patient will receive intensive rehabilitation, pain management, and further interventions as necessary.

5. Operative Note: Urgent surgical intervention was performed on a patient with a moderate diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. The surgical procedure included synovectomy, tenosynovectomy, and bone erosion repair. The patient's follow-up appointments will be scheduled based on the severity of symptoms and the response to treatment. The patient will receive appropriate pain management, rehabilitation, and further interventions if required.

6. Operative Note: A patient with a mild diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere underwent surgical intervention. Synovial debridement, tenolysis, and bone erosion repair were performed. The patient's follow-up appointments will be arranged based on the severity of symptoms and the progression of the disease. The patient will receive appropriate pain management, rehabilitative therapy, and periodic evaluations.

7. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved extensive synovectomy, tenosynovectomy, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be frequent and closely monitored due to the severity of the diagnosis. The patient will receive intensive rehabilitation, pain management, and further interventions as necessary.

8. Operative Note: Urgent surgical intervention was performed on a patient with a moderate diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. The surgical procedure included synovial debridement, tenolysis, and bone erosion repair. The patient's follow-up appointments will be scheduled based on the severity of symptoms and the response to treatment. The patient will receive appropriate pain management, rehabilitation, and further interventions if required.

9. Operative Note: A patient with a mild diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere underwent surgical intervention. Synovectomy, tenosynovectomy, and bone erosion repair were performed. The patient's follow-up appointments will be arranged based on

the severity of symptoms and the progression of the disease. The patient will receive appropriate pain management, rehabilitative therapy, and periodic evaluations.

10. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved an extensive synovial debridement, tenolysis, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be frequent and closely monitored due to the severity of the diagnosis. The patient will receive intensive rehabilitation, pain management, and further interventions as necessary.

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## M70.0 Chronic crepitant synovitis of hand and wrist

1. Operative Note: Patient underwent arthroscopic synovectomy for chronic crepitant synovitis of the hand and wrist. A 2 cm incision was made, and the arthroscope was inserted to visualize the joint. The synovial tissue was excised using a shaver and biopsy forceps. Hemostasis was achieved, and the incision was closed with sutures.

2. Operative Note: Patient underwent open synovectomy for chronic crepitant synovitis of the hand and wrist. A dorsal approach was utilized, and the extensor retinaculum was incised. The synovial tissue was identified and excised meticulously. Hemostasis was achieved, and the wound was closed in layers using sutures.

3. Operative Note: Patient underwent ultrasound-guided corticosteroid injection for chronic crepitant synovitis of the hand and wrist. Under aseptic conditions, the synovial sheath was identified using ultrasound guidance. A mixture of local anesthetic and corticosteroid was injected into the affected area, aiming for symptomatic relief. The patient tolerated the procedure well, and post-injection instructions were provided.

4. Operative Note: Patient underwent joint lavage and debridement for chronic crepitant synovitis of the hand and wrist. A volar approach was used, and the joint capsule was opened. Copious irrigation was performed using sterile saline, followed by meticulous debridement of the synovial tissue. The joint was thoroughly inspected, and the wound was closed with sutures.

5. Operative Note: Patient underwent synovial biopsy for chronic crepitant synovitis of the hand and wrist. A 1 cm incision was made, and the synovial membrane was exposed. A small tissue sample was obtained for histopathological examination. Hemostasis was ensured, and the incision was closed using sutures. The specimen was sent to the pathology department for analysis.

6. Operative Note: Patient underwent arthroscopic synovial biopsy for chronic crepitant synovitis of the hand and wrist. Small portals were created, and the arthroscope was introduced into the joint. A biopsy punch was used to obtain multiple synovial tissue samples for pathological evaluation. Hemostasis was achieved, and the portals were closed with sutures.

7. Operative Note: Patient underwent synovial fluid aspiration for chronic crepitant synovitis of the hand and wrist. A sterile technique was employed, and the joint space was identified. Using a needle and syringe, synovial fluid was aspirated for analysis. The procedure was well-tolerated by the patient, and post-procedure instructions were given.

8. Operative Note: Patient underwent synovial fenestration for chronic crepitant synovitis of the hand and wrist. A dorsal approach was taken, and multiple small incisions were made over the affected joints. The synovial membrane was fenestrated using a needle or electrocautery to promote fluid drainage. The wounds were dressed, and the patient was educated about wound care.

9. Operative Note: Patient underwent tenosynovectomy for chronic crepitant synovitis of the hand and wrist. A radial or ulnar approach was used, and the affected tendon sheath was exposed. Careful dissection was performed to remove the inflamed synovial tissue. Hemostasis was achieved, and the wound was closed using sutures.

10. Operative Note: Patient underwent joint immobilization for chronic crepitant synovitis of the hand and wrist. The joint was stabilized using a custom-made splint or cast. Proper positioning and immobilization were ensured to minimize joint movement. The

patient was instructed on proper splint/cast care and follow-up appointments for evaluation of symptoms and joint function.

1. Operative Note: Patient underwent arthroscopic synovial debridement for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The synovial tissue was carefully debrided using arthroscopic instruments, ensuring removal of any loose bodies or adhesions. Hemostasis was achieved, and the incisions were closed with sutures.

2. Operative Note: Patient underwent joint irrigation with corticosteroid injection for chronic crepitant synovitis of the hand and wrist. A dorsal approach was utilized, and the joint capsule was opened. The joint was thoroughly irrigated with sterile saline, followed by the injection of a corticosteroid solution into the joint space. The joint capsule was closed, and the wound was sutured in layers.

3. Operative Note: Patient underwent synovial biopsy with synovectomy for chronic crepitant synovitis of the hand and wrist. A volar approach was used, and the synovial tissue was exposed. A biopsy sample was obtained for pathological analysis, and then a synovectomy was performed to remove the inflamed synovium. Hemostasis was achieved, and the wound was closed meticulously.

4. Operative Note: Patient underwent joint arthrodesis for chronic crepitant synovitis of the hand and wrist. An incision was made, and the affected joint surfaces were prepared. Fixation was achieved using screws, plates, or other hardware to promote fusion. The joint was immobilized, and the wound was closed layer by layer. Postoperative instructions were given regarding immobilization and rehabilitation.

5. Operative Note: Patient underwent ultrasound-guided hydrodissection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, an ultrasound probe was used to identify the affected area. Saline solution was injected to create a space between the synovial tissue and surrounding structures, promoting pain relief and improved mobility. The procedure was performed successfully without complications.

6. Operative Note: Patient underwent tenosynovectomy with tendon repair for chronic crepitant synovitis of the hand and wrist. A radial or ulnar approach was chosen, and the inflamed tendon sheath was exposed. The synovial tissue was excised, and any associated tendon injuries were repaired. Hemostasis was ensured, and the wound was closed with sutures.

7. Operative Note: Patient underwent joint denervation for chronic crepitant synovitis of the hand and wrist. A dorsal or volar approach was utilized, and the affected joint was exposed. The sensory nerves supplying the joint were identified and selectively denervated to alleviate pain. Hemostasis was achieved, and the wound was closed meticulously.

8. Operative Note: Patient underwent intra-articular hyaluronic acid injection for chronic crepitant synovitis of the hand and wrist. Under aseptic conditions, the joint space was accessed, and hyaluronic acid was injected to improve joint lubrication and reduce inflammation. The patient tolerated the procedure well, and post-injection instructions were provided.

9. Operative Note: Patient underwent arthroscopic synovial biopsy and synovial plication for chronic crepitant synovitis of the hand and wrist. Multiple portals were created, and the arthroscope was introduced into the joint. Biopsy samples were obtained for pathological analysis, and synovial plication was performed to tighten and stabilize the synovial membrane. The portals were closed, and the patient was discharged with appropriate postoperative

care instructions.

10. Operative Note: Patient underwent joint resurfacing for chronic crepitant synovitis of the hand and wrist. An incision was made, and the joint surfaces were prepared. The damaged cartilage was removed, and a synthetic or biological implant was used to resurface the joint. The implant was secured in place, and the wound was closed meticulously. Postoperative rehabilitation plan was discussed with the patient.

1. Operative Note: Patient underwent arthroscopic synovectomy for chronic crepitant synovitis of the hand and wrist under local anesthesia. A 2 cm incision was made, and the arthroscope was inserted to visualize the joint. The synovial tissue was excised using a shaver and biopsy forceps. Hemostasis was achieved, and the incision was closed with sutures. The patient remained comfortable throughout the procedure with local anesthesia.

2. Operative Note: Patient underwent open synovectomy for chronic crepitant synovitis of the hand and wrist under regional anesthesia. A dorsal approach was utilized, and the extensor retinaculum was incised. The synovial tissue was identified and excised meticulously. Hemostasis was achieved, and the wound was closed in layers using sutures. The patient had adequate pain control with regional anesthesia.

3. Operative Note: Patient underwent ultrasound-guided corticosteroid injection for chronic crepitant synovitis of the hand and wrist under conscious sedation. Under aseptic conditions, the synovial sheath was identified using ultrasound guidance. A mixture of local anesthetic and corticosteroid was injected into the affected area, aiming for symptomatic relief. The patient was comfortable and cooperative during the procedure with conscious sedation.

4. Operative Note: Patient underwent joint lavage and debridement for chronic crepitant synovitis of the hand and wrist under general anesthesia. A volar approach was used, and the joint capsule was opened. Copious irrigation was performed using sterile saline, followed by meticulous debridement of the synovial tissue. The joint was thoroughly inspected, and the wound was closed with sutures. The patient was asleep throughout the procedure under general anesthesia.

5. Operative Note: Patient underwent synovial biopsy for chronic crepitant synovitis of the hand and wrist under monitored anesthesia care (MAC). A 1 cm incision was made, and the synovial membrane was exposed. A small tissue sample was obtained for histopathological examination. Hemostasis was ensured, and the incision was closed using sutures. The patient was comfortable and responsive under MAC.

6. Operative Note: Patient underwent arthroscopic synovial biopsy for chronic crepitant synovitis of the hand and wrist under moderate sedation. Small portals were created, and the arthroscope was introduced into the joint. A biopsy punch was used to obtain multiple synovial tissue samples for pathological evaluation. Hemostasis was achieved, and the portals were closed with sutures. The patient remained calm and relaxed with moderate sedation.

7. Operative Note: Patient underwent synovial fluid aspiration for chronic crepitant synovitis of the hand and wrist under local anesthesia. A sterile technique was employed, and the joint space was identified. Using a needle and syringe, synovial fluid was aspirated for analysis. The procedure was well-tolerated by the patient, and post-procedure instructions were given. Local anesthesia provided adequate pain control.

8. Operative Note: Patient underwent synovial fenestration for chronic crepitant synovitis of the hand and wrist under regional anesthesia. A dorsal approach was taken, and multiple small incisions were made over the affected joints. The synovial membrane was fenestrated using a needle or electrocautery to promote fluid drainage. The wounds were dressed, and the patient was educated about wound care. Regional anesthesia provided effective pain relief.

9. Operative Note: Patient underwent tenosynovectomy for

chronic crepitant synovitis of the hand and wrist under general anesthesia. A radial or ulnar approach was used, and the affected tendon sheath was exposed. Careful dissection was performed to remove the inflamed synovial tissue. Hemostasis was achieved, and the wound was closed using sutures. The patient was comfortably asleep throughout the procedure under general anesthesia.

10. Operative Note: Patient underwent joint immobilization for chronic crepitant synovitis of the hand and wrist under local anesthesia with sedation. The joint was stabilized using a custom-made splint or cast. Proper positioning and immobilization were ensured to minimize joint movement. The patient was relaxed and pain-free during the procedure with a combination of local anesthesia and sedation.

1. Operative Note: Patient underwent arthroscopic synovectomy with bone erosion repair for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The synovial tissue was excised, and areas of bone erosion were identified. Bone grafts were meticulously placed to promote bone regeneration. Hemostasis was achieved, and the incisions were closed with sutures.

2. Operative Note: Patient underwent open synovectomy with bone grafting for chronic crepitant synovitis of the hand and wrist. A dorsal approach was utilized, and the extensor retinaculum was incised. The synovial tissue was identified and excised, revealing underlying bone erosion. Bone grafts were carefully placed to fill the defects. Hemostasis was achieved, and the wound was closed in layers using sutures.

3. Operative Note: Patient underwent joint reconstruction with bone augmentation for chronic crepitant synovitis of the hand and wrist. An incision was made, and the joint surfaces were exposed. The eroded bone areas were meticulously debrided, and bone grafts or synthetic bone substitutes were used to reconstruct the damaged bone. The joint was stabilized, and the wound was closed meticulously.

4. Operative Note: Patient underwent joint arthrodesis with bone fusion for chronic crepitant synovitis of the hand and wrist. An incision was made, and the affected joint surfaces were prepared. Bone resection was performed to remove the eroded areas, followed by fixation using screws, plates, or other hardware to promote bone fusion. The joint was immobilized, and the wound was closed layer by layer.

5. Operative Note: Patient underwent joint resurfacing with bone grafting for chronic crepitant synovitis of the hand and wrist. An incision was made, and the damaged joint surfaces were carefully prepared. Bone grafts were harvested from the patient or obtained from a bone bank, and these grafts were used to resurface the eroded bone areas. The grafts were secured in place, and the wound was closed meticulously.

6. Operative Note: Patient underwent arthroscopic bone debridement and bone grafting for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was introduced into the joint. The eroded bone areas were carefully debrided using arthroscopic instruments. Bone grafts were then placed to fill the defects. Hemostasis was achieved, and the incisions were closed with sutures.

7. Operative Note: Patient underwent joint reconstruction with autologous bone grafting for chronic crepitant synovitis of the hand and wrist. A dorsal or volar approach was used, and the joint was exposed. The eroded bone areas were meticulously debrided, and autologous bone grafts harvested from the patient were used for reconstruction. The joint was stabilized, and the wound was closed meticulously.

8. Operative Note: Patient underwent joint fusion with bone grafting and internal fixation for chronic crepitant synovitis of the hand and wrist. An incision was made, and the eroded joint surfaces were prepared. Bone grafts were placed between the joint surfaces to promote fusion. Internal fixation with screws or plates was performed to provide stability. The joint was immobilized, and the wound was closed layer by layer.

9. Operative Note: Patient underwent joint reconstruction with allograft bone grafting for chronic crepitant synovitis of the hand

and wrist. A volar approach was chosen, and the joint was exposed. The eroded bone areas were carefully debrided, and allograft bone grafts were used for reconstruction. The joint was stabilized, and the wound was closed meticulously.

10. Operative Note: Patient underwent joint arthroplasty with bone augmentation for chronic crepitant synovitis of the hand and wrist. An incision was made, and the eroded joint surfaces were resected. Bone augmentation with bone grafts or bone substitutes was performed to restore bone integrity. The joint prosthesis was then implanted, and the wound was closed meticulously.

1. Operative Note: Patient underwent arthroscopic synovectomy for chronic crepitant synovitis of the hand and wrist due to severe bone pain. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The synovial tissue was meticulously excised to alleviate inflammation and reduce bone pain. Hemostasis was achieved, and the incisions were closed with sutures.

2. Operative Note: Patient underwent joint denervation for chronic crepitant synovitis of the hand and wrist to address severe bone pain. A dorsal or volar approach was utilized, and the affected joint was exposed. The sensory nerves supplying the joint were identified and selectively denervated to interrupt pain signals. Hemostasis was achieved, and the wound was closed meticulously.

3. Operative Note: Patient underwent joint resurfacing with bone grafting for chronic crepitant synovitis of the hand and wrist associated with severe bone pain. An incision was made, and the damaged joint surfaces were prepared. Bone grafts were meticulously placed to restore bone integrity and alleviate bone pain. The grafts were secured in place, and the wound was closed meticulously.

4. Operative Note: Patient underwent joint fusion for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the affected joint surfaces were prepared. The eroded bone areas were meticulously debrided, followed by fixation using screws, plates, or other hardware to promote bone fusion and eliminate painful joint movement. The joint was immobilized, and the wound was closed layer by layer.

5. Operative Note: Patient underwent joint reconstruction with autologous bone grafting for chronic crepitant synovitis of the hand and wrist presenting with severe bone pain. A dorsal or volar approach was used, and the joint was exposed. The eroded bone areas were meticulously debrided, and autologous bone grafts harvested from the patient were used for reconstruction to alleviate severe bone pain. The joint was stabilized, and the wound was closed meticulously.

6. Operative Note: Patient underwent joint arthrodesis for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the affected joint surfaces were prepared. The eroded bone areas were meticulously removed, and the joint was fixed in a fused position using screws, plates, or other hardware to eliminate painful joint movement. The joint was immobilized, and the wound was closed layer by layer.

7. Operative Note: Patient underwent joint debridement with bone augmentation for chronic crepitant synovitis of the hand and wrist and severe bone pain. A volar approach was chosen, and the joint was exposed. The eroded bone areas were meticulously debrided, and bone grafts or bone substitutes were placed to support bone regeneration and alleviate severe bone pain. The wound was closed meticulously.

8. Operative Note: Patient underwent joint replacement for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the eroded joint surfaces were resected. A joint prosthesis was meticulously implanted to provide stability and relieve severe bone pain. The wound was closed meticulously, and postoperative pain management was discussed with the patient.

9. Operative Note: Patient underwent joint reconstruction with allograft bone grafting for chronic crepitant synovitis of the hand and wrist accompanied by severe bone pain. A volar approach was chosen, and the joint was exposed. The eroded bone areas were meticulously de

brided, and allograft bone grafts were used for reconstruction to alleviate severe bone pain. The joint was stabilized, and the wound was closed meticulously.

10. Operative Note: Patient underwent joint immobilization for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the joint was stabilized using a custom-made splint or cast. Proper positioning and immobilization were ensured to minimize joint movement and alleviate severe bone pain. The patient was instructed on postoperative pain management and provided with appropriate pain medications.

1. Operative Note: Patient underwent arthroscopic synovectomy with joint irrigation and debridement for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The inflamed synovial tissue was meticulously excised, followed by thorough irrigation and debridement of the joint. Hemostasis was achieved, and the incisions were closed using sutures.

2. Operative Note: Patient underwent ultrasound-guided corticosteroid injection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, ultrasound guidance was used to accurately locate the affected area. A mixture of local anesthetic and corticosteroid was injected into the inflamed synovial tissue to reduce inflammation and alleviate symptoms. The injection site was dressed, and post-procedure instructions were given.

3. Operative Note: Patient underwent magnetic resonance imaging (MRI)-guided synovial biopsy for chronic crepitant synovitis of the hand and wrist. The patient was positioned in the MRI scanner, and the affected joint was accurately targeted. A biopsy needle was guided into the synovial tissue for sampling. Hemostasis was achieved, and appropriate wound care instructions were provided.

4. Operative Note: Patient underwent intra-articular hyaluronic acid injection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, the affected joint was accessed, and hyaluronic acid was injected into the joint space to provide lubrication and reduce pain. The injection site was dressed, and post-injection care instructions were discussed with the patient.

5. Operative Note: Patient underwent ultrasound-guided aspiration and corticosteroid injection for chronic crepitant synovitis of the hand and wrist. Ultrasound guidance was used to locate the affected joint and guide the aspiration of synovial fluid. After aspiration, a mixture of corticosteroid and local anesthetic was injected into the joint space to reduce inflammation and alleviate pain. The injection site was dressed, and post-procedure instructions were given.

6. Operative Note: Patient underwent arthroscopic synovial plication for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The redundant synovial tissue was meticulously folded and plicated to reduce synovial volume and improve joint stability. Hemostasis was achieved, and the incisions were closed using sutures.

7. Operative Note: Patient underwent ultrasound-guided platelet-rich plasma (PRP) injection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, ultrasound guidance was used to accurately locate the affected area. PRP, prepared from the patient's own blood, was injected into the inflamed synovial tissue to promote healing and reduce inflammation. The injection site was dressed, and post-injection care instructions were provided.

8. Operative Note: Patient underwent joint arthroscopy with thermal capsulorrhaphy for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. Thermal energy was used to shrink and tighten the joint capsule, providing stability and reducing pain. Hemostasis was achieved, and the incisions were closed using sutures.

9. Operative Note: Patient underwent joint manipulation under anesthesia for chronic crepitant synovitis of the hand and wrist. The patient was placed under general anesthesia, and the affected joint was manipulated to break up adhes

ions and improve range of motion. The joint was carefully mobilized, and post-procedure instructions were given to the patient.

10. Operative Note: Patient underwent open synovectomy with joint reconstruction for chronic crepitant synovitis of the hand and wrist. An incision was made, and the affected joint was exposed. The inflamed synovial tissue was meticulously excised, followed by joint reconstruction using autograft or allograft. Hemostasis was achieved, and the wound was closed meticulously.

1. Operative Note: Patient underwent emergency joint irrigation and debridement for chronic crepitant synovitis of the hand and wrist with severe infection. An urgent incision was made, and the joint was accessed. Copious irrigation with sterile saline and antiseptic solution was performed to flush out the infected material. Infected tissues, including the synovium, were meticulously debrided. Antibiotic-impregnated beads or irrigation was utilized. Hemostasis was achieved, and the wound was left open for further management.

2. Operative Note: Patient underwent urgent joint arthroscopy with abscess drainage for chronic crepitant synovitis of the hand and wrist with a severe infected abscess. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The abscess was identified and meticulously drained. Thorough irrigation with antimicrobial solution was performed. The joint was assessed for any signs of damaged tissue or erosions. Hemostasis was achieved, and the incisions were closed using sutures.

3. Operative Note: Patient underwent joint fusion with extensive debridement for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the eroded joint surfaces were thoroughly debrided. The infected tissue and any necrotic bone were meticulously removed. The joint was fused using hardware and bone grafts to eliminate infection and provide stability. Hemostasis was achieved, and the wound was closed meticulously.

4. Operative Note: Patient underwent amputation of the affected extremity for chronic crepitant synovitis of the hand and wrist with severe joint infection that was unresponsive to conservative measures. An incision was made proximal to the affected joint, and disarticulation was performed. Careful hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management and rehabilitation plans were discussed with the patient.

5. Operative Note: Patient underwent radical synovectomy and joint reconstruction for chronic crepitant synovitis of the hand and wrist with severe joint infection. An extensive incision was made, and the joint was exposed. The infected synovium and surrounding tissues were meticulously excised. Joint reconstruction was performed using autograft or allograft, followed by thorough irrigation with antimicrobial solution. Hemostasis was achieved, and the wound was closed meticulously.

6. Operative Note: Patient underwent urgent joint washout with soft tissue debridement for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the infected joint was meticulously irrigated with sterile saline and antiseptic solution to remove infected material. Soft tissue debridement was performed to remove necrotic or devitalized tissue. Antibiotic-impregnated dressings were applied, and postoperative care instructions were provided.

7. Operative Note: Patient underwent joint salvage procedure for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the joint was exposed. Extensive debridement of the infected tissues was performed, followed by meticulous irrigation with antimicrobial solution. A combination of local or systemic antibiotics was administered. The joint was stabilized, and the wound was closed meticulously.

8. Operative Note: Patient underwent urgent joint resection arthroplasty for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the affected joint was meticulously resected to remove the infected and damaged tissue.

The joint surfaces were smoothed, and the wound was thoroughly irrigated. Hemostasis was achieved, and the wound was closed using sutures.

9. Operative Note: Patient underwent joint lavage with infected tissue debridement for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the joint was accessed. Copious lavage with sterile saline and antimicrobial solution was performed to flush out the infected material. Infected tissues, including the synovium and surrounding structures, were meticulously debrided. Antibiotic-impregnated dressings were applied, and the wound was dressed.

10. Operative Note: Patient underwent urgent joint amputation for chronic crepitant synovitis of the hand and wrist with severe joint infection that posed a significant risk to the patient's overall health. An incision was made proximal to the affected joint, and disarticulation was performed. Careful hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management, rehabilitation, and appropriate antibiotic therapy were discussed with the patient.

1. Operative Note: Patient underwent joint synovectomy and anti-inflammatory cytokine therapy for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the inflamed synovial tissue was meticulously excised. Intraoperative anti-inflammatory cytokine therapy was administered directly into the joint to reduce inflammation and promote healing. Hemostasis was achieved, and the wound was closed using sutures.

2. Operative Note: Patient underwent joint arthroscopy with synovial biopsy for chronic crepitant synovitis of the hand and wrist with severe inflammation. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. Synovial tissue samples were obtained for histopathological examination to evaluate the extent of inflammation. The joint was thoroughly irrigated, and the incisions were closed using sutures.

3. Operative Note: Patient underwent ultrasound-guided injection of anti-inflammatory medication for chronic crepitant synovitis of the hand and wrist with recurrent inflammation. Under sterile conditions, ultrasound guidance was used to accurately locate the affected area. An anti-inflammatory medication, such as corticosteroid or nonsteroidal anti-inflammatory drug, was injected into the inflamed synovial tissue to alleviate inflammation and associated symptoms. The injection site was dressed, and post-injection care instructions were provided.

4. Operative Note: Patient underwent joint fusion with synovial debridement for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the eroded joint surfaces were meticulously debrided. The inflamed synovial tissue was excised to reduce inflammation. The joint was stabilized using hardware and bone grafts to eliminate painful joint movement. Hemostasis was achieved, and the wound was closed meticulously.

5. Operative Note: Patient underwent joint irrigation and anti-inflammatory drug washout for chronic crepitant synovitis of the hand and wrist with acute exacerbation of inflammation. An incision was made, and the joint was thoroughly irrigated with sterile saline to remove inflammatory factors. An anti-inflammatory drug solution was used for washout to further reduce inflammation. Hemostasis was achieved, and the wound was closed using sutures.

6. Operative Note: Patient underwent joint denervation and anti-inflammatory therapy for chronic crepitant synovitis of the hand and wrist with persistent inflammation. A volar approach was utilized, and the affected joint was exposed. The sensory nerves supplying the joint were identified and selectively denervated to alleviate pain and reduce inflammation. Anti-inflammatory therapy, such as corticosteroid injection or intra-articular hyaluronic acid, was administered to further mitigate inflammation. The wound was closed meticulously.

7. Operative Note: Patient underwent open synovectomy with adjunctive anti-inflammatory phototherapy for chronic crepitant synovitis of the hand and wrist with refractory inflammation. An incision was made, and the inflamed synovial tissue was meticulously excised. Adjunctive anti-inflammatory phototherapy, such as low-level laser therapy, was applied to the surgical site to stimulate tissue healing and reduce inflammation. Hemostasis was achieved, and the wound was closed using sutures.

8. Operative Note: Patient underwent joint lavage with anti-inflammatory irrigation for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the joint was thoroughly irrigated with a solution containing an anti-inflammatory agent to reduce inflammation. Copious lavage was performed to flush out inflammatory factors and debris. Hemostasis was achieved, and

the wound was closed using sutures.

9. Operative Note: Patient underwent joint arthroscopy with intra-articular anti-inflammatory drug delivery for chronic crepitant synovitis of the hand and wrist with recurrent inflammation. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. An anti-inflammatory drug, such as a corticosteroid or hyaluronic acid, was delivered directly into the joint to alleviate inflammation and improve joint function. The incisions were closed using sutures.

10. Operative Note: Patient underwent joint synovectomy with intraoperative biologic therapy for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the inflamed synovial tissue was meticulously excised. Intraoperative biologic therapy, such as platelet-rich plasma or mesenchymal stem cell injection, was administered to modulate the inflammatory response and promote tissue regeneration. Hemostasis was achieved, and the wound was closed using sutures.

1. Operative Note: Patient underwent joint synovectomy for chronic crepitant synovitis of the hand and wrist. The inflamed synovial tissue was meticulously excised. The patient will follow up in two weeks for wound assessment and suture removal. Depending on the response, further follow-up visits and physical therapy sessions will be scheduled accordingly.

2. Operative Note: Patient underwent arthroscopic debridement and irrigation for chronic crepitant synovitis of the hand and wrist. Loose fragments and debris were removed, and the joint was thoroughly irrigated. The patient will have a postoperative appointment in one week to assess the recovery progress. Further follow-up visits will be scheduled based on the patient's symptoms and response to treatment.

3. Operative Note: Patient underwent joint fusion for chronic crepitant synovitis of the hand and wrist. The joint was stabilized using hardware and bone grafts. The patient will be closely monitored during the initial healing phase. Follow-up visits will be scheduled at regular intervals to assess fusion progress and address any concerns or complications that may arise.

4. Operative Note: Patient underwent synovial biopsy for chronic crepitant synovitis of the hand and wrist. The synovial tissue samples were sent for histopathological examination to determine the underlying cause. The patient will follow up in one week to discuss the biopsy results and formulate a treatment plan based on the findings.

5. Operative Note: Patient underwent joint washout with extensive debridement for chronic crepitant synovitis of the hand and wrist. The infected and inflamed tissue was meticulously removed, and the joint was thoroughly irrigated. The patient will have frequent follow-up visits in the initial postoperative period to monitor for signs of infection resolution and assess the need for additional treatment or antibiotics.

6. Operative Note: Patient underwent joint manipulation and splinting for chronic crepitant synovitis of the hand and wrist. The joint was carefully manipulated to improve range of motion, followed by application of a splint to maintain proper alignment. The patient will be seen in one week to assess the response to manipulation and adjust the splint if necessary. Further follow-up visits will be scheduled based on the patient's progress.

7. Operative Note: Patient underwent ultrasound-guided injection for chronic crepitant synovitis of the hand and wrist. A corticosteroid and anesthetic mixture was injected into the inflamed synovial tissue. The patient will have a follow-up appointment in three weeks to evaluate the response to the injection and determine the need for additional treatments or adjustments to the medication regimen.

8. Operative Note: Patient underwent joint arthroscopy with cartilage repair for chronic crepitant synovitis of the hand and wrist. The damaged cartilage surfaces were treated using cartilage repair techniques. The patient will follow up in six weeks for a postoperative evaluation, including imaging studies, to assess the success of the cartilage repair and determine the next steps in rehabilitation and treatment.

9. Operative Note: Patient underwent joint reconstruction for chronic crepitant synovitis of the hand and wrist. The joint was reconstructed using autograft or allograft to address the underlying joint damage. The patient will have regular follow-up visits to monitor the healing process, assess functional improvement, and adjust the rehabilitation plan as needed.

10. Operative Note: Patient underwent joint amputation for chronic crepitant synovitis of the hand and wrist with extensive joint damage and irreparable complications. The patient will be closely monitored during the initial postoperative phase for wound healing

and pain management. Follow-up visits will be scheduled to address prosthesis fitting, rehabilitation, and psychological support to ensure optimal recovery and adjustment to the amputation.

## M70.1 Bursitis of hand

1. Patient presented with acute hand bursitis. Following local anesthesia, a small incision was made over the inflamed bursa. The bursa was drained and irrigated, and a sterile dressing was applied. Patient instructed to elevate and immobilize the hand. Prescribed nonsteroidal anti-inflammatory drugs (NSAIDs) for pain relief. Follow-up appointment scheduled in two weeks for assessment of healing and further management if necessary.

2. Operative intervention performed for chronic hand bursitis. Under sterile conditions, a longitudinal incision was made to expose the affected bursa. Excision of the bursa was conducted, followed by thorough irrigation and hemostasis. Wound closure was achieved using absorbable sutures. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain control. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis. A small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered to reduce inflammation. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis. An incision was made to expose the inflamed bursa. Debridement of necrotic tissue was conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Postoperative instructions included hand immobilization and regular dressing changes. Prescribed analgesics for pain management. A follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis. A wide incision was made to drain the abscess. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. A drain was placed, and wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Instructed on signs of worsening infection and the need for immediate medical attention. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis. Two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and then injected with corticosteroids. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement for chronic hand bursitis. Small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous hemostasis was achieved. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis. An incision was made to explore the injured area. Hematoma evacuation and thorough irrigation were performed. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and persistent pain. Ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. A compression bandage was applied, and the patient was instructed to rest and elevate the hand

. Prescribed NSAIDs for pain relief. Advised to report any signs of infection or worsening symptoms. Follow-up appointment scheduled in two weeks for evaluation and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis. A small incision was made, and a specialized instrument was used to decompress the inflamed bursa. The procedure was completed under local anesthesia. Incision closed with adhesive strips and a sterile dressing applied. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Operative intervention performed for chronic hand bursitis. A dorsal incision was made over the affected area. The bursa was excised, and meticulous hemostasis was achieved. The wound was closed using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Instructed to avoid strenuous activities. Follow-up appointment scheduled in four weeks for wound evaluation and potential rehabilitation.

2. Patient presented with recurrent hand bursitis. Ultrasound-guided needle aspiration was performed to drain the inflamed bursa. The bursa was injected with a corticosteroid solution to alleviate inflammation. Sterile dressing applied, and hand immobilization instructed. Prescribed NSAIDs for pain relief. Follow-up appointment scheduled in two weeks for reassessment and further management if needed.

3. The patient underwent open bursectomy for severe hand bursitis. A transverse incision was made, and the inflamed bursa was excised. Thorough irrigation and hemostasis were ensured. The wound was closed using absorbable sutures. Postoperative instructions included hand elevation and regular dressing changes. Prescribed analgesics and advised on gradual hand mobilization. Follow-up appointment scheduled in three weeks for wound assessment and potential rehabilitation.

4. Surgical intervention performed for infected hand bursitis. An incision was made to drain the purulent material and debride the infected tissue. Copious irrigation with antiseptic solution was done. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised on daily dressing changes. Instructed on signs of worsening infection and the need for immediate medical attention. Follow-up appointment scheduled in two days.

5. Patient presented with bilateral hand bursitis. Two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and injected with a corticosteroid solution. Incisions closed using sutures, and sterile dressings applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and potential further interventions.

6. The patient underwent ultrasound-guided percutaneous needle aspiration for hand bursitis. The inflamed bursa was visualized using ultrasound guidance, and a needle was inserted to aspirate the fluid. Corticosteroid injection was administered for anti-inflammatory effect. Applied a compression bandage and instructed on hand elevation. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

7. Operative intervention performed for traumatic hand bursitis. An incision was made, and hematoma evacuation was conducted. Thorough irrigation was done, and the wound was closed using sutures. Prescribed analgesics and antibiotics. Instructed on hand immobilization and elevation. Follow-up appointment scheduled in one week for wound assessment and potential suture removal.

8. Patient presented with chronic hand bursitis unresponsive to conservative measures. A dorsal incision was made to expose the affected bursa. Bursectomy was performed, and meticulous hemostasis was achieved. The wound was closed using absorbable sutures. Postoperative instructions included hand immobilization, ice application, and prescribed NSAIDs. Follow-up appointment scheduled in four weeks for wound evaluation and potential rehabilitation.

9. The patient underwent arthroscopic debridement and bursectomy for refractory hand bursitis. Small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was meticulously excised, and thorough irrigation was performed. The incisions were closed with sutures, and

sterile dressings were applied. Postoperative instructions included hand elevation and regular dressing changes. Follow-up appointment scheduled in four weeks for wound assessment and potential rehabilitation.

10. Surgical intervention performed for hand bursitis with associated calcification. An incision was made to expose the calcified bursa, which was excised along with the surrounding calcific deposits. Thorough irrigation and hemostasis were ensured. The wound was closed using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential rehabilitation.

1. Patient presented with acute hand bursitis. Following local anesthesia with 10 ml of 1% lidocaine, a small incision was made over the inflamed bursa. The bursa was drained and irrigated, and a sterile dressing was applied. Prescribed nonsteroidal anti-inflammatory drugs (NSAIDs) for pain relief. Follow-up appointment scheduled in two weeks for assessment of healing and further management if necessary.

2. Operative intervention performed for chronic hand bursitis. Under sterile conditions, after administering regional anesthesia with an ulnar nerve block, a longitudinal incision was made to expose the affected bursa. Excision of the bursa was conducted, followed by thorough irrigation and hemostasis. Wound closure was achieved using absorbable sutures. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain control. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered to reduce inflammation. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa. Debridement of necrotic tissue was conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Postoperative instructions included hand immobilization and regular dressing changes. Prescribed analgesics for pain management. A follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. A drain was placed, and the wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Instructed on signs of worsening infection and the need for immediate medical attention. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and then injected with corticosteroids. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous hemostasis was achieved. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis. After administering local

anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area. Hematoma evacuation and thorough irrigation were performed. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and persistent pain. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. The procedure was completed under local anesthesia. Incision closed with adhesive strips and a sterile dressing applied. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Patient presented with hand bursitis and significant bone erosion. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa and the eroded bone. Debridement of necrotic tissue and bone was performed, followed by thorough irrigation and hemostasis. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. Operative intervention performed for chronic hand bursitis with bone erosion. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa and the eroded bone. Excision of the bursa and thorough debridement of the eroded bone were conducted, followed by meticulous irrigation and hemostasis. Wound closure was achieved using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis and progressive bone erosion. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered for inflammation reduction. Additional debridement of eroded bone was performed. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis with extensive bone erosion. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the eroded bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis and concurrent bone erosion. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the eroded bone. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. Additional debridement of eroded bone was performed. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis with extensive bone erosion. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae and the eroded bone. Both bursae were drained, irrigated, and injected with corticosteroids. Additional debridement of eroded bone was conducted. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement and bone erosion repair for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was

carefully excised, and meticulous debridement and repair of eroded bone were performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis with bone erosion. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area, drain the hematoma, and expose the eroded bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis with significant bone erosion. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. Incision closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Patient presented with severe bone pain associated with hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa and the affected bone. Debridement of necrotic tissue and thorough excision of the eroded bone were performed, followed by meticulous irrigation and hemostasis. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. Operative intervention performed for chronic hand bursitis with severe bone pain. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa and the painful bone. Excision of the bursa and thorough debridement of the eroded bone were conducted, followed by meticulous irrigation and hemostasis. Wound closure was achieved using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis and severe bone pain. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered for inflammation reduction. Additional debridement of eroded bone was performed to alleviate bone pain. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis with extensive bone pain. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the painful bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis and severe bone pain. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the eroded bone. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. Additional debridement of eroded bone was performed to alleviate bone pain. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis with severe bone pain. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae and the painful bones. Both bursae were drained, irrigated, and injected with corticosteroids. Additional debridement of eroded bone was conducted to alleviate bone pain. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement and bone erosion repair for chronic hand bursitis with severe bone pain. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl,

small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous debridement and repair of eroded bone were performed to alleviate severe bone pain. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis with severe bone pain. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area, drain the hematoma, and expose the eroded bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted to alleviate severe bone pain. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion causing severe bone pain. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted to alleviate severe bone pain. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis with significant bone erosion and severe bone pain. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. Incision closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Surgical intervention performed for chronic hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. The bursa was carefully excised, and meticulous debridement of necrotic tissue was conducted. Thorough irrigation was performed, followed by wound closure using interrupted sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. The patient underwent surgical excision for persistent hand bursitis. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Excision of the bursa and thorough debridement were performed, followed by meticulous irrigation and hemostasis. Wound closure was achieved using absorbable sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery and determine the need for additional interventions.

3. Surgical intervention performed for recurrent hand bursitis. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered for inflammation reduction. Additional debridement of necrotic tissue was conducted. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient instructed to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. The patient underwent surgical debridement and excision of eroded bone for severe hand bursitis. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the eroded bone. Thorough debridement of necrotic tissue and excision of the eroded bone were performed. Meticulous irrigation and exploration were conducted. Wound closure was achieved using interrupted sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Surgical intervention performed for infected hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the affected bursa. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. Debridement of necrotic tissue was performed. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and injected with corticosteroids. Debridement of necrotic tissue was conducted. Incisions were closed using absorbable sutures, and sterile dressings were applied. Patient instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement and repair for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised,

and meticulous debridement of necrotic tissue was performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area and drain the hematoma. The inflamed bursa and necrotic tissue were carefully excised. Thorough irrigation and exploration were conducted. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive surgical treatment for hand bursitis with significant bone erosion. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. Incision closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Surgical intervention performed for refractory hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. Extensive debridement of necrotic tissue was conducted, followed by thorough irrigation and hemostasis. A biological tissue graft was applied to promote healing. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. The patient underwent surgical debridement and bursectomy for chronic hand bursitis. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Complete excision of the bursa and meticulous debridement were performed, followed by thorough irrigation and exploration. The wound was closed using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery and determine the need for additional interventions.

3. Surgical intervention performed for recurrent hand bursitis with secondary infection. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the infected bursa was drained using a syringe. Extensive debridement of necrotic tissue and thorough irrigation with antiseptic solution were conducted. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days for wound reassessment.

4. The patient underwent surgical excision of eroded bone and debridement for severe hand bursitis. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the eroded bone. Thorough debridement of necrotic tissue and excision of the eroded bone were performed. Meticulous irrigation and exploration were conducted. The wound was closed using layered sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Surgical intervention performed for infected hand bursitis with abscess formation. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the affected bursa. Pus was aspirated, and extensive debridement of necrotic tissue was conducted. The wound was thoroughly irrigated with antiseptic solution. A drain was placed to facilitate drainage. Prescribed broad-spectrum antibiotics and instructed on daily dressing changes. Follow-up appointment scheduled in two days for wound reassessment.

6. Operative intervention performed for bilateral hand bursitis with persistent symptoms. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae. Complete excision of the bursae and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wounds were closed using absorbable sutures, and sterile dressings were applied. Patient instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic bursectomy and debridement for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed

bursa was carefully excised, and extensive debridement of necrotic tissue was performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis with eroded bone. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area and drain the hematoma. The inflamed bursa and eroded bone were carefully excised. Thorough irrigation and exploration were conducted. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion causing persistent symptoms. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive surgical treatment for hand bursitis with significant bone erosion and persistent symptoms. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. The incision was closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Urgent surgical intervention performed for severe infection of the extreme moving joint in the hand. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, a midline incision was made to expose the infected joint. Extensive debridement of necrotic tissue and thorough irrigation with antiseptic solution were conducted. The joint was stabilized, and a drain was placed for continuous drainage. Prescribed broad-spectrum antibiotics and instructed on hand immobilization. Scheduled for frequent wound reassessment and further interventions as needed.

2. The patient underwent emergency surgical drainage and debridement for a severe infection on the extreme moving joint in the hand. After administering regional anesthesia with a median nerve block, a curvilinear incision was made to access the infected joint. Pus was drained, and extensive debridement of necrotic tissue was performed. Thorough irrigation with antiseptic solution was conducted. A drain was inserted, and the wound was closed using interrupted sutures. Prescribed intravenous antibiotics and scheduled for daily wound dressing changes.

3. Surgical intervention performed for acute severe infection of the extreme moving joint in the hand. After administering local anesthesia with 10 ml of 1% lidocaine, a longitudinal incision was made to expose the infected joint. Purulent material was drained, and thorough debridement of necrotic tissue was conducted. The joint was irrigated with antiseptic solution and stabilized. A drain was placed for continuous drainage. Prescribed broad-spectrum antibiotics and advised on hand immobilization. Follow-up appointment scheduled in two days for wound reassessment and potential further interventions.

4. The patient underwent emergent surgical debridement and bursectomy for severe infection on the extreme moving joint in the hand. After administering regional anesthesia with an axillary nerve block, a curved incision was made to expose the infected joint. Complete excision of the infected bursa and meticulous debridement were performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a drain was inserted for continuous drainage. Prescribed intravenous antibiotics and scheduled for frequent wound assessment and interventions as needed.

5. Surgical intervention performed for advanced severe infection on the extreme moving joint in the hand. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, a midline incision was made to access the infected joint. Extensive debridement of necrotic tissue and purulent material was conducted. The joint was thoroughly irrigated with antiseptic solution and stabilized. A vacuum-assisted closure device was applied for continuous wound management. Prescribed broad-spectrum antibiotics and scheduled for regular wound evaluation and potential further interventions.

6. The patient underwent emergency surgical drainage and debridement for a severe infection of the extreme moving joint in the hand. After administering regional anesthesia with a median nerve block, a curvilinear incision was made to expose the infected joint. Pus was drained, and extensive debridement of necrotic tissue was performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a negative pressure wound therapy system was applied. Prescribed intravenous antibiotics and scheduled for frequent wound dressing changes and reassessment.

7. Surgical intervention performed for acute severe infection of the extreme moving joint in the hand. After administering local anesthesia with 10 ml of 1% lidocaine, a longitudinal incision was made to access the infected joint. Purulent material was drained, and meticulous debridement of necrotic tissue was conducted. The joint was irrigated with antiseptic solution and stabilized.

A vacuum-assisted closure device was applied for effective wound management. Prescribed broad-spectrum antibiotics and scheduled for regular wound evaluation and potential further interventions.

8. The patient underwent emergent surgical debridement and bursectomy for severe infection on the extreme moving joint in the hand. After administering regional anesthesia with an axillary nerve block, a curved incision was made to expose the infected joint. Complete excision of the infected bursa and extensive debridement were performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a negative pressure wound therapy system was initiated. Prescribed intravenous antibiotics and scheduled for frequent wound assessment and interventions as needed.

9. Surgical intervention performed for advanced severe infection on the extreme moving joint in the hand. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, a midline incision was made to access the infected joint. Extensive debridement of necrotic tissue and purulent material was conducted. The joint was thoroughly irrigated with antiseptic solution and stabilized. A vacuum-assisted closure device was applied for continuous wound management. Prescribed broad-spectrum antibiotics and scheduled for regular wound evaluation and potential further interventions.

10. The patient underwent emergency surgical drainage and debridement for a severe infection of the extreme moving joint in the hand. After administering regional anesthesia with a median nerve block, a curvilinear incision was made to expose the infected joint. Pus was drained, and extensive debridement of necrotic tissue was performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a negative pressure wound therapy system was applied. Prescribed intravenous antibiotics and scheduled for frequent wound dressing changes and reassessment.

1. Surgical intervention performed for chronic hand bursitis with severe inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. Extensive debridement of necrotic tissue was conducted, followed by thorough irrigation and hemostasis. The inflamed bursa was excised, and a biological tissue graft was applied for enhanced healing. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. The patient underwent surgical debridement and bursectomy for acute hand bursitis with moderate inflammation. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Meticulous debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with interrupted sutures. Prescribed postoperative analgesics and instructed on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery and determine the need for additional interventions.

3. Surgical intervention performed for recurrent hand bursitis with mild inflammation. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the inflamed bursa was drained using a syringe. Debridement of necrotic tissue and thorough irrigation with antiseptic solution were conducted. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days for wound reassessment.

4. The patient underwent surgical excision of the inflamed bursa and debridement for severe hand bursitis with marked inflammation. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa. Thorough debridement of necrotic tissue and meticulous irrigation were performed. The wound was closed using layered sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Surgical intervention performed for acute hand bursitis with moderate inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the inflamed bursa. Thorough debridement of necrotic tissue and irrigation with antiseptic solution were conducted. The inflamed bursa was excised, and the wound was closed using absorbable sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

6. The patient underwent minimally invasive surgical treatment for hand bursitis with mild inflammation. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. The procedure was completed under local anesthesia. The incision was closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

7. Surgical intervention performed for chronic hand bursitis with moderate inflammation. After administering regional anesthesia with an axillary nerve block, a curvilinear incision was made to expose the inflamed burs

a. Complete excision of the bursa and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wounds were closed using absorbable sutures, and sterile dressings were applied. Patient instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

8. The patient underwent arthroscopic bursectomy and debridement for chronic hand bursitis with mild inflammation. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and thorough debridement was performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

9. Surgical intervention performed for acute hand bursitis with marked inflammation and swelling. After administering local anesthesia with 10 ml of 1% lidocaine, a longitudinal incision was made to expose the inflamed bursa. Pus and fluid were drained, and extensive debridement of necrotic tissue was conducted. The inflamed bursa was excised, and thorough irrigation with antiseptic solution was performed. The wound was closed using interrupted sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in two weeks for wound reassessment and potential further interventions.

10. The patient underwent surgical debridement and bursectomy for chronic hand bursitis with mild inflammation. After administering regional anesthesia with a median nerve block, a curved incision was made to expose the affected bursa. Complete excision of the bursa and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wound was closed using absorbable sutures, and sterile dressings were applied. Prescribed postoperative analgesics and instructed on hand immobilization. Follow-up appointment scheduled in four weeks for evaluation and potential additional interventions.

1. The patient underwent surgical intervention for severe hand bursitis with extensive inflammation. After administering regional anesthesia with an axillary nerve block, a curvilinear incision was made to access the affected bursa. Thorough debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for frequent wound assessment and hand therapy sessions based on the severity of symptoms and healing progress.

2. Surgical intervention performed for moderate hand bursitis with persistent inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the inflamed bursa. Debridement of necrotic tissue and irrigation were conducted. Partial excision of the inflamed bursa was performed. The wound was closed with sutures. Prescribed postoperative analgesics and instructed on hand elevation. Follow-up appointment scheduled in two weeks to assess the response to treatment and determine the need for further interventions.

3. The patient underwent minimally invasive surgical treatment for mild hand bursitis with minimal inflammation. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. Thorough irrigation was conducted. The incision was closed with adhesive strips, and a sterile dressing was applied. Prescribed NSAIDs for pain management. Instructed on hand elevation and movement exercises. Follow-up appointment scheduled in four weeks for reassessment and potential additional interventions.

4. Surgical intervention performed for recurrent hand bursitis with moderate inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to expose the inflamed bursa. Thorough debridement of necrotic tissue and irrigation were conducted. The inflamed bursa was excised, and the wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for a follow-up visit in three weeks to monitor the healing progress and evaluate the need for further interventions.

5. The patient underwent surgical debridement and bursectomy for chronic hand bursitis with mild inflammation. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Complete excision of the bursa and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wounds were closed using absorbable sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in two weeks to assess the response to treatment and determine the need for further interventions.

6. Surgical intervention performed for acute hand bursitis with severe inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. Extensive debridement of necrotic tissue was conducted, followed by thorough irrigation and hemostasis. The inflamed bursa was excised, and a biological tissue graft was applied for enhanced healing. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in three weeks for wound evaluation and potential further interventions based on the severity of symptoms.

7. The patient underwent surgical debridement and bursectomy for chronic hand bursitis with moderate inflammation. After administering regional anesthesia with an axillary nerve block,

a curvilinear incision was made to access the affected bursa. Thorough debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for regular wound assessment and hand therapy sessions based on the severity of symptoms and healing progress.

8. Surgical intervention performed for mild hand bursitis with minimal inflammation. After administering local anesthesia with 5 ml of 1% lidocaine, an incision was made to explore the inflamed bursa. Debridement of necrotic tissue and thorough irrigation were conducted. The inflamed bursa was partially excised, and the wound was closed with sutures. Prescribed NSAIDs for pain management. Instructed on hand elevation and movement exercises. Follow-up appointment scheduled in six weeks to assess the response to treatment and evaluate the need for further interventions based on the severity of symptoms.

9. The patient underwent minimally invasive surgical treatment for moderate hand bursitis with persistent inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. Thorough irrigation was conducted. The incision was closed with adhesive strips, and a sterile dressing was applied. Prescribed NSAIDs and instructed on hand elevation and movement exercises. Follow-up appointment scheduled in four weeks for reassessment and potential additional interventions based on the severity of symptoms and healing progress.

10. Surgical intervention performed for severe hand bursitis with extensive inflammation. After administering regional anesthesia with an axillary nerve block, a curvilinear incision was made to access the affected bursa. Thorough debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for frequent wound assessment and hand therapy sessions based on the severity of symptoms and healing progress. A follow-up appointment was scheduled in two weeks to assess the response to treatment and determine the need for further interventions.

## M70.2 Olecranon bursitis

1. Patient presented with swelling and tenderness over the olecranon bursa. Aspiration performed, yielding serosanguinous fluid. Bursa irrigated with saline solution and 10 mL of corticosteroid injected. Adequate pressure dressing applied.

2. Surgical excision of olecranon bursa performed due to chronic bursitis. Skin incision made over the affected area. Bursa dissected and removed completely. Wound closed with sutures and sterile dressing applied.

3. Patient underwent ultrasound-guided needle aspiration of olecranon bursa for acute bursitis. Approximately 30 mL of turbid fluid aspirated. Bursa irrigated with sterile saline and corticosteroid injected. Compression dressing applied.

4. Open bursectomy performed for chronic olecranon bursitis. Elliptical incision made over the bursa, and bursal sac excised. Wound irrigated and closed with sutures. Sterile dressing applied for healing.

5. Ultrasound-guided injection of corticosteroid administered for olecranon bursitis. Needle inserted into the bursa under real-time imaging guidance. 5 mL of corticosteroid solution injected into the bursa. Patient advised rest and application of cold packs.

6. Patient presented with recurrent olecranon bursitis. Incision and drainage performed. Bursa opened, purulent fluid drained, and cavity irrigated with saline solution. Wound packed with sterile dressing for continued drainage.

7. Minimally invasive bursectomy performed using endoscopic techniques for olecranon bursitis. Small incisions made, and endoscope inserted to visualize the bursa. Bursa dissected and removed. Incisions closed with sutures, and sterile dressing applied.

8. Patient with septic olecranon bursitis underwent surgical debridement. Bursa opened, necrotic tissue excised, and thorough irrigation performed. Antibiotic-impregnated packing inserted into the wound. Daily dressing changes and intravenous antibiotics initiated.

9. Needle aspiration and corticosteroid injection performed for acute olecranon bursitis. Aspiration yielded cloudy fluid, and bursa irrigated with saline. 2 mL of corticosteroid injected, and pressure dressing applied.

10. Arthroscopic bursectomy performed for refractory olecranon bursitis. Small incisions made, arthroscope inserted to visualize the bursa, and bursectomy carried out using specialized instruments. Incisions closed with sutures, and sterile dressing applied.

1. Patient presented with chronic olecranon bursitis. Ultrasound-guided aspiration performed, yielding thick, yellowish fluid. Bursa thoroughly irrigated, and corticosteroid injected. Compression bandage applied for support.

2. Surgical excision of infected olecranon bursa performed. Incision made, bursa carefully dissected, and purulent contents drained. Wound irrigated and closed with sutures. Antibiotics prescribed for postoperative management.

3. Patient with traumatic olecranon bursitis underwent needle aspiration. Serous fluid aspirated, and bursa irrigated with saline. Non-steroidal anti-inflammatory medication recommended for pain relief.

4. Bursectomy performed for recurrent olecranon bursitis. Skin incision made, bursa excised, and surrounding tissues debrided. Wound closed meticulously, and sterile dressing applied.

5. Ultrasound-guided corticosteroid injection administered for olecranon bursitis. Needle carefully inserted into the bursa, and 3 mL of corticosteroid solution injected. Patient advised to avoid excessive pressure on the elbow.

6. Patient presented with acute olecranon bursitis. Aspiration performed, yielding serosanguinous fluid. Bursa flushed with saline, and antibiotic injection administered. Elbow immobilized with a splint.

7. Minimally invasive endoscopic bursectomy performed for persistent olecranon bursitis. Small incisions made, endoscope inserted, and bursa removed using specialized instruments. Incisions closed and dressed.

8. Patient with septic olecranon bursitis underwent surgical drainage and debridement. Bursa opened, purulent contents drained, and necrotic tissue excised. Wound packed with sterile dressing for ongoing wound care.

9. Needle aspiration and corticosteroid injection performed for recurrent olecranon bursitis. Fluid aspirated, and bursa irrigated with saline. 5 mL of corticosteroid injected, followed by a compression bandage.

10. Arthroscopic bursectomy with lavage performed for refractory olecranon bursitis. Small portals created, arthroscope inserted, and bursa debrided and thoroughly irrigated. Portals closed with sutures, and sterile dressing applied.

1. Patient underwent local anesthesia-assisted needle aspiration for olecranon bursitis. Bursa aspirated under sterile conditions, and serous fluid obtained. Bursa irrigated, and local anesthetic administered for pain management during the procedure.

2. Surgical excision of olecranon bursa performed under general anesthesia due to chronic bursitis. Incision made, bursa dissected, and completely removed. Wound closed with sutures. Patient monitored closely during anesthesia and postoperatively.

3. Ultrasound-guided needle aspiration of olecranon bursa performed under conscious sedation. Approximately 20 mL of turbid fluid aspirated. Bursa irrigated with saline, and mild sedation administered for patient comfort.

4. Open bursectomy performed under regional anesthesia for chronic olecranon bursitis. Incision made, bursa excised, and surrounding tissues debrided. Regional anesthesia provided effective pain control during the procedure.

5. Ultrasound-guided injection of corticosteroid administered under local anesthesia for olecranon bursitis. Needle inserted into the bursa with minimal discomfort, and corticosteroid solution injected. Local anesthesia ensured patient comfort.

6. Patient presented with recurrent olecranon bursitis. Incision and drainage performed under general anesthesia. Bursa opened, purulent fluid drained, and cavity irrigated with saline solution. Wound packed under appropriate anesthesia for continued drainage.

7. Minimally invasive bursectomy performed using endoscopic techniques under regional anesthesia for olecranon bursitis. Small incisions made, and endoscope inserted to visualize the bursa. Bursa dissected and removed, with regional anesthesia providing pain control.

8. Patient with septic olecranon bursitis underwent surgical debridement under general anesthesia. Bursa opened, necrotic tissue excised, and thorough irrigation performed. General anesthesia ensured patient comfort and immobility during the procedure.

9. Needle aspiration and corticosteroid injection performed under local anesthesia for acute olecranon bursitis. Aspiration yielded cloudy fluid, and bursa irrigated with saline. Corticosteroid injected under local anesthesia, minimizing discomfort.

10. Arthroscopic bursectomy performed under regional anesthesia for refractory olecranon bursitis. Small incisions made, arthroscope inserted to visualize the bursa, and bursectomy carried out using specialized instruments. Regional anesthesia provided effective pain control throughout the procedure.

1. Patient presented with extensive bone erosion associated with chronic olecranon bursitis. Surgical intervention performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed with autograft. Wound closed meticulously, and postoperative imaging ordered for follow-up assessment.

2. Ultrasound-guided aspiration of olecranon bursa performed under local anesthesia. Significant bone erosion observed on imaging. Bursa aspirated, lavaged, and corticosteroid injected. Patient advised to undergo further evaluation for bone integrity.

3. Surgical excision and debridement of infected olecranon bursa and bone erosion performed under general anesthesia. Bursa removed, necrotic bone excised, and irrigation with antibiotic solution performed. Wound closed with sutures, and intravenous antibiotics initiated.

4. Patient with traumatic olecranon bursitis and associated bone erosion underwent arthroscopic evaluation and debridement under regional anesthesia. Bursa inspected, necrotic bone fragments removed, and thorough irrigation performed. Regional anesthesia provided optimal pain control during the procedure.

5. Ultrasound-guided corticosteroid injection performed under local anesthesia for olecranon bursitis and evident bone erosion. Corticosteroid injected into the bursa, and patient referred for further imaging and orthopedic consultation for bone evaluation.

6. Patient presented with chronic olecranon bursitis and significant bone erosion. Open bursectomy and bone grafting performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed using allograft. Wound closed meticulously, and postoperative immobilization prescribed.

7. Needle aspiration and corticosteroid injection performed under local anesthesia for olecranon bursitis with associated bone erosion. Aspiration yielded fluid mixed with bone fragments, and corticosteroid injected. Patient referred for orthopedic evaluation to assess bone erosion.

8. Minimally invasive endoscopic bursectomy and bone debridement performed under regional anesthesia for olecranon bursitis and evident bone erosion. Endoscope inserted, bursa removed, and necrotic bone fragments excised. Regional anesthesia ensured patient comfort during the procedure.

9. Patient with septic olecranon bursitis and extensive bone erosion underwent surgical debridement and bone grafting under general anesthesia. Bursa opened, necrotic tissue and bone removed, and irrigation performed. Bone defect reconstructed with autograft. Postoperative antibiotics initiated.

10. Arthroscopic evaluation and bone debridement performed under regional anesthesia for refractory olecranon bursitis with bone erosion. Arthroscope inserted, bursa and bone assessed, and debridement performed. Regional anesthesia provided optimal pain control throughout the procedure.

1. Patient presented with severe bone pain associated with chronic olecranon bursitis and bone erosion. Surgical intervention performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed with autograft. Postoperative pain management plan initiated for adequate pain control.

2. Ultrasound-guided aspiration of olecranon bursa performed under local anesthesia for severe bone pain. Aspiration yielded turbid fluid, and corticosteroid injected. Patient prescribed analgesics for bone pain relief and advised for further evaluation.

3. Surgical excision and debridement of infected olecranon bursa and bone erosion performed under general anesthesia. Bursa removed, necrotic bone excised, and thorough irrigation performed. Postoperative pain control optimized with a multimodal analgesic regimen.

4. Patient with traumatic olecranon bursitis and severe bone pain underwent arthroscopic evaluation and debridement under regional anesthesia. Bursa inspected, necrotic bone fragments removed, and thorough irrigation performed. Regional anesthesia provided effective pain control during the procedure.

5. Ultrasound-guided corticosteroid injection performed under local anesthesia for severe bone pain associated with olecranon bursitis and bone erosion. Corticosteroid injected into the bursa, and patient referred for further orthopedic evaluation and management of bone pain.

6. Patient presented with chronic olecranon bursitis and severe bone pain. Open bursectomy and bone grafting performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed using allograft. Enhanced pain management initiated postoperatively.

7. Needle aspiration and corticosteroid injection performed under local anesthesia for olecranon bursitis with severe bone pain. Aspiration yielded fluid mixed with bone fragments, and corticosteroid injected. Patient referred for orthopedic evaluation and comprehensive pain management.

8. Minimally invasive endoscopic bursectomy and bone debridement performed under regional anesthesia for olecranon bursitis and severe bone pain. Endoscope inserted, bursa removed, and necrotic bone fragments excised. Regional anesthesia ensured optimal pain control during the procedure.

9. Patient with septic olecranon bursitis and severe bone pain underwent surgical debridement and bone grafting under general anesthesia. Bursa opened, necrotic tissue and bone removed, and irrigation performed. Bone defect reconstructed with autograft. Aggressive postoperative pain management implemented.

10. Arthroscopic evaluation and bone debridement performed under regional anesthesia for refractory olecranon bursitis with severe bone pain. Arthroscope inserted, bursa and bone assessed, and debridement performed. Regional anesthesia provided effective pain control throughout the procedure, and tailored pain management plan implemented postoperatively.

1. Patient with severe bone pain and chronic olecranon bursitis underwent surgical intervention with open bursectomy and bone debridement. General anesthesia administered, bursa excised, necrotic bone removed, and thorough irrigation performed. Postoperative pain management initiated for optimal pain control.

2. Surgical intervention in the form of arthroscopic bursectomy and bone debridement performed for severe bone pain and refractory olecranon bursitis. Regional anesthesia administered, bursa inspected and removed, and necrotic bone fragments excised. Postoperative pain control optimized with a multimodal approach.

3. Patient presented with septic olecranon bursitis and severe bone pain necessitating surgical intervention. Under general anesthesia, bursa opened, infected material drained, and bone debridement performed. Postoperative pain management initiated for effective pain relief.

4. Surgical intervention in the form of open bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with chronic olecranon bursitis. General anesthesia administered, bursa excised, necrotic bone removed, and bone defect reconstructed with graft material. Postoperative pain control optimized.

5. Patient with traumatic olecranon bursitis and severe bone pain underwent surgical intervention with arthroscopic bursectomy and bone debridement. Regional anesthesia provided, bursa inspected, necrotic bone fragments removed, and thorough irrigation performed. Postoperative pain management implemented for adequate pain relief.

6. Surgical intervention in the form of open bursectomy and bone grafting performed for severe bone pain and extensive bone erosion associated with olecranon bursitis. General anesthesia administered, bursa excised, necrotic bone debrided, and bone defect reconstructed with graft material. Enhanced postoperative pain control initiated.

7. Patient presented with chronic olecranon bursitis, severe bone pain, and failed conservative management, necessitating surgical intervention. Under general anesthesia, bursa excised, necrotic bone removed, and thorough irrigation performed. Postoperative pain management tailored for optimal pain relief.

8. Surgical intervention with endoscopic bursectomy and bone debridement performed for severe bone pain and refractory olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and necrotic bone fragments excised. Postoperative pain control optimized with a comprehensive approach.

9. Patient with septic olecranon bursitis and severe bone pain underwent urgent surgical intervention with open bursectomy and bone debridement. General anesthesia administered, bursa opened, infected material drained, and necrotic bone removed. Postoperative pain management initiated for effective pain control.

10. Surgical intervention in the form of arthroscopic bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with chronic olecranon bursitis. Regional anesthesia administered, bursa inspected, necrotic bone fragments removed, and bone defect reconstructed with graft material. Postoperative pain control optimized for improved comfort.

1. Patient with severe bone pain and chronic olecranon bursitis underwent surgical intervention with arthroscopic bursectomy, bone debridement, and platelet-rich plasma injection. Regional anesthesia administered, bursa excised, necrotic bone fragments removed, and platelet-rich plasma injected for tissue regeneration. Postoperative pain management initiated for optimal pain control.

2. Surgical intervention in the form of open bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with refractory olecranon bursitis. General anesthesia administered, bursa excised, necrotic bone removed, and bone defect reconstructed with autograft. Comprehensive postoperative pain management implemented.

3. Patient presented with septic olecranon bursitis and severe bone pain requiring urgent surgical intervention. Under general anesthesia, bursa opened, infected material drained, bone debridement performed, and antibiotic-impregnated bone cement applied. Postoperative pain control optimized for effective pain relief.

4. Surgical intervention with endoscopic bursectomy, bone debridement, and bone substitute application performed for severe bone pain and chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, necrotic bone fragments excised, and bone substitute applied for tissue regeneration. Postoperative pain management tailored for optimal comfort.

5. Patient with traumatic olecranon bursitis and severe bone pain underwent surgical intervention with open bursectomy, bone debridement, and internal fixation. General anesthesia administered, bursa excised, necrotic bone removed, and bone fragments stabilized with screws. Postoperative pain control optimized with a multimodal analgesic regimen.

6. Surgical intervention in the form of arthroscopic bursectomy, bone debridement, and microfracture procedure performed for severe bone pain associated with chronic olecranon bursitis. Regional anesthesia administered, bursa inspected, necrotic bone fragments removed, and microfracture technique utilized for tissue healing. Comprehensive postoperative pain management implemented.

7. Patient presented with chronic olecranon bursitis, severe bone pain, and extensive bone erosion necessitating surgical intervention. Under general anesthesia, open bursectomy, bone debridement, and allograft bone reconstruction performed. Postoperative pain control optimized with a tailored pain management plan.

8. Surgical intervention with endoscopic bursectomy, bone debridement, and radiofrequency ablation performed for severe bone pain and refractory olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, necrotic bone fragments excised, and radiofrequency energy used for pain relief. Postoperative pain management initiated for effective pain control.

9. Patient with septic olecranon bursitis and severe bone pain underwent surgical intervention with open bursectomy, bone debridement, and vacuum-assisted closure. General anesthesia administered, bursa opened, infected material drained, necrotic bone removed, and wound managed with vacuum-assisted closure for enhanced healing. Postoperative pain control optimized.

10. Surgical intervention in the form of arthroscopic bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with chronic olecranon bursitis. Regional anesthesia administered, bursa inspected, necrotic bone fragments removed, and bone defect reconstructed with allograft. Postoperative pain control optimized for improved comfort.

1. Patient with severe infection on the extreme moving joint of olecranon bursitis underwent emergent surgical intervention. Under general anesthesia, incision made, infected material drained, extensive debridement performed, and wound thoroughly irrigated. Intravenous antibiotics initiated, and postoperative wound care plan established.

2. Surgical intervention with open bursectomy and aggressive debridement performed for severe infection on the extreme moving joint associated with olecranon bursitis. General anesthesia administered, bursa excised, necrotic tissue removed, and wound irrigated with antiseptic solution. Postoperative antibiotic therapy initiated.

3. Patient presented with septic olecranon bursitis and severe infection on the extreme moving joint, necessitating immediate surgical intervention. Under general anesthesia, bursa opened, purulent material drained, and thorough debridement performed. Wound closed with drains in place, and intravenous antibiotics initiated.

4. Surgical intervention in the form of arthroscopic bursectomy and extensive debridement performed for severe infection on the extreme moving joint associated with refractory olecranon bursitis. Regional anesthesia provided, bursa inspected, infected tissue removed, and joint lavaged with antibiotic solution. Postoperative antibiotic therapy implemented.

5. Patient with traumatic olecranon bursitis and severe infection on the extreme moving joint underwent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa excised, necrotic tissue removed, and joint irrigated with antimicrobial solution. Postoperative antibiotic treatment initiated.

6. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe infection on the extreme moving joint associated with chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and infected tissue meticulously debrided. Postoperative antibiotic regimen initiated.

7. Patient presented with septic olecranon bursitis and severe infection on the extreme moving joint, necessitating urgent surgical intervention. Under general anesthesia, open bursectomy, extensive debridement, and joint irrigation performed. Postoperative intravenous antibiotics initiated, and wound closely monitored.

8. Surgical intervention in the form of arthroscopic bursectomy, debridement, and irrigation performed for severe infection on the extreme moving joint associated with refractory olecranon bursitis. Regional anesthesia administered, bursa inspected, infected tissue removed, and joint lavaged with antibiotic solution. Postoperative antibiotic therapy implemented.

9. Patient with chronic olecranon bursitis and severe infection on the extreme moving joint underwent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa excised, necrotic tissue removed, and joint irrigated with antimicrobial solution. Postoperative antibiotic treatment initiated.

10. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe infection on the extreme moving joint associated with olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and infected tissue meticulously debrided. Postoperative antibiotic regimen initiated, and wound care instructions given.

1. Patient presented with severe inflammation and erythema of the extreme moving joint associated with olecranon bursitis. Surgical intervention performed under general anesthesia, including open bursectomy, extensive debridement, and joint irrigation. Postoperative anti-inflammatory medications initiated for inflammation control.

2. Surgical intervention in the form of arthroscopic bursectomy and debridement performed for severe inflammation and edema of the extreme moving joint associated with refractory olecranon bursitis. Regional anesthesia provided, bursa inspected, inflamed tissue removed, and joint lavaged. Postoperative anti-inflammatory therapy implemented.

3. Patient with septic olecranon bursitis and severe joint inflammation underwent urgent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa opened, infected material drained, and inflamed tissue meticulously removed. Postoperative anti-inflammatory treatment initiated.

4. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe joint inflammation and swelling associated with chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and inflamed tissue meticulously debrided. Postoperative anti-inflammatory regimen initiated.

5. Patient presented with chronic olecranon bursitis, severe joint inflammation, and edema necessitating surgical intervention. Under general anesthesia, open bursectomy, debridement, and joint irrigation performed. Postoperative anti-inflammatory medications prescribed for inflammation control.

6. Surgical intervention in the form of arthroscopic bursectomy, debridement, and joint irrigation performed for severe joint inflammation and erythema associated with refractory olecranon bursitis. Regional anesthesia administered, bursa inspected, inflamed tissue removed, and joint lavaged. Postoperative anti-inflammatory therapy implemented.

7. Patient with septic olecranon bursitis and severe joint inflammation underwent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa opened, infected material drained, and inflamed tissue meticulously removed. Postoperative anti-inflammatory treatment initiated.

8. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe joint inflammation and swelling associated with chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and inflamed tissue meticulously debrided. Postoperative anti-inflammatory regimen initiated.

9. Patient presented with chronic olecranon bursitis, severe joint inflammation, and edema necessitating surgical intervention. Under general anesthesia, open bursectomy, debridement, and joint irrigation performed. Postoperative anti-inflammatory medications prescribed for inflammation control.

10. Surgical intervention in the form of arthroscopic bursectomy, debridement, and joint irrigation performed for severe joint inflammation and erythema associated with refractory olecranon bursitis. Regional anesthesia administered, bursa inspected, inflamed tissue removed, and joint lavaged. Postoperative anti-inflammatory therapy implemented.

1. Patient diagnosed with mild olecranon bursitis advised conservative management with rest, ice, compression, and elevation (RICE) technique. Scheduled for a follow-up appointment in two weeks to assess improvement and consider further interventions if necessary.

2. Patient diagnosed with moderate olecranon bursitis prescribed a course of nonsteroidal anti-inflammatory drugs (NSAIDs) and physical therapy. Follow-up scheduled in four weeks to evaluate response to treatment and discuss additional options if needed.

3. Patient diagnosed with severe olecranon bursitis and persistent symptoms referred for a corticosteroid injection. Scheduled for a follow-up visit in one week to assess the response to the injection and discuss further management options if necessary.

4. Patient diagnosed with chronic olecranon bursitis and significant functional limitations referred to an orthopedic specialist for evaluation. A follow-up appointment scheduled in two weeks to review the specialist's recommendations and determine the course of treatment.

5. Patient diagnosed with acute infectious olecranon bursitis prescribed a course of oral antibiotics and instructed to monitor for signs of improvement or worsening. Advised to follow up in one week for reassessment and adjustment of the treatment plan if needed.

6. Patient diagnosed with recurrent olecranon bursitis referred for an ultrasound-guided aspiration and corticosteroid injection. Follow-up scheduled in two weeks to evaluate the response to the intervention and consider further management options if necessary.

7. Patient diagnosed with severe olecranon bursitis and associated bone erosion referred for a surgical consultation. Scheduled for a follow-up appointment in one week to discuss the surgical options, risks, and benefits, and to plan the intervention.

8. Patient diagnosed with moderate olecranon bursitis advised a trial of a customized splint and physical therapy. Follow-up scheduled in four weeks to assess the response to conservative management and determine the need for additional interventions.

9. Patient diagnosed with chronic olecranon bursitis and persistent pain referred for a diagnostic ultrasound and aspiration. Follow-up appointment scheduled in two weeks to review the results, evaluate the response to the procedure, and discuss further treatment options.

10. Patient diagnosed with severe infectious olecranon bursitis admitted for intravenous antibiotics and close monitoring. A follow-up appointment scheduled upon discharge to assess the response to treatment and ensure adequate healing of the infection.

## M70.3 Other bursitis of elbow

Operative Note 1:

Patient underwent surgical intervention for other bursitis of the elbow. After administering general anesthesia, a sterile field was established. A curvilinear incision was made over the affected area, and the skin and subcutaneous tissues were carefully dissected. The bursa was identified and excised completely. Hemostasis was achieved using electrocautery. The wound was irrigated with sterile saline, and the incision was closed using absorbable sutures. A sterile dressing was applied, and the patient tolerated the procedure well. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 2:

The patient was prepared for surgery, and local anesthesia was administered. A longitudinal incision was made over the elbow region. Dissection was carried down through the subcutaneous tissues until the bursa was visualized. The bursa was carefully excised, ensuring complete removal. Hemostasis was achieved using bipolar cautery. The wound was thoroughly irrigated with saline solution, and the incision was closed using interrupted sutures. A sterile dressing was applied, and the patient was awakened from anesthesia without any complications. Postoperative instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 3:

Under general anesthesia, the patient's elbow was prepped and draped in a sterile manner. A transverse incision was made over the site of the bursitis. Sharp dissection was carried out down to the bursa, which was excised in its entirety. Hemostasis was obtained using electrocautery. The wound was irrigated with saline solution and closed with interrupted sutures. A sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were noted. Postoperatively, the patient was instructed on wound care and discharged home in stable condition.

Operative Note 4:

The patient was placed under general anesthesia, and the affected elbow was prepped and draped aseptically. A curvilinear incision was made over the bursal prominence. Careful dissection was performed to expose the bursa. The bursa was then meticulously excised, ensuring complete removal. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and there were no immediate complications. Postoperative instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 5:

After administering general anesthesia, the patient's elbow was prepared and draped in a sterile fashion. An elliptical incision was made over the affected bursa. Dissection was carried out, and the bursa was identified and completely excised. Hemostasis was achieved with bipolar electrocautery. The wound was irrigated with normal saline, and meticulous closure was performed using interrupted sutures. A sterile dressing was applied. The patient recovered uneventfully from anesthesia. Postoperative care instructions were provided, and the patient was discharged in stable condition.

Operative Note 6:

Under general anesthesia, the elbow was prepped and draped in a sterile manner. A curvilinear incision was made over the bursal prominence. Sharp dissection was performed down to the bursa, which was excised completely. Hemostasis was obtained using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient emerged from anesthesia without any complications. Postoperative instructions were given, and the patient was discharged home in satisfactory condition.

Operative Note 7:

The patient received general anesthesia, and the elbow was aseptically prepped and draped. A trans

verse incision was made overlying the affected bursa. Dissection was carried out, and the bursa was identified and excised in its entirety. Hemostasis was achieved using electrocautery. The wound was irrigated with sterile saline, and closure was performed with interrupted absorbable sutures. A sterile dressing was applied. The patient recovered from anesthesia smoothly. Postoperative care instructions were provided, and the patient was discharged in stable condition.

Operative Note 8:

After induction of general anesthesia, the elbow was prepared and draped in a sterile fashion. An oblique incision was made over the bursa. Sharp dissection was performed, and the bursa was completely excised. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with normal saline, and closure was achieved with interrupted sutures. A sterile dressing was applied. The patient recovered without complications from anesthesia. Postoperative instructions were given, and the patient was discharged home in a satisfactory state.

Operative Note 9:

The patient was placed under general anesthesia, and the elbow was prepared and draped in a sterile manner. A longitudinal incision was made over the affected bursa. Dissection was carried out to expose the bursa, which was then excised completely. Hemostasis was obtained using bipolar electrocautery. The wound was irrigated with saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and there were no immediate postoperative issues. Postoperative care instructions were provided, and the patient was discharged in stable condition.

Operative Note 10:

Under general anesthesia, the elbow was aseptically prepped and draped. A curvilinear incision was made over the bursa. Sharp dissection was performed to expose and excise the bursa completely. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution, and closure was performed using absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia. Postoperative instructions were given, and the patient was discharged in a satisfactory state.

Operative Note 11:

After administering general anesthesia, the patient's elbow was prepped and draped in a sterile manner. A midline incision was made over the affected bursa. Careful dissection was performed to expose the bursa, which was completely excised. Hemostasis was achieved using electrocautery. The wound was thoroughly irrigated with saline solution and closed with interrupted sutures. A sterile dressing was applied. The patient recovered well from anesthesia without any immediate complications. Postoperative instructions were provided, and the patient was discharged home in stable condition.

Operative Note 12:

The patient received regional anesthesia, and the elbow was aseptically prepped and draped. A radial incision was made overlying the bursal prominence. Sharp dissection was performed, and the bursa was identified and excised in its entirety. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia. Postoperative care instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 13:

Under general anesthesia, the elbow was prepared and draped in a sterile fashion. An oblique incision was made over the bursal prominence. Careful dissection was carried out, and the bursa was completely excised. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with normal saline solution and closed with interrupted absorbable sutures. A sterile dressing was applied. The patient emerged from anesthesia without complications. Postoperative instructions were provided, and the patient was discharged home in a stable state.

Operative Note 14:

The patient underwent surgical intervention for other bursitis of the elbow. After induction of general anesthesia, a sterile field was established. A curvilinear incision was made over the affected bursa. Dissection was carried out, and the bursa was identified and excised completely. Hemostasis was achieved using electrocautery. The wound was irrigated with sterile saline solution, and the incision was closed using absorbable sutures. A sterile dressing was applied, and the patient tolerated the procedure well. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 15:

Under general anesthesia, the elbow was aseptically prepped and draped. A longitudinal incision was made over the bursal prominence. Sharp dissection was performed, and the bursa was excised completely. Hemostasis was obtained using bipolar electrocautery. The wound was irrigated with normal saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered without complications from anesthesia. Postoperative instructions were provided, and the patient was discharged home in satisfactory condition.

Operative Note 16:

After induction of general anesthesia, the elbow was prepped and draped in a sterile manner. A transverse incision was made over the affected bursa. Careful dissection was performed, and the bursa was identified and completely excised. Hemostasis was achieved with bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with interrupted absorbable sutures. A sterile dressing was applied. The patient emerged from anesthesia without any complications. Postoperative care instructions were given, and the patient was discharged in stable condition.

Operative Note 17:

The patient was placed under general anesthesia, and the elbow was prepared and draped in a sterile fashion. A curvilinear incision was made over the bursal prominence. Dissection was carried out down to the bursa, which was excised completely. Hemostasis was obtained using bipolar electro

cautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and there were no immediate complications. Postoperatively, the patient was instructed on wound care and discharged home in stable condition.

Operative Note 18:

Under general anesthesia, the patient's elbow was prepped and draped in a sterile manner. A transverse incision was made over the site of the bursitis. Sharp dissection was carried out to expose the bursa, which was excised completely. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with normal saline, and closure was performed with interrupted sutures. A sterile dressing was applied. The patient recovered from anesthesia without any complications. Postoperative instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 19:

After administering general anesthesia, the elbow was prepared and draped aseptically. A curvilinear incision was made over the affected bursa. Sharp dissection was performed down to the bursa, which was excised completely. Hemostasis was obtained using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and there were no immediate complications. Postoperative care instructions were provided, and the patient was discharged home in stable condition.

Operative Note 20:

The patient received general anesthesia, and the elbow was prepped and draped in a sterile manner. An elliptical incision was made over the bursal prominence. Dissection was carried out, and the bursa was completely excised. Hemostasis was achieved using electrocautery. The wound was irrigated with sterile saline, and closure was performed with interrupted sutures. A sterile dressing was applied. The patient recovered well from anesthesia without any immediate complications. Postoperative instructions were given, and the patient was discharged home in a stable state.

Operative Note 21:

The patient underwent surgical intervention for other bursitis of the elbow. After induction of general anesthesia with appropriate dosage adjustments based on the patient's weight and medical history, a sterile field was established. A curvilinear incision was made over the affected bursa. Dissection was carried out, and the bursa was identified and excised completely. Hemostasis was achieved using electrocautery. The wound was irrigated with sterile saline solution, and the incision was closed using absorbable sutures. A sterile dressing was applied, and the patient tolerated the procedure well. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 22:

Under regional anesthesia, with proper dosage adjustments based on the patient's weight and comorbidities, the elbow was aseptically prepped and draped. A transverse incision was made overlying the bursal prominence. Sharp dissection was performed, and the bursa was completely excised. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia, and there were no immediate postoperative issues. Postoperative care instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 23:

After administering a reduced dosage of general anesthesia, the elbow was prepared and draped in a sterile manner. A midline incision was made over the affected bursa. Careful dissection was performed to expose the bursa, which was completely excised. Hemostasis was achieved using bipolar electrocautery. The wound was thoroughly irrigated with saline solution and closed with interrupted sutures. A sterile dressing was applied. The patient recovered well from anesthesia without any immediate complications. Postoperative instructions were provided, and the patient was discharged home in stable condition.

Operative Note 24:

The patient received a modified dosage of general anesthesia, and the elbow was aseptically prepped and draped. A radial incision was made over the bursal prominence. Sharp dissection was performed, and the bursa was identified and excised in its entirety. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia. Postoperative care instructions were given, and the patient was discharged home in satisfactory condition.

Operative Note 25:

Under general anesthesia with adjusted dosages considering the patient's age and medical condition, the elbow was prepped and draped in a sterile fashion. An oblique incision was made over the bursal prominence. Careful dissection was carried out, and the bursa was completely excised. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with normal saline solution and closed with interrupted absorbable sutures. A sterile dressing was applied. The patient emerged from anesthesia without complications. Postoperative instructions were provided, and the patient was discharged home in a stable state.

Operative Note 26:

After adjusting the anesthesia dosage based on the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. A curvilinear incision was made over the bursal prominence. Dissection was carried out down to the bursa, which was excised completely. Hemostasis was obtained using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and there were no immediate complications. Postoperatively, the patient was instructed on wound care and discharged

home in stable condition.

Operative Note 27:

Under regional anesthesia with adjusted dosages according to the patient's weight and comorbidities, the elbow was prepped and draped in a sterile fashion. A curvilinear incision was made over the bursal prominence. Sharp dissection was performed to expose the bursa, which was excised completely. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia, and there were no immediate complications. Postoperative care instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 28:

After administering a reduced dosage of general anesthesia based on the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. An elliptical incision was made over the bursal prominence. Dissection was carried out, and the bursa was completely excised. Hemostasis was achieved using electrocautery. The wound was irrigated with sterile saline, and closure was performed with interrupted sutures. A sterile dressing was applied. The patient recovered well from anesthesia without any immediate complications. Postoperative instructions were given, and the patient was discharged home in a stable state.

Operative Note 29:

Under general anesthesia with adjusted dosages to ensure optimal patient safety, the elbow was aseptically prepped and draped. A longitudinal incision was made over the affected bursa. Sharp dissection was performed, and the bursa was excised completely. Hemostasis was obtained using bipolar electrocautery. The wound was irrigated with normal saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered without complications from anesthesia. Postoperative instructions were provided, and the patient was discharged home in satisfactory condition.

Operative Note 30:

After carefully determining the appropriate anesthesia dosage based on the patient's weight and medical condition, the elbow was prepped and draped in a sterile manner. A transverse incision was made over the site of the bursitis. Dissection was carried out to expose the bursa, which was excised completely. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with interrupted absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia without any complications. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 31:

Under general anesthesia, with appropriate adjustments based on the patient's weight and medical history, the elbow was aseptically prepped and draped. A longitudinal incision was made over the affected bursa, revealing significant bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone debridement and curettage were carried out to remove the eroded bone fragments. Hemostasis was achieved using electrocautery. The wound was irrigated with sterile saline solution and closed in layers. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 32:

The patient received regional anesthesia, with appropriate dosage adjustments considering the bone erosion and the patient's medical condition. The elbow was prepared and draped in a sterile manner. A curvilinear incision was made over the bursal prominence, exposing bone erosion beneath the bursa. Careful dissection was performed to excise the eroded bursa and address the bone defect. Bone grafting was performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with normal saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 33:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. An oblique incision was made over the affected bursa, revealing extensive bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting was performed to restore the integrity of the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was thoroughly irrigated with saline solution and closed with interrupted sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative instructions were provided.

Operative Note 34:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. A radial incision was made overlying the bursal prominence, revealing significant bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting and bone cement were utilized to reconstruct the eroded area. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 35:

After administering general anesthesia, the elbow was prepared and draped in a sterile manner. A transverse incision was made over the affected bursa, exposing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting and internal fixation were employed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with interrupted absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 36:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's medical condition, the elbow was prepped and draped in a sterile fashion. An elliptical incision was made over the bursal prominence, revealing extensive bone erosion. Dissection was carried out to excise the eroded bursa and address the underlying bone defect. Bone grafting and osteosynthesis were performed to reconstruct the eroded area. Hemostasis was obtained using bipolar electroca

utery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 37:

The patient received regional anesthesia, with appropriate dosage adjustments considering the bone erosion and the patient's weight and medical history. The elbow was prepared and draped in a sterile manner. A transverse incision was made over the site of the bursitis, exposing bone erosion. Dissection was carried out to excise the eroded bursa and address the underlying bone pathology. Bone debridement and augmentation were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed in layers. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 38:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. A curvilinear incision was made over the affected bursa, revealing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting and fixation were utilized to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative instructions were given.

Operative Note 39:

After administering regional anesthesia, with appropriate dosage adjustments considering the bone erosion and the patient's weight and medical condition, the elbow was prepped and draped in a sterile fashion. An oblique incision was made over the bursal prominence, exposing bone erosion. Dissection was carried out to excise the eroded bursa and address the underlying bone pathology. Bone grafting and structural reinforcement were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 40:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. A radial incision was made over the affected bursa, revealing significant bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting and bone substitute placement were employed to reconstruct the eroded area. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 81:

The patient underwent surgical intervention for other bursitis of the elbow with severe bone pain. After induction of general anesthesia, the elbow was aseptically prepped and draped. A longitudinal incision was made over the affected bursa, revealing significant bone pain upon palpation. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of local anesthetic with corticosteroid was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 82:

Under general anesthesia, with adjusted dosages considering the severe bone pain and the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. An oblique incision was made over the affected bursa, revealing significant bone pain and tenderness. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of systemic analgesics was done to relieve bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 83:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. A radial incision was made over the affected bursa, exposing severe bone pain upon manipulation. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of local anesthetic and nerve block was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were provided.

Operative Note 84:

Under general anesthesia, with adjusted dosages considering the severe bone pain and the patient's weight and medical history, the elbow was aseptically prepped and draped. A curvilinear incision was made over the affected bursa, revealing significant bone pain and tenderness. Sharp dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of analgesics, including opioids, was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 85:

After induction of general anesthesia, the elbow was prepared and draped in a sterile manner. A transverse incision was made over the affected bursa, exposing severe bone pain upon palpation. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of systemic analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs) was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the recovery area.

Operative Note 86:

Under general anesthesia, with adjusted dosages considering the severe bone pain and the patient's weight and medical history, the elbow was aseptically prepped and draped. An oblique incision was made over the affected bursa, revealing significant bone pain and tenderness. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of local anesthetic with corticosteroid was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 87:

After induction of general anesthesia, the elbow was prepped and draped in a sterile

fashion. A radial incision was made over the affected bursa, exposing severe bone pain upon manipulation. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of local anesthetic and nerve block was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were provided.

Operative Note 88:

Under general anesthesia, with adjusted dosages considering the severe bone pain and the patient's weight and medical history, the elbow was aseptically prepped and draped. A curvilinear incision was made over the affected bursa, revealing significant bone pain and tenderness. Sharp dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of analgesics, including opioids, was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 89:

After induction of general anesthesia, the elbow was prepared and draped in a sterile manner. A transverse incision was made over the affected bursa, exposing severe bone pain upon palpation. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of systemic analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs) was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the recovery area.

Operative Note 90:

Under general anesthesia, with adjusted dosages considering the severe bone pain and the patient's weight and medical history, the elbow was aseptically prepped and draped. An oblique incision was made over the affected bursa, revealing significant bone pain and tenderness. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of local anesthetic with corticosteroid was done to alleviate bone pain. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 41:

The patient underwent surgical intervention for other bursitis of the elbow. After induction of general anesthesia, the elbow was aseptically prepped and draped. A curvilinear incision was made over the affected bursa, revealing bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting and internal fixation were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 42:

Under general anesthesia, with appropriate dosage adjustments based on the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. A longitudinal incision was made over the affected bursa, exposing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, debridement, and arthroscopic irrigation were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed in layers. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 43:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. A radial incision was made over the bursal prominence, revealing bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting and endoscopic debridement were performed to reconstruct the eroded area. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with normal saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 44:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. An oblique incision was made over the affected bursa, revealing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, curettage, and application of bone substitute were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 45:

The patient underwent surgical intervention under general anesthesia, with appropriate adjustments based on the bone erosion and the patient's weight and medical condition. The elbow was prepared and draped in a sterile manner. A transverse incision was made over the site of the bursitis, revealing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, osteotomy, and fixation were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with interrupted absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative instructions were provided.

Operative Note 46:

Under regional anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and comorbidities, the elbow was prepped and draped in a sterile fashion. A curvilinear incision was made over the affected bursa, revealing bone erosion. Sharp dissection was performed to excise the eroded b

ursa and address the underlying bone defect. Bone grafting, resection, and reconstruction were performed to restore the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 47:

After administering general anesthesia, the elbow was prepared and draped in a sterile manner. A longitudinal incision was made over the affected bursa, exposing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, debridement, and joint arthroplasty were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed in layers. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 48:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. A radial incision was made over the affected bursa, revealing bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, reconstruction, and application of bone substitute were employed to restore the eroded area. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 49:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. An oblique incision was made over the bursal prominence, exposing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, reconstruction, and arthroscopic debridement were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with normal saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 50:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. A curvilinear incision was made over the affected bursa, revealing bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, reconstruction, and bone cement placement were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 51:

The patient underwent surgical intervention for other bursitis of the elbow. After induction of general anesthesia, the elbow was aseptically prepped and draped. A transverse incision was made over the affected bursa, revealing bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, debridement, and reconstruction with a mesh graft were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 52:

Under general anesthesia, with appropriate dosage adjustments based on the bone erosion and the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. A curvilinear incision was made over the affected bursa, exposing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, debridement, and application of bone substitute were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed in layers. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 53:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. A radial incision was made over the bursal prominence, revealing bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, curettage, and arthroscopic debridement were performed to reconstruct the eroded area. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with normal saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 54:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. An oblique incision was made over the affected bursa, revealing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, reconstruction, and osteosynthesis were employed to restore the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 55:

The patient underwent surgical intervention under general anesthesia, with appropriate adjustments based on the bone erosion and the patient's weight and medical condition. The elbow was prepared and draped in a sterile manner. A transverse incision was made over the site of the bursitis, revealing bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, osteotomy, and fixation with plates and screws were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with interrupted absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative instructions were provided.

Operative Note 56:

Under regional anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and comorbidities, the elbow was prepped and draped in a sterile fashion. A curvilinear incision was made over the affected

bursa, revealing bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, reconstruction, and application of bone substitute were employed to restore the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable suture

Operative Note 57:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. A radial incision was made over the affected bursa, revealing extensive bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, reconstruction, and placement of a bone allograft were performed to restore the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 58:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. An oblique incision was made over the bursal prominence, exposing significant bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, debridement, and placement of a bone substitute were performed to reconstruct the eroded area. Hemostasis was ensured with bipolar electrocautery. The wound was irrigated with normal saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 59:

Under general anesthesia, with adjusted dosages considering the bone erosion and the patient's weight and medical history, the elbow was aseptically prepped and draped. A transverse incision was made over the affected bursa, revealing extensive bone erosion. Sharp dissection was performed to excise the eroded bursa and address the underlying bone defect. Bone grafting, reconstruction, and application of a bone cement spacer were employed to restore the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 60:

After induction of general anesthesia, the elbow was prepared and draped in a sterile manner. A curvilinear incision was made over the affected bursa, exposing extensive bone erosion. Careful dissection was performed to excise the eroded bursa and address the underlying bone pathology. Bone grafting, reconstruction, and placement of a bone autograft were performed to reconstruct the eroded area. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated with sterile saline solution and closed in layers. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 61:

The patient underwent surgical intervention for severe infection in the extreme moving joint of the elbow. After induction of general anesthesia, the elbow was aseptically prepped and draped. A longitudinal incision was made over the infected joint, exposing severe joint destruction. Extensive debridement of infected tissues, including synovium and bone, was performed. Copious irrigation with antimicrobial solution was done to eradicate the infection. A combination of bone grafting and joint fusion was performed to stabilize the joint. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the recovery area in stable condition.

Operative Note 62:

Under general anesthesia, with adjusted dosages considering the severe infection and the patient's weight and medical history, the elbow joint was prepared and draped in a sterile manner. An arthrotomy was performed, revealing severe joint destruction and purulent fluid collection. Thorough debridement of necrotic tissues was carried out, and samples were sent for culture and sensitivity testing. The joint was thoroughly irrigated with antibiotic solution. Intra-articular antibiotic beads were placed, and the joint was stabilized using external fixators. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 63:

After induction of general anesthesia, the elbow joint was prepped and draped in a sterile fashion. A radial incision was made over the severely infected joint, exposing extensive joint destruction. Aggressive debridement of necrotic tissues, including bone and infected synovium, was performed. Copious irrigation with antibiotic solution was done to eliminate the infection. The joint was temporarily stabilized with external fixators. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the postoperative recovery area.

Operative Note 64:

Under general anesthesia, with adjusted dosages considering the severe infection and the patient's weight and medical history, the elbow joint was aseptically prepped and draped. An oblique incision was made over the infected joint, revealing extensive joint destruction and pus formation. Thorough debridement of infected tissues was performed, including the synovium and eroded bone. The joint was meticulously irrigated with antibiotic solution. Bone grafting and joint stabilization with internal fixation were performed. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 65:

After induction of general anesthesia, the elbow joint was prepared and draped in a sterile manner. A curvilinear incision was made over the severely infected joint, exposing significant joint destruction and abscess formation. Aggressive debridement of necrotic tissues, including bone and synovium, was carried out. Thorough irrigation with antibiotic solution was performed. The joint was temporarily stabilized with external fixation. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the post-anesthesia care unit.

Operative Note 66:

Under general anesthesia, with adjusted dosages considering the severe infection and the patient's weight and medical history, the elbow joint was prepped and draped in a sterile fashion. A transverse incision was made over the infected joint, revealing extensive joint destruction and purulent material. Thorough debridement of necrotic tissues was performed, including bone and infected synovium. Copious irrigation with antibiotic solution was done to eliminate the infection. The joint was temporarily stabilized with an external fixator. The wound was closed in layers using absorbable sutures. A sterile

dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 67:

After induction of general anesthesia, the elbow joint was aseptically prepped and draped. A longitudinal incision was made over the severely infected joint, exposing severe joint destruction and purulent fluid collection. Extensive debridement of infected tissues, including bone and synovium, was performed. Copious irrigation with antibiotic solution was done to eliminate the infection. Joint fusion was performed to stabilize the joint. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the recovery area in stable condition.

Operative Note 68:

Under general anesthesia, with adjusted dosages considering the severe infection and the patient's weight and medical history, the elbow joint was prepared and draped in a sterile manner. An arthrotomy was performed, revealing severe joint destruction and purulent fluid accumulation. Thorough debridement of necrotic tissues was carried out, and samples were sent for microbiological analysis. The joint was thoroughly irrigated with antimicrobial solution. Intra-articular antibiotic beads were placed, and the joint was stabilized using external fixators. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia.

Operative Note 69:

After induction of general anesthesia, the elbow joint was prepped and draped in a sterile fashion. A radial incision was made over the severely infected joint, exposing extensive joint destruction and purulent material. Aggressive debridement of necrotic tissues, including bone and synovium, was performed. Copious irrigation with antibiotic solution was done to eliminate the infection. The joint was temporarily stabilized with external fixators. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the postoperative recovery area.

Operative Note 70:

Under general anesthesia, with adjusted dosages considering the severe infection and the patient's weight and medical history, the elbow joint was aseptically prepped and draped. An oblique incision was made over the infected joint, revealing extensive joint destruction and abscess formation. Thorough debridement of necrotic tissues was performed, including the synovium and eroded bone. The joint was meticulously irrigated with antibiotic solution. Joint fusion and stabilization with internal fixation were performed. The wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 71:

The patient underwent surgical intervention for other bursitis of the elbow with severe inflammation. After induction of general anesthesia, the elbow was aseptically prepped and draped. A transverse incision was made over the inflamed bursa, revealing significant inflammation and erythema. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative irrigation with saline solution was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 72:

Under general anesthesia, with adjusted dosages considering the severe inflammation and the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. An oblique incision was made over the inflamed bursa, revealing extensive inflammation and swelling. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative corticosteroid injection was administered to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 73:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. A radial incision was made over the affected bursa, exposing severe inflammation and edema. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative application of anti-inflammatory agents was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were provided.

Operative Note 74:

Under general anesthesia, with adjusted dosages considering the severe inflammation and the patient's weight and medical history, the elbow was aseptically prepped and draped. A curvilinear incision was made over the inflamed bursa, revealing significant inflammation and erythema. Sharp dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative irrigation with sterile saline solution containing anti-inflammatory medication was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 75:

After induction of general anesthesia, the elbow was prepared and draped in a sterile manner. A transverse incision was made over the inflamed bursa, exposing extensive inflammation and swelling. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative administration of systemic anti-inflammatory medication was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the recovery area.

Operative Note 76:

Under general anesthesia, with adjusted dosages considering the severe inflammation and the patient's weight and medical history, the elbow was prepped and draped in a sterile fashion. An oblique incision was made over the affected bursa, revealing severe inflammation and edema. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative application of topical anti-inflammatory gel was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 77:

After induction of general anesthesia, the elbow was aseptically prepped and draped. A radial incision was made over the inflamed bursa, exposing significant inflammation and erythema. Careful dissection was performed to excise the inflamed

bursa and address the underlying pathology. Intraoperative corticosteroid injection was administered to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were given.

Operative Note 78:

Under general anesthesia, with adjusted dosages considering the severe inflammation and the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. A curvilinear incision was made over the inflamed bursa, revealing extensive inflammation and swelling. Sharp dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative irrigation with sterile saline solution containing anti-inflammatory medication was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well and was transferred to the recovery area.

Operative Note 79:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. A transverse incision was made over the inflamed bursa, exposing severe inflammation and edema. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative application of anti-inflammatory agents was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered well from anesthesia, and postoperative care instructions were provided.

Operative Note 80:

Under general anesthesia, with adjusted dosages considering the severe inflammation and the patient's weight and medical history, the elbow was aseptically prepped and draped. An oblique incision was made over the affected bursa, revealing significant inflammation and erythema. Sharp dissection was performed to excise the inflamed bursa and address the underlying pathology. Intraoperative irrigation with sterile saline solution containing anti-inflammatory medication was done to reduce inflammation. The wound was closed with absorbable sutures. A sterile dressing was applied. The patient recovered smoothly from anesthesia.

Operative Note 91:

After induction of general anesthesia, the elbow was aseptically prepped and draped. A longitudinal incision was made over the affected bursa, revealing a moderate diagnosis of other bursitis of the elbow. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will require a follow-up appointment in two weeks for wound assessment and further evaluation of symptoms.

Operative Note 92:

Under general anesthesia, with adjusted dosages considering the severity of diagnosis and the patient's weight and medical history, the elbow was prepared and draped in a sterile manner. An oblique incision was made over the affected bursa, exposing a mild diagnosis of other bursitis of the elbow. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will be scheduled for a follow-up appointment in four weeks for assessment of healing progress.

Operative Note 93:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. A radial incision was made over the affected bursa, revealing a severe diagnosis of other bursitis of the elbow. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will require a follow-up appointment in one week for close monitoring of wound healing and further management.

Operative Note 94:

Under general anesthesia, with adjusted dosages considering the severity of diagnosis and the patient's weight and medical history, the elbow was aseptically prepped and draped. A curvilinear incision was made over the affected bursa, exposing a moderate diagnosis of other bursitis of the elbow. Sharp dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will be scheduled for a follow-up appointment in three weeks to assess the response to treatment and address any ongoing symptoms.

Operative Note 95:

After induction of general anesthesia, the elbow was prepared and draped in a sterile manner. A transverse incision was made over the affected bursa, revealing a mild diagnosis of other bursitis of the elbow. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will require a follow-up appointment in six weeks for evaluation of pain and functional improvement.

Operative Note 96:

Under general anesthesia, with adjusted dosages considering the severity of diagnosis and the patient's weight and medical history, the elbow was aseptically prepped and draped. An oblique incision was made over the affected bursa, exposing a moderate diagnosis of other bursitis of the elbow. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will be scheduled for a follow-up appointment in two weeks for assessment of pain relief and range of motion.

Operative Note 97:

After induction of general anesthesia, the elbow was prepped and draped in a sterile fashion. A radial incision was made over the affected bursa, revealing a severe diagnosis of other bursitis of the elbow. Careful dissection was performed to excise the inflamed

bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will require a follow-up appointment in one week to evaluate the response to treatment and determine the need for further interventions.

Operative Note 98:

Under general anesthesia, with adjusted dosages considering the severity of diagnosis and the patient's weight and medical history, the elbow was aseptically prepped and draped. A curvilinear incision was made over the affected bursa, exposing a moderate diagnosis of other bursitis of the elbow. Sharp dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will be scheduled for a follow-up appointment in three weeks to assess the response to treatment and determine the need for further interventions.

Operative Note 99:

After induction of general anesthesia, the elbow was prepared and draped in a sterile manner. A transverse incision was made over the affected bursa, revealing a mild diagnosis of other bursitis of the elbow. Careful dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will require a follow-up appointment in six weeks for evaluation of pain relief and functional improvement.

Operative Note 100:

Under general anesthesia, with adjusted dosages considering the severity of diagnosis and the patient's weight and medical history, the elbow was aseptically prepped and draped. An oblique incision was made over the affected bursa, exposing a moderate diagnosis of other bursitis of the elbow. Thorough dissection was performed to excise the inflamed bursa and address the underlying pathology. The wound was closed with absorbable sutures, and a sterile dressing was applied. The patient will be scheduled for a follow-up appointment in two weeks to assess the response to treatment and determine the need for further interventions.

## M70.4 Prepatellar bursitis

Operative Note 1:

Patient presented with prepatellar bursitis, exhibiting localized swelling and tenderness over the patella. After administering local anesthesia, a 1 cm incision was made overlying the inflamed bursa. The bursa was then dissected and excised using meticulous technique to avoid damage to surrounding structures. Hemostasis was achieved, and the wound was closed using absorbable sutures. A sterile dressing was applied, and the patient was provided with postoperative care instructions.

Operative Note 2:

A patient with chronic prepatellar bursitis underwent an operative intervention. After sterile preparation and draping, a longitudinal incision was made over the prepatellar area. The bursa was meticulously dissected and debrided to remove inflamed tissue. Irrigation with saline solution was performed to ensure thorough cleansing. Hemostasis was obtained, and the wound was closed using interrupted sutures. Postoperatively, a sterile dressing was applied, and the patient was advised to follow up for further evaluation.

Operative Note 3:

Patient with prepatellar bursitis underwent an arthroscopic procedure. Under general anesthesia, standard portals were established, and the joint was inspected. The bursa was identified and excised using arthroscopic instruments, ensuring complete removal of inflamed tissue. Hemostasis was achieved, and the portals were closed with sutures. The patient tolerated the procedure well, and a sterile dressing was applied. Postoperative instructions were provided, and the patient was scheduled for a follow-up appointment.

Operative Note 4:

A patient with recurrent prepatellar bursitis underwent a bursectomy. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was carefully dissected and excised, ensuring complete removal of the inflamed tissue. Hemostasis was obtained, and the wound was closed in layers using absorbable sutures. The patient tolerated the procedure without complications. A sterile dressing was applied, and the patient was advised to elevate the leg and use ice packs for pain management.

Operative Note 5:

A patient with prepatellar bursitis underwent an ultrasound-guided aspiration and corticosteroid injection. The bursa was identified using ultrasound imaging, and aseptic technique was employed. The bursa was aspirated using a 21-gauge needle, and clear fluid was obtained. Following aspiration, a mixture of local anesthetic and corticosteroid was injected into the bursa. The patient tolerated the procedure well without immediate complications. Post-procedure instructions were provided, including rest, elevation, and activity modification.

Operative Note 6:

Patient presented with prepatellar bursitis and underwent a minimally invasive bursectomy. After marking the surgical site, a small incision was made, and a trocar was inserted. Using endoscopic visualization, the bursa was carefully dissected and excised. Hemostasis was achieved, and the trocar site was closed using sutures. The patient experienced no intraoperative complications. A sterile dressing was applied, and the patient was discharged with instructions for wound care and a follow-up appointment.

Operative Note 7:

A patient with prepatellar bursitis underwent an open bursectomy. After preparing the surgical field, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and removed, ensuring complete excision of the inflamed tissue. Hemostasis was obtained, and the wound was closed in layers using absorbable sutures. The patient tolerated the procedure well, and a sterile dressing was applied. Postoperative instructions were provided, including rest, elevation, and the use of non-ster

oidal anti-inflammatory drugs for pain control.

Operative Note 8:

Patient with chronic prepatellar bursitis underwent a percutaneous drainage procedure. After sterile preparation, a needle was inserted into the bursa under ultrasound guidance. The bursa was aspirated, and cloudy fluid was obtained. The bursa was then flushed with saline to ensure proper drainage. A compression dressing was applied, and the patient was instructed to keep the leg elevated and apply ice packs for pain relief. Follow-up was scheduled to monitor the patient's progress and determine the need for further interventions.

Operative Note 9:

A patient with acute prepatellar bursitis underwent an aspiration and lavage procedure. After sterile preparation, a needle was inserted into the bursa, and fluid was aspirated. Lavage was performed using sterile saline solution to irrigate the bursa and remove inflammatory debris. The bursa was then aspirated again to ensure proper drainage. A sterile dressing was applied, and the patient was advised to avoid activities that could aggravate the condition.

Operative Note 10:

Patient with prepatellar bursitis underwent a minimally invasive bursal debridement. After establishing a sterile field, a small incision was made over the bursa. The bursa was meticulously debrided using arthroscopic instruments, removing inflamed and necrotic tissue. Copious irrigation was performed to ensure thorough cleansing. Hemostasis was obtained, and the wound was closed using absorbable sutures. A sterile dressing was applied, and the patient was advised to follow postoperative instructions, including rest, elevation, and the use of anti-inflammatory medication.

Operative Note 11:

Patient presented with chronic prepatellar bursitis and underwent a minimally invasive ultrasound-guided fenestration procedure. After sterile preparation, a needle was inserted into the bursa under ultrasound guidance. Multiple fenestrations were made in the bursa using a scalpel blade, allowing for improved fluid drainage and reduction of inflammation. The bursa was then irrigated with saline solution. A sterile dressing was applied, and the patient was provided with postoperative care instructions.

Operative Note 12:

A patient with prepatellar bursitis underwent a minimally invasive radiofrequency ablation (RFA) procedure. After appropriate anesthesia, a needle electrode was inserted into the bursa under ultrasound guidance. Radiofrequency energy was delivered to the bursal lining to achieve controlled cauterization and destruction of the inflamed tissue. The electrode was then removed, and the procedure was repeated as necessary. The patient tolerated the procedure well, and postoperative instructions were given, including pain management and activity modification.

Operative Note 13:

Patient with chronic prepatellar bursitis underwent a sclerotherapy procedure. After sterile preparation, a needle was inserted into the bursa under ultrasound guidance. A sclerosing agent, such as sodium morrhuate, was injected into the bursa to promote fibrosis and reduce fluid accumulation. The needle was then removed, and the bursa was compressed using a sterile dressing. The patient was instructed to elevate the leg and apply ice packs for pain relief. Follow-up was scheduled to assess the response to the treatment.

Operative Note 14:

A patient with prepatellar bursitis underwent a minimally invasive aspiration and platelet-rich plasma (PRP) injection procedure. After sterile preparation, the bursa was aspirated using a needle, and fluid was collected. Autologous PRP was then prepared from the patient's blood and injected into the bursa to promote healing and reduce inflammation. The needle was removed, and a sterile dressing was applied. The patient was advised on postoperative care, including activity modification and the use of anti-inflammatory medication, if needed.

Operative Note 15:

Patient presented with recurrent prepatellar bursitis and underwent a surgical excision with primary closure. After appropriate anesthesia, a curvilinear incision was made over the bursa, and the skin flaps were elevated. The bursa was carefully dissected and completely excised, ensuring removal of the entire inflamed sac. Hemostasis was achieved, and the wound was closed using interrupted sutures. A sterile dressing was applied, and the patient was provided with postoperative care instructions, including wound care and follow-up appointments.

Operative Note 16:

A patient with prepatellar bursitis underwent a minimally invasive ultrasound-guided alcohol sclerotherapy procedure. After sterile preparation, a needle was inserted into the bursa under ultrasound guidance. Ethyl alcohol was injected into the bursa to induce chemical inflammation and fibrosis. The needle was removed, and the bursa was compressed using a sterile dressing. The patient was instructed to elevate the leg and apply ice packs for pain relief. Follow-up was scheduled to monitor the response to the treatment.

Operative Note 17:

Patient with chronic prepatellar bursitis underwent a minimally invasive arthroscopic bursectomy. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, ensuring complete removal of the inflamed tissue. Hemostasis was achieved, and the portals were closed with sutures. The patient tolerated the procedure well, and a sterile dressing was applied. Postoperative instructions were

provided, including rest, elevation, and physical therapy for rehabilitation.

Operative Note 18:

A patient with recurrent prepatellar bursitis underwent a percutaneous ethanol injection (PEI) procedure. After sterile preparation, a needle was inserted into the bursa under ultrasound guidance. Ethanol was injected into the bursa to induce chemical sclerosis and reduce fluid accumulation. The needle was removed, and a compression dressing was applied. The patient was advised on postoperative care, including pain management and the need for repeat injections if necessary.

Operative Note 19:

Patient with prepatellar bursitis underwent a minimally invasive bursectomy using a radiofrequency ablation (RFA) device. After appropriate anesthesia, the RFA device was inserted into the bursa, and radiofrequency energy was applied to cauterize and remove the inflamed bursal lining. Hemostasis was obtained, and the device was removed. A sterile dressing was applied, and the patient was instructed on postoperative care, including rest, elevation, and the use of non-steroidal anti-inflammatory drugs for pain control.

Operative Note 20:

A patient with prepatellar bursitis underwent a minimally invasive arthroscopic bursectomy with synovectomy. Under general anesthesia, standard portals were established, and the arthroscope was introduced into the joint. The bursa and inflamed synovium were identified and meticulously removed using arthroscopic instruments. Hemostasis was achieved, and the portals were closed with sutures. The patient tolerated the procedure well, and a sterile dressing was applied. Postoperative instructions were provided, including rest, elevation, and a rehabilitation program to restore range of motion and strength.

Operative Note 21:

Patient presented with prepatellar bursitis and underwent an open bursectomy under local anesthesia. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, ensuring complete removal of the inflamed tissue. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient remained comfortable throughout the procedure under local anesthesia. A sterile dressing was applied, and postoperative instructions were provided, including rest, elevation, and the use of analgesics for pain management.

Operative Note 22:

A patient with chronic prepatellar bursitis underwent an arthroscopic bursectomy under spinal anesthesia. After establishing sterile conditions, standard portals were created, and the joint was visualized. The bursa was identified and excised using arthroscopic instruments, ensuring complete removal of the inflamed tissue. Hemostasis was achieved, and the portals were closed with sutures. The patient remained stable throughout the procedure under spinal anesthesia. A sterile dressing was applied, and postoperative care instructions were given.

Operative Note 23:

Patient with prepatellar bursitis underwent an open bursectomy under general anesthesia. After appropriate preoperative measures, a curvilinear incision was made over the bursa. The bursa was carefully dissected and completely excised, ensuring removal of the entire inflamed sac. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient remained stable under general anesthesia throughout the procedure. A sterile dressing was applied, and postoperative instructions were provided for pain management and wound care.

Operative Note 24:

A patient with recurrent prepatellar bursitis underwent a percutaneous ethanol injection (PEI) procedure under conscious sedation. After sterile preparation, a needle was inserted into the bursa under ultrasound guidance. Ethanol was injected into the bursa to induce chemical sclerosis. The patient remained comfortable and cooperative under conscious sedation throughout the procedure. The needle was removed, and a compression dressing was applied. The patient was provided with postoperative instructions and discharged with appropriate pain medications.

Operative Note 25:

Patient presented with prepatellar bursitis and underwent a minimally invasive bursectomy under monitored anesthesia care (MAC). After sterile preparation, a small incision was made over the bursa. The bursa was meticulously dissected and excised, ensuring complete removal of the inflamed tissue. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient remained calm and comfortable under MAC throughout the procedure. A sterile dressing was applied, and postoperative instructions were given, including pain management and wound care.

Operative Note 26:

A patient with prepatellar bursitis underwent an arthroscopic bursectomy under regional anesthesia. After establishing sterile conditions, standard portals were created, and the joint was visualized. The bursa was identified and excised using arthroscopic instruments, ensuring complete removal of the inflamed tissue. Hemostasis was achieved, and the portals were closed with sutures. The patient remained stable and experienced no pain under regional anesthesia throughout the procedure. A sterile dressing was applied, and postoperative care instructions were provided.

Operative Note 27:

Patient with chronic prepatellar bursitis underwent an open bursectomy under moderate sedation. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and removed, ensuring complete excision of the inflamed tissue. Hemostasis was obtained, and the wound was closed in layers using absorbable sutures. The patient remained comfortable and relaxed

under moderate sedation throughout the procedure. A sterile dressing was applied, and postoperative instructions were given, including pain management and wound care.

Operative Note 28:

A patient with prepatellar bursitis underwent a minimally invasive bursectomy under general anesthesia. After appropriate preoperative measures, a small incision was made over the bursa. The bursa was carefully dissected and completely excised, ensuring removal of the entire inflamed sac. Hemostasis was achieved, and the wound was closed using interrupted sutures. The patient remained stable and asleep under general anesthesia throughout the procedure. A sterile dressing was applied, and postoperative instructions were provided for pain management and wound care.

Operative Note 29:

Patient presented with prepatellar bursitis and underwent an open bursectomy under regional anesthesia. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, ensuring complete removal of the inflamed tissue. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient remained calm and pain-free under regional anesthesia throughout the procedure. A sterile dressing was applied, and postoperative instructions were provided, including pain management and wound care.

Operative Note 30:

A patient with recurrent prepatellar bursitis underwent a percutaneous ethanol injection (PEI) procedure under local anesthesia. After sterile preparation, a needle was inserted into the bursa under ultrasound guidance. Ethanol was injected into the bursa to induce chemical sclerosis. The patient remained comfortable and cooperative under local anesthesia throughout the procedure. The needle was removed, and a compression dressing was applied. The patient was given postoperative instructions and discharged with appropriate pain medications.

Operative Note 31:

Patient with prepatellar bursitis and associated bone erosion underwent an open bursectomy with bone debridement. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and attention was then turned to the eroded bone. The eroded areas were debrided using surgical instruments, removing the necrotic and damaged bone tissue. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including weight-bearing restrictions and follow-up imaging to assess bone healing.

Operative Note 32:

A patient with chronic prepatellar bursitis and bone erosion underwent an arthroscopic bursectomy with bone grafting. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous debridement of the eroded bone. A bone graft was then harvested and placed over the eroded area to promote bone regeneration. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including immobilization and weight-bearing restrictions.

Operative Note 33:

Patient presented with prepatellar bursitis and significant bone erosion requiring surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and attention was then turned to the eroded bone. The eroded areas were carefully debrided, removing the diseased bone tissue. Hemostasis was obtained, and the wound was closed in layers using absorbable sutures. Postoperative instructions were given, emphasizing the need for limited weight-bearing and rehabilitation for optimal recovery.

Operative Note 34:

A patient with prepatellar bursitis and extensive bone erosion underwent an open bursectomy with bone grafting and stabilization. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and thorough debridement of the eroded bone was performed. A bone graft was then harvested and secured over the eroded area using appropriate fixation devices. Hemostasis was achieved, and the wound was closed in layers. The patient was provided with postoperative instructions, including weight-bearing restrictions and physical therapy for rehabilitation.

Operative Note 35:

Patient with chronic prepatellar bursitis and underlying bone erosion underwent an arthroscopic bursectomy with bone microfracture. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous debridement of the eroded bone. Microfracture technique was utilized to create small channels in the bone, stimulating the formation of new cartilage. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including weight-bearing restrictions and rehabilitation exercises.

Operative Note 36:

A patient with prepatellar bursitis and bone erosion underwent an open bursectomy with bone grafting and fixation. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and the eroded bone was thoroughly debrided. A bone graft was then obtained and placed over the eroded area, securing it with appropriate fixation devices. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions, emphasizing the need for limited weight-bearing and regular follow-up evaluations.

Operative Note 37

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Patient presented with prepatellar bursitis and extensive bone erosion requiring surgical intervention. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and the eroded bone was debrided using specialized instruments. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including the need for immobilization and non-weight-bearing activities to facilitate bone healing and prevent further damage.

Operative Note 38:

A patient with chronic prepatellar bursitis and underlying bone erosion underwent an arthroscopic bursectomy with bone marrow stimulation. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous debridement of the eroded bone. Bone marrow stimulation techniques, such as microfracture or drilling, were performed to promote the formation of new cartilage. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including weight-bearing restrictions and physical therapy.

Operative Note 39:

Patient with prepatellar bursitis and significant bone erosion underwent an open bursectomy with bone grafting and augmentation. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and the eroded bone was thoroughly debrided. A bone graft was then obtained and placed over the eroded area, supported by additional bone augmentation materials. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient was provided with postoperative instructions, including immobilization, restricted weight-bearing, and regular follow-up evaluations.

Operative Note 40:

A patient with prepatellar bursitis and extensive bone erosion underwent an arthroscopic bursectomy with bone grafting and fixation. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous debridement of the eroded bone. A bone graft was then obtained and secured over the eroded area using appropriate fixation devices. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, emphasizing the need for limited weight-bearing and physical therapy for optimal recovery.

Operative Note 41:

Patient presented with prepatellar bursitis and severe bone pain requiring surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and attention was then turned to the underlying bone. Thorough debridement was performed to remove any diseased or necrotic bone tissue contributing to the severe pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management strategies and referral to a pain specialist for further evaluation and treatment.

Operative Note 42:

A patient with chronic prepatellar bursitis and severe bone pain underwent an arthroscopic bursectomy with bone resection. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous resection of the bone in the affected area to alleviate the severe bone pain. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management modalities and physical therapy for rehabilitation.

Operative Note 43:

Patient with prepatellar bursitis and associated severe bone pain underwent an open bursectomy with bone curettage. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and the underlying bone was carefully curetted to alleviate the severe pain. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. Postoperative instructions were given, emphasizing the need for pain management strategies, including medication and rehabilitation, to address the severe bone pain.

Operative Note 44:

A patient with prepatellar bursitis and severe bone pain underwent an arthroscopic bursectomy with bone microfracture and nerve ablation. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous bone microfracture to promote healing and alleviate the severe bone pain. Nerve ablation was performed to interrupt pain signals. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management strategies and follow-up evaluations.

Operative Note 45:

Patient presented with prepatellar bursitis and severe bone pain necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and attention was then turned to the underlying bone. Extensive bone debridement was performed to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management strategies, such as medication and physical therapy, to address the severe bone pain.

Operative Note 46:

A patient with chronic prepatellar bursitis and severe bone pain underwent an open bursectomy with bone grafting and neurolysis. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and the eroded bone was thoroughly debrided. A bone graft was then obtained and placed over the affected area. Neurolysis was performed to relieve the severe bone pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management strategies and rehabilitative measures.

Operative Note 47:

Patient with prepatellar burs

itis and severe bone pain underwent an arthroscopic bursectomy with bone debridement and nerve decompression. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous debridement of the eroded bone. Nerve decompression was performed to alleviate the severe bone pain. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management modalities and physical therapy for rehabilitation.

Operative Note 48:

A patient with prepatellar bursitis and severe bone pain underwent an open bursectomy with bone resection and radiofrequency ablation. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and the underlying bone was resected to alleviate the severe bone pain. Radiofrequency ablation was performed to provide long-term pain relief. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including pain management strategies and referral to a pain specialist for further evaluation and treatment.

Operative Note 49:

Patient presented with prepatellar bursitis and severe bone pain requiring surgical intervention. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and attention was then turned to the underlying bone. Thorough debridement was performed to remove any diseased or necrotic bone tissue contributing to the severe pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management strategies and referral to a pain management team for comprehensive care.

Operative Note 50:

A patient with chronic prepatellar bursitis and severe bone pain underwent an arthroscopic bursectomy with bone resection and nerve block. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous resection of the bone to alleviate the severe bone pain. Nerve block was performed to provide immediate pain relief. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management strategies and rehabilitation measures.

Operative Note 51:

Patient presented with refractory prepatellar bursitis and failed conservative management, necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissue. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient tolerated the procedure well, and postoperative instructions were given, including wound care, pain management, and physical therapy for optimal recovery.

Operative Note 52:

A patient with recurrent prepatellar bursitis underwent an arthroscopic bursectomy with surgical lavage. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by thorough irrigation and lavage of the joint to remove inflammatory debris. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including activity modification, pain management, and follow-up evaluations to monitor the patient's progress.

Operative Note 53:

Patient presented with chronic prepatellar bursitis and persistent symptoms, warranting surgical intervention. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and attention was then turned to the underlying structures for further evaluation. Intraoperative findings revealed associated synovitis, which was addressed with synovectomy. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including pain management, activity restrictions, and follow-up appointments for ongoing care.

Operative Note 54:

A patient with prepatellar bursitis and significant functional impairment underwent an open bursectomy with capsulotomy. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by careful release of the tight joint capsule to improve range of motion. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient was provided with postoperative instructions, including rehabilitation exercises, pain management, and follow-up visits for monitoring and further intervention, if necessary.

Operative Note 55:

Patient with chronic prepatellar bursitis and recurrent infections underwent an excision and drainage procedure. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough irrigation and drainage of the infected fluid. Cultures were obtained, and appropriate antibiotics were administered. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including wound care, antibiotic therapy, and regular follow-up to monitor for resolution of the infection.

Operative Note 56:

A patient with prepatellar bursitis and severe pain refractory to conservative measures underwent a bursectomy with corticosteroid injection. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, and a corticosteroid solution was injected into the surrounding tissues to alleviate inflammation and pain. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient received postoperative instructions, including pain management, activity modification, and follow-up appointments for ongoing care.

Operative Note 57:

Patient presented with recurrent prepatellar bursitis and functional impairment, necessitating surgical intervention. After sterile preparation, a curvilinear incision was made over

the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissue. A tissue flap was then created and transferred to the area to promote healing and prevent recurrence. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative care instructions were provided, emphasizing wound care, pain management, and rehabilitation exercises.

Operative Note 58:

A patient with chronic prepatellar bursitis and persistent pain underwent an arthroscopic bursectomy with intra-articular debridement. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous debridement of the intra-articular structures to address any underlying pathology contributing to the pain. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management strategies, activity restrictions, and follow-up evaluations for continued management.

Operative Note 59:

Patient presented with prepatellar bursitis and recurrent effusions requiring surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough irrigation and drainage of the accumulated fluid. The joint capsule was also addressed, with a partial synovectomy performed to reduce the likelihood of further effusion. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including wound care, activity modifications, and follow-up appointments for ongoing assessment.

Operative Note 60:

A patient with prepatellar bursitis and debilitating pain underwent an open bursectomy with tenotomy. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by careful tenotomy of the involved tendon to relieve tension and alleviate the pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient was provided with postoperative instructions, including pain management strategies, physical therapy, and regular follow-up evaluations to monitor progress and address any further concerns.

Operative Note 61:

Patient presented with chronic prepatellar bursitis and persistent symptoms, warranting surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. A biologic scaffold was then applied to promote tissue regeneration and facilitate healing. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. Postoperative instructions were given, including wound care, pain management, and a structured rehabilitation program for optimal recovery.

Operative Note 62:

A patient with prepatellar bursitis and functional impairment underwent an arthroscopic bursectomy with patellar tendon repair. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous repair of the damaged patellar tendon using sutures and anchors. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including protected weight-bearing, physical therapy, and regular follow-up evaluations for monitoring and rehabilitation progress.

Operative Note 63:

Patient presented with prepatellar bursitis and persistent pain refractory to conservative treatment, necessitating surgical intervention. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. A regenerative medicine technique, such as platelet-rich plasma (PRP) injection, was administered to promote healing and reduce pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including pain management, activity modification, and follow-up appointments for ongoing care.

Operative Note 64:

A patient with chronic prepatellar bursitis and recurrent infections underwent an open bursectomy with wound debridement and primary closure. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough irrigation and debridement of the infected tissue. The wound was then carefully closed using sutures, ensuring optimal approximation. Hemostasis was achieved, and a sterile dressing was applied. Postoperative care instructions were provided, including wound care, antibiotic therapy, and regular follow-up to monitor for resolution of the infection.

Operative Note 65:

Patient presented with prepatellar bursitis and debilitating pain necessitating surgical intervention. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. A local anesthetic and corticosteroid mixture were injected into the area to provide immediate pain relief. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, emphasizing pain management strategies, activity modifications, and regular follow-up appointments for ongoing care.

Operative Note 66:

A patient with prepatellar bursitis and significant functional impairment underwent an arthroscopic bursectomy with synovectomy. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous removal of the inflamed synovial tissue. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including protected weight-bearing, pain management, and a structured rehabilitation program for optimal recovery and restoration of joint function.

Operative Note 67:

Patient presented with chronic prepatellar bursitis and severe pain refractory to conservative management, necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. A nerve ablation procedure, such as radiofrequency ablation, was performed to alleviate the severe pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including pain management strategies, activity modifications, and regular follow-up appointments for ongoing care.

Operative Note 68:

A patient with prepatellar bursitis and persistent pain underwent an open bursectomy with autologous tissue transfer. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by the transfer of healthy autologous tissue to the area to promote healing and prevent recurrence. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient was provided with postoperative instructions, including wound care, pain management, and a structured rehabilitation program to optimize outcomes.

Operative Note 69:

Patient presented with refractory prepatellar bursitis and failed conservative management, necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. A regenerative medicine technique, such as adipose-derived stem cell injection, was administered to promote tissue repair and reduce inflammation. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including pain management, activity modification, and follow-up appointments for ongoing care.

Operative Note 70:

A patient with prepatellar bursitis and severe pain underwent an arthroscopic bursectomy with bone erosion repair. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous repair of the eroded bone using bone grafting techniques. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management, protected weight-bearing, and regular follow-up evaluations for monitoring and rehabilitation.

Operative Note 71:

A patient with prepatellar bursitis and severe infection involving the extreme moving joint underwent an emergency open bursectomy with joint debridement and irrigation. After appropriate anesthesia, an extensive incision was made over the bursa and the affected joint. The bursa was meticulously dissected and excised, followed by thorough debridement of infected tissues and irrigation with antimicrobial solution. The joint was inspected for any further signs of infection or damage. Hemostasis was achieved, and the wound was closed using sutures. Postoperative care included intravenous antibiotics, wound care, and close monitoring for resolution of the infection.

Operative Note 72:

Patient presented with prepatellar bursitis and severe infection involving the extreme moving joint, necessitating urgent surgical intervention. After sterile preparation, an incision was made over the bursa and extended to the joint. The bursa was meticulously dissected and excised, followed by extensive debridement of infected tissues and thorough irrigation with antibiotic solution. Any compromised joint structures were addressed as necessary. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient received postoperative instructions, including intravenous antibiotics, wound care, and close follow-up for ongoing management.

Operative Note 73:

A patient with chronic prepatellar bursitis and severe infection involving the extreme moving joint underwent an arthroscopic bursectomy with joint lavage and debridement. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous lavage and debridement of infected tissues. Special attention was given to the affected joint structures. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions included intravenous antibiotics, pain management, and close monitoring for resolution of the infection.

Operative Note 74:

Patient presented with prepatellar bursitis and severe infection involving the extreme moving joint, necessitating immediate surgical intervention. After appropriate anesthesia, an incision was made over the bursa and extended to the joint. The bursa was meticulously dissected and excised, followed by thorough debridement of infected tissues and extensive irrigation with antimicrobial solution. Any compromised joint structures were addressed and repaired as necessary. Hemostasis was achieved, and the wound was closed using sutures. Postoperative care included intravenous antibiotics, wound care, and close monitoring for resolution of the infection.

Operative Note 75:

A patient with prepatellar bursitis and severe infection involving the extreme moving joint underwent an open bursectomy with joint exploration and debridement. After sterile preparation, an incision was made over the bursa and extended to the joint. The bursa was meticulously dissected and excised, followed by thorough exploration and debridement of infected tissues within the joint. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative care instructions included intravenous antibiotics, wound care, and close monitoring for resolution of the infection.

Operative Note 76:

Patient presented with chronic prepatellar bursitis and severe infection involving the extreme moving joint, necessitating surgical intervention. After appropriate anesthesia, an incision was made over the bursa and extended to the joint. The bursa was meticulously dissected and excised, followed by extensive debridement of infected tissues and thorough irrigation with antimicrobial solution. Any compromised joint structures were addressed as necessary. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient received postoperative instructions, including intravenous antibiotics, wound care, pain management, and close follow-up for ongoing management.

Operative Note 77:

A patient with prepatellar bursitis and severe infection involving the extreme moving joint underwent an urgent arthroscopic bursectomy with joint washout and debridement. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous irrigation and debridement of infected tissues. Special attention was given to the affected joint structures. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions included intravenous antibiotics, pain management, and close monitoring for resolution of the infection.

Operative Note 78:

Patient presented with prepatellar bursitis and severe infection involving the extreme moving joint, necessitating immediate surgical intervention. After appropriate anesthesia, an incision was made over the bursa and extended to the joint. The bursa was meticulously dissected and excised, followed by thorough debridement of infected tissues and extensive irrigation with antimicrobial solution. Any compromised joint structures were addressed and repaired as necessary. Hemostasis was achieved, and the wound was closed using sutures. Postoperative care included intravenous antibiotics, wound care, and close monitoring for resolution of the infection.

Operative Note 79:

A patient with chronic prepatellar bursitis and severe infection involving the extreme moving joint underwent an open bursectomy with joint exploration and debridement. After sterile preparation, an incision was made over the bursa and extended to the joint. The bursa was meticulously dissected and excised, followed by thorough exploration and debridement of infected tissues within the joint. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative care instructions included intravenous antibiotics, wound care, pain management, and close monitoring for resolution of the infection.

Operative Note 80:

Patient presented with prepatellar bursitis and severe infection involving the extreme moving joint, necessitating urgent surgical intervention. After appropriate anesthesia, an incision was made over the bursa and extended to the joint. The bursa was meticulously dissected and excised, followed by thorough debridement of infected tissues and extensive irrigation with antimicrobial solution. Any compromised joint structures were addressed and repaired as necessary. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient received postoperative instructions, including intravenous antibiotics, wound care, pain management, and close follow-up for ongoing management.

Operative Note 81:

A patient with prepatellar bursitis and severe inflammation underwent an arthroscopic bursectomy with intra-articular corticosteroid injection. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous irrigation of the joint. A corticosteroid solution was then injected into the joint to reduce inflammation and alleviate symptoms. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions included pain management, activity modification, and follow-up evaluations for continued management.

Operative Note 82:

Patient presented with chronic prepatellar bursitis and recurrent inflammation necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough irrigation and debridement of the surrounding inflamed tissues. A biologic membrane was applied to the area to reduce inflammation and promote healing. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management strategies, activity modifications, and regular follow-up appointments for ongoing care.

Operative Note 83:

A patient with prepatellar bursitis and severe inflammation underwent an open bursectomy with intraoperative anti-inflammatory drug administration. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. An anti-inflammatory medication, such as triamcinolone, was administered directly into the area to reduce inflammation. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient was provided with postoperative instructions, including pain management, activity modification, and follow-up appointments for ongoing care.

Operative Note 84:

Patient presented with prepatellar bursitis and severe inflammation refractory to conservative management, necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. An anti-inflammatory foam dressing was applied to the area to reduce inflammation and promote healing. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management strategies, activity modifications, and regular follow-up appointments for ongoing care.

Operative Note 85:

A patient with chronic prepatellar bursitis and persistent inflammation underwent an arthroscopic bursectomy with intra-articular anti-inflammatory drug injection. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous irrigation of the joint. An anti-inflammatory medication, such as corticosteroid or hyaluronic acid, was injected into the joint to reduce inflammation. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management, activity modification, and follow-up evaluations for continued management.

Operative Note 86:

Patient presented with prepatellar bursitis and severe inflammation refractory to conservative management, necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. An anti-inflammatory medication, such as diclofenac gel, was applied topically to the area to reduce inflammation. Hemostasis

was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including pain management, activity modification, and regular follow-up appointments for ongoing care.

Operative Note 87:

A patient with prepatellar bursitis and severe inflammation refractory to conservative management underwent an open bursectomy with intraoperative anti-inflammatory drug administration. After sterile preparation, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. An anti-inflammatory medication, such as methylprednisolone, was injected directly into the area to reduce inflammation. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient was provided with postoperative instructions, including pain management, activity modification, and follow-up appointments for ongoing care.

Operative Note 88:

Patient presented with prepatellar bursitis and severe inflammation refractory to conservative management, necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. A biological scaffold was applied to the area to reduce inflammation and promote tissue healing. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management strategies, activity modifications, and regular follow-up appointments for ongoing care.

Operative Note 89:

A patient with chronic prepatellar bursitis and persistent inflammation underwent an arthroscopic bursectomy with intra-articular corticosteroid injection. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous irrigation of the joint. A corticosteroid solution was then injected into the joint to reduce inflammation and alleviate symptoms. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions included pain management, activity modification, and follow-up evaluations for continued management.

Operative Note 90:

Patient presented with prepatellar bursitis and severe inflammation refractory to conservative management, necessitating surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding inflamed tissues. An anti-inflammatory medication, such as ibuprofen, was administered systemically to reduce inflammation. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient received postoperative instructions, including pain management, activity modification, and regular follow-up appointments for ongoing care.

Operative Note 91:

A patient with prepatellar bursitis and moderate severity of diagnosis underwent an arthroscopic bursectomy with joint lavage and debridement. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous lavage and debridement of the affected area. Any associated joint pathology was addressed as necessary. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management, activity modification, and a follow-up appointment in two weeks for evaluation of the patient's progress.

Operative Note 92:

Patient presented with chronic prepatellar bursitis and mild severity of diagnosis, requiring surgical intervention. After appropriate anesthesia, a curvilinear incision was made over the bursa. The bursa was meticulously dissected and excised, followed by thorough debridement of the surrounding tissues. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative instructions were given, including pain management, activity modification, and a follow-up appointment in four weeks for further assessment of the patient's condition.

Operative Note 93:

A patient with prepatellar bursitis and severe severity of diagnosis underwent an open bursectomy with extensive debridement. After sterile preparation, a curvilinear incision was made over the bursa, and the bursa was meticulously dissected and excised. The affected tissues were extensively debrided, and any necrotic or infected material was removed. Hemostasis was achieved, and the wound was closed using sutures. The patient received postoperative instructions, including pain management, activity modification, and a follow-up appointment in one week to assess the healing progress and address any concerns.

Operative Note 94:

Patient presented with chronic prepatellar bursitis and moderate severity of diagnosis, necessitating an arthroscopic bursectomy with joint washout and corticosteroid injection. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous irrigation and debridement. A corticosteroid solution was injected into the joint to reduce inflammation. Hemostasis was achieved, and the portals were closed with sutures. The patient was provided with postoperative instructions, including pain management, activity modification, and a follow-up appointment in six weeks to evaluate the response to the treatment.

Operative Note 95:

A patient with prepatellar bursitis and mild severity of diagnosis underwent an open bursectomy with debridement. After appropriate anesthesia, a curvilinear incision was made over the bursa, and the bursa was meticulously dissected and excised. The surrounding tissues were debrided, and any inflammatory or necrotic material was removed. Hemostasis was achieved, and the wound was closed using sutures. Postoperative instructions were given, including pain management, activity modification, and a follow-up appointment in three weeks to assess the patient's progress and determine the need for further interventions.

Operative Note 96:

Patient presented with chronic prepatellar bursitis and severe severity of diagnosis, requiring an open bursectomy with extensive debridement and biologic membrane application. After sterile preparation, a curvilinear incision was made over the bursa, and the bursa was meticulously dissected and excised. The affected tissues were extensively debrided, and a biologic membrane was applied to aid in the healing process. Hemostasis was achieved, and the wound was closed

using sutures. The patient received postoperative instructions, including pain management, activity modification, and a follow-up appointment in two weeks for assessment and further treatment planning.

Operative Note 97:

A patient with prepatellar bursitis and mild severity of diagnosis underwent an arthroscopic bursectomy with joint lavage. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous lavage of the joint to remove any inflammatory debris. Hemostasis was achieved, and the portals were closed with sutures. Postoperative care instructions were provided, including pain management, activity modification, and a follow-up appointment in six weeks for evaluation of the patient's condition and consideration of further interventions, if necessary.

Operative Note 98:

Patient presented with chronic prepatellar bursitis and moderate severity of diagnosis, necessitating an open bursectomy with debridement and application of a biologic scaffold. After appropriate anesthesia, a curvilinear incision was made over the bursa, and the bursa was meticulously dissected and excised. The affected tissues were debrided, and a biologic scaffold was applied to promote healing and reduce the risk of recurrence. Hemostasis was achieved, and the wound was closed using sutures. The patient received postoperative instructions, including pain management, activity modification, and a follow-up appointment in four weeks for assessment and consideration of further interventions, if required.

Operative Note 99:

A patient with prepatellar bursitis and severe severity of diagnosis underwent an arthroscopic bursectomy with extensive debridement and intra-articular corticosteroid injection. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by meticulous debridement of the affected area. A corticosteroid solution was injected into the joint to reduce inflammation and provide symptomatic relief. Hemostasis was achieved, and the portals were closed with sutures. The patient was provided with postoperative instructions, including pain management, activity modification, and a follow-up appointment in three weeks to evaluate the response to treatment and determine the need for further interventions.

Operative Note 100:

Patient presented with chronic prepatellar bursitis and mild severity of diagnosis, necessitating an arthroscopic bursectomy with joint washout. Under general anesthesia, standard portals were established, and the arthroscope was inserted into the joint. The bursa was identified and excised using arthroscopic instruments, followed by thorough irrigation and debridement of the joint. Hemostasis was achieved, and the portals were closed with sutures. Postoperative instructions were given, including pain management, activity modification, and a follow-up appointment in eight weeks to assess the patient's progress and determine the need for further interventions.

## M70.5 Other bursitis of knee

1. Operative Note: Patient underwent a surgical procedure for other bursitis of the knee. A small incision was made over the affected bursa, and the bursa was excised. Hemostasis was achieved, and the incision was closed with sutures. Postoperative care instructions were given, and the patient was discharged in stable condition.

2. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The affected bursa was identified and carefully dissected. A bursectomy was carried out, followed by meticulous hemostasis. The incision was closed using sutures. The patient tolerated the procedure well, and postoperative instructions were provided before discharge.

3. Operative Note: The patient underwent a surgical procedure for other bursitis of the knee. After identifying the affected bursa, it was excised using sharp dissection. Hemostasis was achieved, and the wound was closed with sutures. The patient was informed about postoperative care measures and discharged in a stable condition.

4. Operative Note: Surgical management was undertaken for other bursitis of the knee. A longitudinal incision was made over the bursa, which was then meticulously excised. Hemostasis was ensured, and the incision was closed with sutures. The patient received postoperative instructions and was discharged without any complications.

5. Operative Note: The patient underwent a surgical procedure for other bursitis of the knee. The affected bursa was approached through a small incision, and complete excision was performed. Hemostasis was achieved, and the wound was closed using sutures. The patient was discharged after receiving postoperative care instructions.

6. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The affected bursa was located and completely excised via a surgical incision. Hemostasis was carefully ensured, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

7. Operative Note: The patient underwent surgical excision for other bursitis of the knee. An incision was made over the bursa, and the bursa was meticulously dissected and removed. Hemostasis was achieved, and the incision was closed with sutures. The patient received postoperative instructions and was discharged without any complications.

8. Operative Note: Surgical management was performed for other bursitis of the knee. The affected bursa was identified and excised using sharp dissection. Hemostasis was secured, and the incision was closed with sutures. The patient was given postoperative care instructions and discharged in stable condition.

9. Operative Note: A surgical procedure was carried out to address other bursitis of the knee. The bursa was accessed through a small incision and carefully excised. Hemostasis was achieved, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient was discharged without any complications.

10. Operative Note: Surgical intervention was performed to treat other bursitis of the knee. The affected bursa was approached through an incision, and complete excision was performed. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care measures were explained to the patient, who was subsequently discharged in stable condition.

Certainly! Here are 10 additional synthetic operative notes pertaining to other bursitis of the knee in 70 words:

1. Operative Note: The patient underwent surgical excision for other bursitis of the knee. An incision was made, and the affected bursa was identified and carefully dissected. Complete removal of the bursa was achieved, followed by meticulous hemostasis. The incision was closed with sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

2. Operative Note: Surgical management was performed to address other bursitis of the knee. The bursa was approached through a small incision, and excision was carried out. Hemostasis was ensured, and the wound was closed using sutures. The patient received postoperative instructions and was discharged without any complications.

3. Operative Note: The patient underwent a surgical procedure for other bursitis of the knee. The affected bursa was identified and carefully excised using sharp dissection. Hemostasis was achieved, and the incision was closed with sutures. Postoperative care measures were discussed, and the patient was discharged in stable condition.

4. Operative Note: Surgical intervention was performed to treat other bursitis of the knee. The affected bursa was accessed through an incision, and meticulous excision was carried out. Hemostasis was secured, and the incision was closed using sutures. The patient was provided with postoperative care instructions and discharged without any complications.

5. Operative Note: A surgical procedure was performed to address other bursitis of the knee. The affected bursa was identified and completely excised through an incision. Hemostasis was ensured, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

6. Operative Note: The patient underwent surgical intervention for other bursitis of the knee. An incision was made over the bursa, which was then carefully excised using sharp dissection. Hemostasis was achieved, and the incision was closed with sutures. The patient received postoperative instructions and was discharged without any complications.

7. Operative Note: Surgical management was undertaken to address other bursitis of the knee. The affected bursa was approached through a small incision, and complete excision was performed. Hemostasis was achieved, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

8. Operative Note: The patient underwent a surgical procedure for other bursitis of the knee. The affected bursa was identified and excised using sharp dissection. Hemostasis was secured, and the incision was closed with sutures. The patient received postoperative care instructions and was discharged without any complications.

9. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The affected bursa was located and completely excised via a surgical incision. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

10. Operative Note: The patient underwent surgical excision for other bursitis of the knee. An incision was made over the bursa, and meticulous dissection was performed to remove the bursa. Hemostasis was achieved, and the incision was closed using sutures. The patient received postoperative instructions and was discharged without any complications.

1. Operative Note: Under general anesthesia, the patient underwent surgical excision for other bursitis of the knee. The affected bursa was identified and carefully dissected. Complete removal was achieved, and meticulous hemostasis was ensured. The incision was closed with sutures. Postoperative care instructions were provided, and the patient recovered smoothly.

2. Operative Note: Local anesthesia with sedation was administered to the patient undergoing surgical management for other bursitis of the knee. The bursa was accessed through a small incision and excised. Hemostasis was ensured, and the wound was closed using sutures. Postoperative instructions were given, and the patient was discharged without complications.

3. Operative Note: Spinal anesthesia was administered to the patient undergoing surgical intervention for other bursitis of the knee. The bursa was approached through an incision, and meticulous excision was performed. Hemostasis was secured, and the incision was closed with sutures. The patient received postoperative care instructions and recovered well.

4. Operative Note: General anesthesia was administered for the surgical procedure addressing other bursitis of the knee. The affected bursa was identified and completely excised through an incision. Hemostasis was ensured, and the wound was closed with sutures. The patient was provided with postoperative care instructions and had an uneventful recovery.

5. Operative Note: Regional anesthesia, combined with conscious sedation, was administered to the patient undergoing surgical management for other bursitis of the knee. The affected bursa was identified and excised through an incision. Hemostasis was achieved, and the incision was closed with sutures. Postoperative instructions were given, and the patient had a smooth recovery.

6. Operative Note: The patient received local anesthesia with intravenous sedation for the surgical procedure addressing other bursitis of the knee. The bursa was accessed through a small incision and meticulously excised. Hemostasis was ensured, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient recovered without complications.

7. Operative Note: General anesthesia was administered to the patient undergoing surgical intervention for other bursitis of the knee. The affected bursa was identified and excised using sharp dissection. Hemostasis was secured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient had a successful recovery.

8. Operative Note: The patient underwent spinal anesthesia with sedation for the surgical procedure addressing other bursitis of the knee. The affected bursa was located and completely excised via an incision. Hemostasis was ensured, and the incision was closed with sutures. Postoperative instructions were provided, and the patient recovered well.

9. Operative Note: Regional anesthesia, combined with monitored anesthesia care, was administered to the patient undergoing surgical management for other bursitis of the knee. The affected bursa was approached through an incision and meticulously excised. Hemostasis was achieved, and the incision was closed using sutures. The patient received postoperative instructions and had a smooth recovery.

10. Operative Note: The patient received general anesthesia with intravenous sedation for the surgical procedure addressing other bursitis of the knee. The bursa was accessed through an incision, and complete excision was performed. Hemostasis was achieved, and the incision was closed with sutures. Postoperative care measures were explained, and the patient had an uneventful recovery

1. Operative Note: The patient underwent surgical excision for other bursitis of the knee with significant bone erosion. After identifying the affected bursa and erosion site, meticulous dissection was performed. Complete removal of the bursa and debridement of eroded bone were achieved. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

2. Operative Note: Under general anesthesia, the patient underwent surgical management for other bursitis of the knee with associated bone erosion. The bursa was approached through an incision, and meticulous excision was performed. Debridement of eroded bone was carried out, and meticulous hemostasis was achieved. The wound was closed using sutures. Postoperative instructions were given, and the patient recovered smoothly.

3. Operative Note: Regional anesthesia, combined with conscious sedation, was administered to the patient undergoing surgical intervention for other bursitis of the knee with bone erosion. The affected bursa was identified and carefully excised. Debridement of eroded bone was performed, and meticulous hemostasis was achieved. The incision was closed with sutures, and postoperative care instructions were provided.

4. Operative Note: The patient received general anesthesia for the surgical procedure addressing other bursitis of the knee with bone erosion. The affected bursa was identified and completely excised through an incision. Extensive debridement of eroded bone was performed, and meticulous hemostasis was ensured. The wound was closed with sutures. Postoperative care instructions were given, and the patient had an uneventful recovery.

5. Operative Note: Under spinal anesthesia, the patient underwent surgical excision for other bursitis of the knee with bone erosion. The bursa was approached through an incision, and complete removal was achieved. Extensive debridement of eroded bone was carried out, and meticulous hemostasis was achieved. The incision was closed using sutures. Postoperative instructions were provided, and the patient recovered well.

6. Operative Note: Local anesthesia with sedation was administered to the patient undergoing surgical management for other bursitis of the knee with bone erosion. The affected bursa was identified and excised through an incision. Debridement of eroded bone was performed meticulously, and hemostasis was ensured. The wound was closed with sutures, and postoperative care instructions were provided.

7. Operative Note: The patient underwent surgical intervention for other bursitis of the knee with significant bone erosion. Under general anesthesia, the affected bursa was approached through an incision. Complete excision of the bursa and meticulous debridement of eroded bone were achieved. Hemostasis was ensured, and the wound was closed with sutures. Postoperative care instructions were given, and the patient had a successful recovery.

8. Operative Note: Regional anesthesia, combined with monitored anesthesia care, was administered to the patient undergoing surgical treatment for other bursitis of the knee with bone erosion. The affected bursa was accessed through an incision, and meticulous excision was performed. Debridement of eroded bone was carried out, and hemostasis was secured. The patient received postoperative instructions and had a smooth recovery.

9. Operative Note: The patient received general anesthesia with intravenous sedation for the surgical procedure addressing other bursitis of the knee with bone erosion. The bursa was approached through an incision, and complete excision was performed. Extensive debridement of eroded bone was achieved, and meticulous hemostasis was ensured. Postoperative care measures were explained, and the patient had an uneventful recovery.

10. Operative Note: Spinal anesthesia was administered to the patient undergoing surgical intervention for other bursitis of the knee with bone erosion. The affected bursa was identified and excised through an incision. Debridement of eroded bone was performed meticulously, and hemostasis was secured. The wound was closed using sutures, and postoperative care instructions were provided to the patient.

1. Operative Note: The patient underwent surgical excision for other bursitis of the knee with severe bone pain. After identifying the affected bursa and addressing bone erosion, meticulous dissection was performed. Complete removal of the bursa and debridement of eroded bone were achieved to alleviate the severe bone pain. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient was discharged in stable condition.

2. Operative Note: Under general anesthesia, the patient underwent surgical management for other bursitis of the knee with severe bone pain. The bursa was approached through an incision, and meticulous excision was performed. Debridement of eroded bone was carried out to alleviate the severe bone pain. Meticulous hemostasis was achieved, and the wound was closed using sutures. Postoperative instructions were given, and the patient recovered smoothly.

3. Operative Note: Regional anesthesia, combined with conscious sedation, was administered to the patient undergoing surgical intervention for other bursitis of the knee with severe bone pain. The affected bursa was identified and carefully excised. Debridement of eroded bone was performed to relieve the severe bone pain. Meticulous hemostasis was achieved, and the incision was closed with sutures. Postoperative care instructions were provided.

4. Operative Note: The patient received general anesthesia for the surgical procedure addressing other bursitis of the knee with severe bone pain. The affected bursa was identified and completely excised through an incision. Extensive debridement of eroded bone was performed to alleviate the severe bone pain. Meticulous hemostasis was ensured, and the wound was closed with sutures. Postoperative care instructions were given, and the patient had an uneventful recovery.

5. Operative Note: Under spinal anesthesia, the patient underwent surgical excision for other bursitis of the knee with severe bone pain. The bursa was approached through an incision, and complete removal was achieved. Extensive debridement of eroded bone was carried out to alleviate the severe bone pain. Meticulous hemostasis was achieved, and the incision was closed using sutures. Postoperative instructions were provided, and the patient recovered well.

6. Operative Note: Local anesthesia with sedation was administered to the patient undergoing surgical management for other bursitis of the knee with severe bone pain. The affected bursa was identified and excised through an incision. Debridement of eroded bone was performed meticulously to alleviate the severe bone pain. Hemostasis was ensured, and the wound was closed with sutures. Postoperative care instructions were provided.

7. Operative Note: The patient underwent surgical intervention for other bursitis of the knee with severe bone pain. Under general anesthesia, the affected bursa was approached through an incision. Complete excision of the bursa and meticulous debridement of eroded bone were achieved to relieve the severe bone pain. Hemostasis was ensured, and the wound was closed with sutures. Postoperative care instructions were given, and the patient had a successful recovery.

8. Operative Note: Regional anesthesia, combined with monitored anesthesia care, was administered to the patient undergoing surgical treatment for other bursitis of the knee with severe bone pain. The affected bursa was accessed through an incision, and meticulous excision was performed. Debridement of eroded bone was carried out to alleviate the severe bone pain. Hemostasis was secured, and the inc

ision was closed with sutures. The patient received postoperative instructions and had a smooth recovery.

9. Operative Note: The patient received general anesthesia with intravenous sedation for the surgical procedure addressing other bursitis of the knee with severe bone pain. The bursa was approached through an incision, and complete excision was performed. Extensive debridement of eroded bone was achieved to alleviate the severe bone pain. Meticulous hemostasis was ensured, and the wound was closed with sutures. Postoperative care measures were explained, and the patient had an uneventful recovery.

10. Operative Note: Spinal anesthesia was administered to the patient undergoing surgical intervention for other bursitis of the knee with severe bone pain. The affected bursa was identified and excised through an incision. Debridement of eroded bone was performed meticulously to alleviate the severe bone pain. Hemostasis was secured, and the incision was closed using sutures. Postoperative care instructions were provided to the patient, and they responded well to the procedure.

1. Operative Note: The patient underwent a surgical intervention for severe other bursitis of the knee. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision was performed, removing the bursa completely. Hemostasis was achieved, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient had a successful recovery without any complications.

2. Operative Note: Surgical intervention was performed on the patient with other bursitis of the knee. Under regional anesthesia, an incision was made to expose the affected bursa. Complete excision of the bursa was carried out, ensuring meticulous hemostasis. The wound was closed with sutures. Postoperative instructions were given, and the patient experienced relief from symptoms during the recovery period.

3. Operative Note: A surgical intervention was performed to address other bursitis of the knee. The patient received general anesthesia, and an incision was made to access the affected bursa. Meticulous excision was performed, removing the bursa entirely. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient's recovery was uneventful.

4. Operative Note: The patient underwent surgical intervention for other bursitis of the knee. Under spinal anesthesia, an incision was made to expose the affected bursa. Meticulous excision was performed, achieving complete removal of the bursa. Hemostasis was achieved, and the incision was closed using sutures. Postoperative care instructions were given, and the patient showed improvement in symptoms after the procedure.

5. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Careful excision of the bursa was performed, ensuring complete removal. Hemostasis was achieved, and the incision was closed using sutures. Postoperative instructions were provided, and the patient experienced relief from knee pain and inflammation.

6. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee. Under general anesthesia, an incision was made to expose the affected bursa. Meticulous excision was performed, completely removing the bursa. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient's recovery was uneventful, with a significant reduction in knee pain and swelling.

7. Operative Note: Surgical intervention was performed to address severe other bursitis of the knee. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Complete excision of the bursa was carried out, ensuring meticulous hemostasis. The wound was closed with sutures. Postoperative instructions were given, and the patient showed improvement in knee mobility and a reduction in pain.

8. Operative Note: A surgical intervention was performed to treat other bursitis of the knee. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, achieving complete removal. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient experienced relief from knee pain and improved range of motion.

9. Operative Note: The patient underwent surgical intervention for other bursitis of the knee. Under spinal anesthesia,

an incision was made to expose the affected bursa. Complete excision of the bursa was performed, ensuring meticulous hemostasis. The wound was closed using sutures. Postoperative instructions were given, and the patient reported a significant reduction in knee pain and improved functionality.

10. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision was performed, achieving complete removal of the bursa. Hemostasis was ensured, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient experienced relief from knee pain and inflammation.

1. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision was performed, completely removing the bursa. Extensive debridement of surrounding tissues was carried out. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient's recovery was uneventful.

2. Operative Note: Surgical intervention was performed to address other bursitis of the knee with severe symptoms. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Complete excision of the bursa was performed, along with extensive debridement of eroded bone. Hemostasis was ensured, and the incision was closed with sutures. Postoperative instructions were given, and the patient showed improvement in knee pain and function.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the knee. The patient received general anesthesia, and an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Extensive debridement of eroded bone was carried out. Hemostasis was achieved, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient experienced relief from knee pain and swelling.

4. Operative Note: The patient underwent a surgical intervention for chronic other bursitis of the knee. Under spinal anesthesia, an incision was made to expose the affected bursa. Meticulous excision was performed, completely removing the bursa. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative instructions were given, and the patient showed improvement in knee function and decreased pain.

5. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was achieved, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient reported reduced knee pain and improved mobility.

6. Operative Note: The patient underwent surgical intervention for other bursitis of the knee. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision was performed, completely removing the bursa. Adjacent bone erosion was debrided. Hemostasis was ensured, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient experienced relief from knee pain and improved range of motion.

7. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Complete excision of the bursa was carried out, along with meticulous debridement of eroded bone. Hemostasis was achieved, and the incision was closed with sutures. Postoperative instructions were given, and the patient showed improved knee function and reduced pain.

8. Operative Note: A surgical intervention was performed to treat severe other bursitis of the knee. The patient received general anesthesia, and an incision was made to

access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Adjacent bone erosion was extensively debrided. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient experienced significant relief from knee pain and improved mobility.

9. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee. Under spinal anesthesia, an incision was made to expose the affected bursa. Meticulous excision was performed, completely removing the bursa. Adjacent bone erosion was extensively debrided. Hemostasis was achieved, and the incision was closed using sutures. Postoperative instructions were given, and the patient showed improved knee function and reduced pain.

10. Operative Note: Surgical intervention was performed to address chronic other bursitis of the knee. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Extensive debridement of eroded bone and surrounding tissues was carried out. Hemostasis was achieved, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient experienced reduced knee pain and improved range of motion.

1. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee with severe infection on the extreme moving joint. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision of the infected bursa was performed, along with debridement of eroded bone. Extensive irrigation and thorough cleansing were carried out. Hemostasis was ensured, and the wound was closed with sutures. Intravenous antibiotics were initiated, and postoperative care instructions were provided.

2. Operative Note: Surgical intervention was performed to address other bursitis of the knee with severe infection on the extreme moving joint. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Complete excision of the infected bursa was carried out, along with meticulous debridement of eroded bone. Intense irrigation with antimicrobial solution was performed. Hemostasis was achieved, and the incision was closed using sutures. Intravenous antibiotics were administered, and postoperative care instructions were given.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the knee with severe infection on the extreme moving joint. The patient received general anesthesia, and an incision was made to access the affected bursa. Meticulous excision of the infected bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Thorough irrigation with antimicrobial solution was performed. Hemostasis was ensured, and the incision was closed with sutures. Intravenous antibiotics were initiated, and postoperative care instructions were provided.

4. Operative Note: The patient underwent a surgical intervention for chronic other bursitis of the knee with severe infection on the extreme moving joint. Under spinal anesthesia, an incision was made to expose the affected bursa. Complete excision of the infected bursa was performed, along with extensive debridement of eroded bone. Thorough irrigation with antibiotic solution was carried out. Hemostasis was achieved, and the incision was closed using sutures. Intravenous antibiotics were administered, and postoperative care instructions were given.

5. Operative Note: Surgical intervention was performed to address other bursitis of the knee with severe infection on the extreme moving joint. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the infected bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Thorough irrigation with antimicrobial solution was performed. Hemostasis was ensured, and the incision was closed using sutures. Intravenous antibiotics were initiated, and postoperative care instructions were provided.

6. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee with severe infection on the extreme moving joint. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision of the infected bursa was performed, completely removing the source of infection. Debridement of eroded bone and surrounding tissues was carried out. Extensive irrigation with antimicrobial solution was performed. Hemostasis was ensured, and the incision was closed using sutures. Intravenous antibiotics were administered, and postoperative care instructions were given.

7. Operative Note: Surgical intervention was performed to address other bursitis of the knee with severe infection on the extreme moving joint. The patient received regional anesthesia, and an incision was

made to expose the affected bursa. Complete excision of the infected bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out meticulously. Thorough irrigation with antimicrobial solution was performed. Hemostasis was achieved, and the incision was closed using sutures. Intravenous antibiotics were initiated, and postoperative care instructions were provided.

8. Operative Note: A surgical intervention was performed to treat other bursitis of the knee with severe infection on the extreme moving joint. The patient received general anesthesia, and an incision was made to access the affected bursa. Meticulous excision of the infected bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out meticulously. Thorough irrigation with antimicrobial solution was performed. Hemostasis was ensured, and the incision was closed with sutures. Intravenous antibiotics were administered, and postoperative care instructions were given.

9. Operative Note: The patient underwent a surgical intervention for chronic other bursitis of the knee with severe infection on the extreme moving joint. Under spinal anesthesia, an incision was made to expose the affected bursa. Complete excision of the infected bursa was performed, along with extensive debridement of eroded bone. Thorough irrigation with antibiotic solution was carried out. Hemostasis was achieved, and the incision was closed using sutures. Intravenous antibiotics were initiated, and postoperative care instructions were provided.

10. Operative Note: Surgical intervention was performed to address other bursitis of the knee with severe infection on the extreme moving joint. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the infected bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out meticulously. Thorough irrigation with antimicrobial solution was performed. Hemostasis was ensured, and the incision was closed using sutures. Intravenous antibiotics were initiated, and postoperative care instructions were given.

1. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee with severe inflammation. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision of the inflamed bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient showed reduced knee inflammation and improved mobility.

2. Operative Note: Surgical intervention was performed to address other bursitis of the knee with moderate inflammation. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Complete excision of the inflamed bursa was carried out, along with meticulous debridement of eroded bone. Hemostasis was achieved, and the incision was closed using sutures. Postoperative instructions were given, and the patient demonstrated decreased knee inflammation and improved range of motion.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the knee with mild inflammation. The patient received general anesthesia, and an incision was made to access the affected bursa. Meticulous excision of the inflamed bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient experienced relief from knee inflammation and enhanced functionality.

4. Operative Note: The patient underwent a surgical intervention for chronic other bursitis of the knee with severe inflammation. Under spinal anesthesia, an incision was made to expose the affected bursa. Complete excision of the inflamed bursa was performed, along with extensive debridement of eroded bone. Hemostasis was achieved, and the incision was closed using sutures. Postoperative instructions were given, and the patient demonstrated reduced knee inflammation and improved knee function.

5. Operative Note: Surgical intervention was performed to address other bursitis of the knee with moderate inflammation. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the inflamed bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient reported decreased knee inflammation and improved mobility.

6. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee with severe inflammation. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision of the inflamed bursa was performed, completely removing the source of inflammation. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed using sutures. Postoperative care instructions were provided, and the patient showed significant reduction in knee inflammation and improved range of motion.

7. Operative Note: Surgical intervention was performed to address other bursitis of the knee with mild inflammation. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Complete excision of the inflamed bursa was carried out, along with meticulous debridement of eroded bone. Hemostasis was achieved, and the incision was closed using sutures. Postoperative instructions were

given, and the patient demonstrated decreased knee inflammation and improved knee function.

8. Operative Note: A surgical intervention was performed to treat other bursitis of the knee with moderate inflammation. The patient received general anesthesia, and an incision was made to access the affected bursa. Meticulous excision of the inflamed bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient experienced relief from knee inflammation and improved functionality.

9. Operative Note: The patient underwent a surgical intervention for chronic other bursitis of the knee with severe inflammation. Under spinal anesthesia, an incision was made to expose the affected bursa. Complete excision of the inflamed bursa was performed, along with extensive debridement of eroded bone. Hemostasis was achieved, and the incision was closed using sutures. Postoperative instructions were given, and the patient demonstrated reduced knee inflammation and improved range of motion.

10. Operative Note: Surgical intervention was performed to address other bursitis of the knee with mild inflammation. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the inflamed bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative care instructions were provided, and the patient reported decreased knee inflammation and enhanced mobility.

1. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee. Under general anesthesia, an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Adjacent bone erosion was debrided. Hemostasis was ensured, and the incision was closed with sutures. Postoperative follow-up will be scheduled based on the severity of the diagnosis, with recommendations for physical therapy and anti-inflammatory medications.

2. Operative Note: Surgical intervention was performed to address chronic other bursitis of the knee. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Complete excision of the bursa was carried out, along with debridement of eroded bone. Hemostasis was achieved, and the incision was closed using sutures. Postoperative follow-up will be determined based on the severity of the diagnosis, with possible recommendations for imaging, further evaluations, and a customized rehabilitation program.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the knee. The patient received general anesthesia, and an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative follow-up will be tailored to the severity of the diagnosis, with consideration for pain management, physical therapy, and a gradual return to activities.

4. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee with associated bone erosion. Under spinal anesthesia, an incision was made to expose the affected bursa. Complete excision of the bursa was performed, along with extensive debridement of eroded bone. Hemostasis was achieved, and the incision was closed using sutures. Postoperative follow-up will be determined based on the severity of the diagnosis, with recommendations for imaging, further assessments, and a personalized rehabilitation plan.

5. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative follow-up will be tailored to the severity of the diagnosis, with considerations for pain management, bracing, and targeted physical therapy sessions.

6. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee with significant bone erosion. Under general anesthesia, an incision was made to access the affected bursa. Complete excision of the bursa was performed, along with meticulous debridement of eroded bone. Hemostasis was ensured, and the incision was closed using sutures. Postoperative follow-up will be scheduled based on the severity of the diagnosis, with recommendations for imaging, specialist consultations, and an individualized rehabilitation plan.

7. Operative Note: Surgical intervention was performed to address other bursitis of the knee. The patient received regional anesthesia, and an incision was made to expose the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Adjacent bone erosion was debrided.

Hemostasis was achieved, and the incision was closed with sutures. Postoperative follow-up will be determined based on the severity of the diagnosis, with considerations for further evaluations, physical therapy, and appropriate pain management strategies.

8. Operative Note: A surgical intervention was performed to treat other bursitis of the knee with extensive bone erosion. The patient received general anesthesia, and an incision was made to access the affected bursa. Complete excision of the bursa was carried out, along with debridement of eroded bone and surrounding tissues. Hemostasis was ensured, and the incision was closed with sutures. Postoperative follow-up will be scheduled based on the severity of the diagnosis, with recommendations for imaging, specialized consultations, and a comprehensive rehabilitation plan.

9. Operative Note: The patient underwent a surgical intervention for other bursitis of the knee. Under spinal anesthesia, an incision was made to expose the affected bursa. Complete excision of the bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out meticulously. Hemostasis was achieved, and the incision was closed using sutures. Postoperative follow-up will be tailored to the severity of the diagnosis, with considerations for pain management, specialized assessments, and targeted physical therapy interventions.

10. Operative Note: Surgical intervention was performed to address other bursitis of the knee with bone erosion. The patient received local anesthesia with sedation, and an incision was made to access the affected bursa. Meticulous excision of the bursa was performed, ensuring complete removal. Debridement of eroded bone and surrounding tissues was carried out. Hemostasis was ensured, and the incision was closed with sutures. Postoperative follow-up will be determined based on the severity of the diagnosis, with recommendations for imaging, further evaluations, and a customized rehabilitation program.

## M70.6 Trochanteric bursitis

1. Patient presented with complaints of lateral hip pain. Examination revealed tenderness over the greater trochanter. Diagnosis of trochanteric bursitis was made. Patient was counseled on conservative measures including rest, ice, and NSAIDs. Physical therapy was recommended. Follow-up scheduled in two weeks.

2. Operative note: Trochanteric bursa was accessed through a lateral incision. Bursal fluid was aspirated and sent for analysis. Bursa was then injected with a mixture of corticosteroid and local anesthetic. Incision was closed with sutures. Patient tolerated the procedure well and was discharged with instructions for pain management and activity modification.

3. Patient underwent ultrasound-guided trochanteric bursa injection. A 22-gauge needle was used to access the bursa, and a mixture of corticosteroid and anesthetic was injected. The procedure was well-tolerated, and the patient reported immediate relief of pain. Post-injection instructions were provided, and the patient was scheduled for a follow-up visit in two weeks.

4. Trochanteric bursitis was treated with a focused rehabilitation program. Patient was instructed to perform stretching exercises for the hip and gluteal muscles, as well as strengthening exercises for the hip abductors. NSAIDs were prescribed for pain management. Patient was advised to avoid activities that aggravate symptoms. Follow-up appointment scheduled in six weeks.

5. Operative note: Trochanteric bursa was visualized using ultrasound guidance. A 25-gauge needle was inserted into the bursa, and 5 mL of a corticosteroid and local anesthetic mixture was injected. The patient experienced immediate pain relief. Post-injection instructions were given, and the patient was advised to follow up in four weeks for reassessment.

6. Patient underwent minimally invasive trochanteric bursectomy. A small incision was made over the greater trochanter, and the bursa was excised using a combination of sharp dissection and electrocautery. Hemostasis was achieved, and the wound was closed in layers. Postoperative pain management instructions were provided, and the patient was scheduled for a follow-up visit in two weeks.

7. Operative note: Trochanteric bursa was accessed using a lateral approach. The bursa was meticulously debrided using a combination of sharp dissection and suction cautery. Care was taken to preserve surrounding structures. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were given, and the patient was scheduled for a follow-up visit in three weeks.

8. Patient received a platelet-rich plasma (PRP) injection for trochanteric bursitis. After preparing the PRP, it was injected into the bursa using ultrasound guidance. The patient tolerated the procedure well and reported improvement in symptoms over the following weeks. Patient was advised to continue conservative management and scheduled for a follow-up visit in six weeks.

9. Operative note: Trochanteric bursa was accessed using a posterior approach. The bursa was meticulously debrided and irrigated. A hemostatic agent was applied, and the wound was closed in layers. Patient was given postoperative care instructions and prescribed NSAIDs for pain management. Follow-up visit scheduled in four weeks for wound check and assessment of symptom improvement.

10. Patient underwent extracorporeal shockwave therapy (ESWT) for trochanteric bursitis. A focused shockwave was delivered to the affected area using a handheld device. The procedure was well-tolerated, and the patient reported a reduction in pain following treatment. Post-ESWT instructions were provided, and the patient was scheduled for a follow-up visit in six weeks to assess treatment efficacy.

1. Operative note: Trochanteric bursa was accessed via a lateral approach. The bursa was thoroughly irrigated with saline solution to remove inflammatory mediators. A corticosteroid and local anesthetic mixture was then injected into the bursa. The procedure was completed without complications, and the patient reported immediate relief. Post-injection instructions were provided, and a follow-up appointment was scheduled in four weeks.

2. Patient underwent ultrasound-guided needle aspiration of the trochanteric bursa. A 21-gauge needle was used to aspirate the bursal fluid for analysis. The procedure was successful in relieving pain, and the fluid sample was sent for laboratory evaluation. Post-aspiration instructions were given, and the patient was scheduled for a follow-up visit in two weeks to discuss the results.

3. Operative note: Trochanteric bursa was accessed through a minimally invasive endoscopic technique. A small incision was made, and an endoscope was inserted to visualize the bursa. The bursa was debrided using specialized instruments, and the wound was closed with sutures. The patient tolerated the procedure well, and postoperative instructions were provided. Follow-up scheduled in four weeks.

4. Patient received a trochanteric bursa injection of hyaluronic acid. The bursa was accessed using ultrasound guidance, and a viscosupplement was injected to provide lubrication and reduce inflammation. The patient reported improvement in symptoms following the injection. Post-injection care instructions were given, and the patient was scheduled for a follow-up visit in six weeks to assess the long-term benefits.

5. Operative note: Trochanteric bursa was accessed through a lateral approach. The bursa was carefully debrided using a combination of sharp and blunt dissection. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well and was provided with postoperative pain management instructions. Follow-up visit scheduled in three weeks for wound evaluation and symptom assessment.

6. Patient underwent ultrasound-guided trochanteric bursa lavage. A sterile saline solution was infused into the bursa through a needle, and the fluid was then aspirated to remove inflammatory debris. The procedure was successful in reducing pain, and the patient was instructed to continue with conservative measures. Follow-up appointment scheduled in four weeks for further evaluation.

7. Operative note: Trochanteric bursa was accessed using a posterior approach. The bursa was carefully excised using sharp dissection techniques. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were given, and the patient was prescribed analgesics for pain management. Follow-up visit scheduled in two weeks for wound check and assessment of symptom improvement.

8. Patient received a trochanteric bursa injection of platelet-rich plasma (PRP). After preparing the PRP, it was injected into the bursa using ultrasound guidance. The patient reported gradual improvement in symptoms over several weeks. Post-injection instructions were provided, and the patient was scheduled for a follow-up visit in eight weeks for reassessment.

9. Operative note: Trochanteric bursa was accessed using a lateral incision. The bursa was carefully dissected and excised using electrocautery. Hemostasis was achieved, and the wound was closed with absorbable sutures. Postoperative care instructions were given, and the patient was prescribed NSAIDs for pain control. Follow-up visit scheduled in three weeks for wound assessment and symptom evaluation.

10. Patient underwent trochanteric bursa injection of a combination of corticosteroid and hyaluronic acid. The bursa was accessed using ultrasound guidance, and the mixture was injected to reduce inflammation and provide lubrication. The patient reported immediate relief of pain following the procedure. Post-injection instructions were given, and a follow-up appointment was scheduled in six weeks to monitor the response.

1. Operative note: Trochanteric bursa was accessed through a lateral incision under local anesthesia. Bursal fluid was aspirated, and a corticosteroid and local anesthetic mixture was injected into the bursa. The patient tolerated the procedure well without any complications. Post-procedure instructions were provided, and a follow-up visit was scheduled in four weeks to assess the response.

2. Patient underwent trochanteric bursa injection under conscious sedation. A moderate dose of intravenous sedative and analgesic was administered to ensure patient comfort during the procedure. The bursa was accessed using ultrasound guidance, and a mixture of corticosteroid and local anesthetic was injected. The patient remained stable throughout the procedure, and post-injection instructions were given.

3. Operative note: Trochanteric bursa was accessed through a lateral approach under general anesthesia. The patient was intubated, and a general anesthetic was administered. The bursa was injected with a corticosteroid and local anesthetic mixture. The patient's vital signs remained stable throughout the procedure, and there were no intraoperative complications. Postoperative care instructions were provided, and a follow-up visit was scheduled in six weeks.

4. Patient underwent trochanteric bursa lavage under spinal anesthesia. A single-shot spinal anesthetic was administered, and the bursa was accessed using ultrasound guidance. Sterile saline solution was infused and then aspirated to cleanse the bursa. The patient reported immediate relief of pain following the procedure. Post-lavage instructions were given, and a follow-up appointment was scheduled in four weeks.

5. Operative note: Trochanteric bursa was accessed through a lateral incision under regional anesthesia. A nerve block was performed to provide localized anesthesia. The bursa was injected with a corticosteroid and local anesthetic solution. The patient remained comfortable throughout the procedure, and there were no complications. Post-injection instructions were given, and a follow-up visit was scheduled in six weeks.

6. Patient underwent trochanteric bursa injection under monitored anesthesia care (MAC). The patient was sedated using intravenous medications and monitored closely throughout the procedure. The bursa was accessed using ultrasound guidance, and a mixture of corticosteroid and local anesthetic was injected. The patient's vital signs were stable, and post-injection instructions were provided.

7. Operative note: Trochanteric bursa was accessed through a lateral approach under local anesthesia with sedation. The patient received a combination of local anesthetic and intravenous sedation for comfort. The bursa was injected with a corticosteroid and local anesthetic solution. The patient tolerated the procedure well, and post-injection instructions were given. Follow-up visit scheduled in four weeks.

8. Patient underwent trochanteric bursa injection under general anesthesia with lighter sedation. The patient was intubated and maintained on a lighter plane of anesthesia for the procedure. The bursa was injected with a corticosteroid and local anesthetic mixture. The patient's vital signs remained stable, and there were no intraoperative complications. Postoperative care instructions were provided, and a follow-up visit was scheduled in six weeks.

9. Operative note: Trochanteric bursa was accessed through a lateral incision under local anesthesia with intravenous analgesia. The patient received a local anesthetic injection at the surgical site, supplemented with intravenous pain medications. The bursa was injected with a corticosteroid and local anesthetic solution. The patient was comfortable throughout the procedure, and post-injection instructions were given. Follow-up visit scheduled in four weeks.

10. Patient underwent trochanteric bursa aspiration and injection under spinal anesthesia. A spinal anesthetic was administered to provide anesthesia from the waist down. Bursal fluid was aspirated, and a corticosteroid and local anesthetic mixture was injected. The patient experienced no discomfort during the procedure, and post-procedure instructions were provided. A follow-up appointment was scheduled in six weeks.

1. Operative note: Trochanteric bursa was accessed through a lateral incision. Intraoperative findings revealed significant bone erosion of the greater trochanter. The bursa was debrided, and bone irregularities were smoothed using a high-speed burr. A corticosteroid and local anesthetic mixture was injected into the bursa. The wound was closed, and postoperative care instructions were provided. Follow-up visit scheduled in six weeks for assessment of bone healing and symptom improvement.

2. Patient underwent trochanteric bursa injection under ultrasound guidance. Imaging revealed evidence of bone erosion at the greater trochanter. A corticosteroid and local anesthetic were injected into the bursa to alleviate inflammation and pain. Post-injection instructions were given, including activity modification. The patient was scheduled for a follow-up visit in four weeks to assess the response to treatment and monitor bone erosion progression.

3. Operative note: Trochanteric bursa was accessed through a lateral approach. Intraoperative examination confirmed extensive bone erosion at the site. The bursa was debrided, and meticulous care was taken to preserve the remaining healthy bone. A corticosteroid and local anesthetic mixture was injected, and the wound was closed. Postoperative instructions were provided, emphasizing the importance of rehabilitation and follow-up evaluations.

4. Patient underwent trochanteric bursa injection under fluoroscopic guidance. Imaging revealed significant bone erosion of the greater trochanter. A mixture of corticosteroid and local anesthetic was injected into the bursa to address inflammation and alleviate pain. The patient was educated about bone erosion management and given post-injection care instructions. A follow-up appointment was scheduled in six weeks to assess the response and monitor bone erosion progression.

5. Operative note: Trochanteric bursa was accessed through a lateral incision. Intraoperative evaluation revealed substantial bone erosion of the greater trochanter. The bursa was debrided, and bone irregularities were smoothed using specialized instruments. A corticosteroid and local anesthetic mixture was injected. The wound was closed, and postoperative care instructions were provided. Follow-up visit scheduled in eight weeks for assessment of bone healing and symptom resolution.

6. Patient underwent trochanteric bursa injection with evidence of bone erosion observed on imaging. A combination of corticosteroid and local anesthetic was injected into the bursa to target inflammation and alleviate pain. Post-injection instructions were given, including the use of assistive devices and modifications in daily activities. The patient was advised to follow up in six weeks for a reassessment of bone erosion and treatment response.

7. Operative note: Trochanteric bursa was accessed through a lateral approach. Intraoperative examination revealed notable bone erosion at the greater trochanter. The bursa was carefully debrided, and measures were taken to smoothen the eroded bone surface. A corticosteroid and local anesthetic mixture was injected into the bursa. The wound was closed, and postoperative instructions were provided. Follow-up visit scheduled in four weeks to evaluate bone healing and symptom improvement.

8. Patient underwent trochanteric bursa injection under ultrasound guidance. Imaging revealed significant bone erosion at the greater trochanter. A mixture of corticosteroid and local anesthetic was injected into the bursa to address inflammation and pain. Post-injection instructions were given, emphasizing the importance of gentle weight-bearing and rehabilitation exercises. The patient was scheduled for a follow-up visit in six weeks to assess bone erosion progression and treatment response.

9. Operative note: Trochanteric bursa was accessed through a lateral incision. Intraoperative evaluation identified extensive bone erosion at the greater trochanter. The bursa was meticulously debrided, and the eroded bone edges were smoothed to promote healing. A corticosteroid and local anesthetic mixture was injected into the bursa. The wound was closed, and postoperative care instructions were provided. Follow-up visit scheduled in eight weeks to monitor bone erosion healing and symptom resolution.

10. Patient received trochanteric bursa injection with evidence of bone erosion noted on imaging studies. A combination of corticosteroid and local anesthetic was injected into the bursa to address inflammation and pain. Post-injection instructions were given, emphasizing the importance of weight-bearing modifications and physical therapy. The patient was advised to follow up in six weeks for a reassessment of bone erosion progression and treatment response.

1. Operative note: Trochanteric bursa was accessed through a lateral incision. The patient presented with severe bone pain at the greater trochanter. The bursa was thoroughly debrided, and a mixture of corticosteroid and local anesthetic was injected into the bursa. The patient reported immediate relief of severe bone pain following the procedure. Postoperative instructions were provided, and a follow-up visit was scheduled in four weeks to assess the resolution of bone pain.

2. Patient underwent trochanteric bursa injection under ultrasound guidance. Severe bone pain at the greater trochanter was reported. A combination of corticosteroid and local anesthetic was injected into the bursa to alleviate inflammation and relieve severe bone pain. Post-injection instructions were given, including pain management strategies. The patient was scheduled for a follow-up visit in six weeks to assess the response and monitor the severity of bone pain.

3. Operative note: Trochanteric bursa was accessed through a lateral approach. The patient presented with severe bone pain localized to the greater trochanter. The bursa was carefully debrided, and a corticosteroid and local anesthetic mixture was injected into the bursa. The patient experienced significant relief from severe bone pain postoperatively. Postoperative care instructions were provided, and a follow-up visit was scheduled in eight weeks to evaluate bone pain resolution.

4. Patient underwent trochanteric bursa injection under fluoroscopic guidance. Severe bone pain at the greater trochanter was documented. A mixture of corticosteroid and local anesthetic was injected into the bursa to address inflammation and alleviate severe bone pain. The patient was educated about pain management strategies and provided with post-injection care instructions. A follow-up appointment was scheduled in four weeks to assess the response and monitor the severity of bone pain.

5. Operative note: Trochanteric bursa was accessed through a lateral incision. Severe bone pain at the greater trochanter was reported by the patient. The bursa was meticulously debrided, and a corticosteroid and local anesthetic mixture was injected into the bursa. The patient experienced immediate relief from severe bone pain following the procedure. Postoperative care instructions were provided, and a follow-up visit was scheduled in six weeks to assess bone pain resolution.

6. Patient underwent trochanteric bursa injection under ultrasound guidance. Severe bone pain at the greater trochanter was observed. A combination of corticosteroid and local anesthetic was injected into the bursa to address inflammation and alleviate severe bone pain. Post-injection instructions were given, including pain management strategies and activity modification. The patient was scheduled for a follow-up visit in four weeks to assess the response and monitor the severity of bone pain.

7. Operative note: Trochanteric bursa was accessed through a lateral approach. The patient presented with severe bone pain localized to the greater trochanter. The bursa was debrided, and a corticosteroid and local anesthetic mixture was injected into the bursa. The patient reported significant relief from severe bone pain postoperatively. Postoperative care instructions were provided, emphasizing pain management strategies. A follow-up visit was scheduled in six weeks to evaluate bone pain resolution.

8. Patient underwent trochanteric bursa injection with severe bone pain noted on examination. A combination of corticosteroid and local anesthetic was injected into the bursa to address inflammation and alleviate severe bone pain. Post-injection instructions were given, including the use of pain medications and activity modification. The patient was advised to follow up in four weeks for a reassessment

of bone pain severity and treatment response.

9. Operative note: Trochanteric bursa was accessed through a lateral incision. The patient presented with severe bone pain at the greater trochanter. The bursa was carefully debrided, and a mixture of corticosteroid and local anesthetic was injected into the bursa. The patient experienced immediate relief from severe bone pain following the procedure. Postoperative care instructions were provided, and a follow-up visit was scheduled in eight weeks to assess bone pain resolution.

10. Patient received trochanteric bursa injection with severe bone pain documented on preoperative evaluation. A combination of corticosteroid and local anesthetic was injected into the bursa to address inflammation and alleviate severe bone pain. Post-injection instructions were given, emphasizing the importance of pain management and rehabilitation exercises. The patient was advised to follow up in six weeks for a reassessment of bone pain severity and treatment response.

1. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia. The patient presented with severe bone pain and failed conservative management. A lateral approach was utilized to access the bursa. The bursa was excised, and meticulous care was taken to address underlying bone erosion. The wound was closed, and postoperative care instructions were provided. A follow-up visit was scheduled in six weeks to assess surgical site healing and pain relief.

2. Patient underwent trochanteric bursa surgical intervention with severe bone pain unresponsive to non-surgical treatments. A lateral incision was made to access the bursa. The bursa was excised, and any associated bone irregularities were addressed. The surgical site was closed, and postoperative pain management strategies were implemented. The patient was scheduled for a follow-up visit in four weeks to evaluate surgical outcomes and pain relief.

3. Operative note: Trochanteric bursa surgical intervention was performed to address severe bone pain refractory to conservative measures. Under general anesthesia, a lateral approach was employed to access the bursa. The bursa was excised, and careful attention was given to address any underlying bone erosion. Closure was performed, and postoperative instructions were provided. A follow-up appointment was scheduled in six weeks to assess surgical site healing and pain resolution.

4. Patient underwent trochanteric bursa surgical intervention due to severe bone pain resistant to conservative treatment. A surgical approach was used to access the bursa. The bursa was excised, and attention was given to address any bone erosion or irregularities. The wound was closed, and postoperative pain management was initiated. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes and pain relief.

5. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia. The patient experienced severe bone pain and failed non-operative interventions. A lateral incision was made to access the bursa. The bursa was excised, and bone debridement was performed to address underlying erosion. The incision was closed, and postoperative care instructions were given. A follow-up visit was scheduled in six weeks to evaluate surgical site healing and pain reduction.

6. Patient underwent trochanteric bursa surgical intervention for severe bone pain that did not respond to conservative treatments. An incision was made to access the bursa, followed by excision of the bursa and meticulous debridement of bone erosions. The surgical site was closed, and postoperative pain management was initiated. The patient was advised to follow up in four weeks for a reassessment of surgical outcomes and pain relief.

7. Operative note: Trochanteric bursa surgical intervention was performed to address severe bone pain unresponsive to conservative measures. A lateral approach was employed, and the bursa was excised. Attention was given to address underlying bone erosion and irregularities. The incision was closed, and postoperative instructions were provided. A follow-up appointment was scheduled in six weeks to evaluate surgical site healing and pain resolution.

8. Patient underwent trochanteric bursa surgical intervention due to severe bone pain that did not improve with non-surgical interventions. A surgical approach was used to access the bursa, followed by excision of the bursa and thorough bone debridement. The wound was closed, and postoperative pain management strategies were implemented. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes and pain relief.

9. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia. The patient presented with severe bone pain refractory to conservative treatment. A

lateral incision was made, and the bursa was excised. Bone irregularities were addressed, and the wound was closed. Postoperative care instructions were given, and a follow-up visit was scheduled in six weeks to assess surgical site healing and pain reduction.

10. Patient underwent trochanteric bursa surgical intervention for severe bone pain that did not respond to non-surgical approaches. An incision was made to access the bursa, followed by excision of the bursa and meticulous bone debridement. The surgical site was closed, and postoperative pain management was initiated. The patient was advised to follow up in four weeks for a reassessment of surgical outcomes and pain relief.

1. Operative note: Trochanteric bursa surgical intervention was performed under spinal anesthesia. The patient presented with severe bone pain and significant functional impairment. A lateral approach was utilized, and the bursa was excised. Bone erosions were carefully addressed, and the wound was closed. Postoperative pain management and rehabilitation instructions were provided. A follow-up visit was scheduled in six weeks to evaluate surgical site healing and functional recovery.

2. Patient underwent trochanteric bursa surgical intervention for severe bone pain unresponsive to conservative measures. A surgical approach was used to access the bursa. The bursa was excised, and bone irregularities were addressed. Postoperative pain management and physical therapy were initiated. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes, pain relief, and functional improvement.

3. Operative note: Trochanteric bursa surgical intervention was performed to alleviate severe bone pain. General anesthesia was administered. A lateral incision was made, and the bursa was excised. Attention was given to address bone erosions and irregularities. The wound was closed, and postoperative care instructions were provided. A follow-up appointment was scheduled in six weeks to assess surgical site healing, pain resolution, and functional recovery.

4. Patient underwent trochanteric bursa surgical intervention under local anesthesia for severe bone pain that significantly impacted daily activities. An incision was made to access the bursa, followed by excision of the bursa and meticulous bone debridement. The wound was closed, and postoperative pain management strategies were implemented. The patient was advised to follow up in four weeks for a reassessment of surgical outcomes, pain relief, and functional improvement.

5. Operative note: Trochanteric bursa surgical intervention was performed under spinal anesthesia to address severe bone pain and functional limitations. A lateral approach was employed, and the bursa was excised. Bone erosions were carefully addressed, and the wound was closed. Postoperative pain management and rehabilitation plans were discussed. A follow-up visit was scheduled in six weeks to evaluate surgical site healing, pain reduction, and functional recovery.

6. Patient underwent trochanteric bursa surgical intervention for severe bone pain that persisted despite conservative treatments. A surgical approach was used to access the bursa, followed by excision of the bursa and thorough bone debridement. The surgical site was closed, and postoperative pain management strategies were implemented. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes, pain relief, and functional improvement.

7. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address severe bone pain and functional impairment. A lateral incision was made, and the bursa was excised. Attention was given to address bone erosions and irregularities. The wound was closed, and postoperative care instructions were provided. A follow-up appointment was scheduled in six weeks to evaluate surgical site healing, pain resolution, and functional recovery.

8. Patient underwent trochanteric bursa surgical intervention for severe bone pain that did not improve with non-surgical interventions. A surgical approach was used to access the bursa, followed by excision of the bursa and meticulous bone debridement. The wound was closed, and postoperative pain management and rehabilitation plans were implemented. The patient was advised to follow up in four weeks for a reassessment of surgical outcomes, pain relief, and functional improvement.

9. Operative note: Trochanteric bursa surgical intervention was performed under spinal anesthesia to address severe bone pain and functional limitations. A lateral incision was made, and the bursa was exc

ised. Bone erosions were carefully addressed, and the wound was closed. Postoperative pain management and rehabilitation instructions were provided. A follow-up visit was scheduled in six weeks to evaluate surgical site healing, pain reduction, and functional recovery.

10. Patient underwent trochanteric bursa surgical intervention for severe bone pain that significantly impacted daily activities. An incision was made to access the bursa, followed by excision of the bursa and meticulous bone debridement. The wound was closed, and postoperative pain management and physical therapy were initiated. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes, pain relief, and functional improvement.

1. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia due to severe infection affecting the extreme moving joint. A lateral approach was utilized, and the infected bursa was excised. Extensive debridement of the surrounding tissues was performed, followed by irrigation with antimicrobial solutions. The wound was closed, and appropriate systemic antibiotics were initiated. Postoperative care instructions and infectious disease consult were provided. Close monitoring and follow-up visits were scheduled to ensure resolution of the severe infection.

2. Patient underwent trochanteric bursa surgical intervention for severe infection involving the extreme moving joint. A surgical approach was used to access the infected bursa. Complete excision of the bursa and thorough debridement of infected tissues were performed. Copious irrigation with antimicrobial solutions was done. The wound was closed, and intravenous antibiotics were initiated. The patient was scheduled for frequent follow-up visits to monitor infection control and joint function.

3. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia due to severe infection in the extreme moving joint. A lateral incision was made, and the infected bursa was excised. Extensive debridement of necrotic tissues was performed, and the joint was thoroughly irrigated with antimicrobial solutions. The wound was closed, and intravenous antibiotics were started. Close postoperative monitoring and infectious disease consultation were arranged to ensure effective resolution of the severe joint infection.

4. Patient underwent trochanteric bursa surgical intervention for severe infection involving the extreme moving joint. A surgical approach was used to access the infected bursa, followed by complete excision and debridement of infected tissues. The joint was meticulously irrigated with antimicrobial solutions. The wound was closed, and intravenous antibiotics were administered. Close follow-up visits were scheduled to monitor infection resolution and joint function restoration.

5. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address a severe infection affecting the extreme moving joint. A lateral approach was employed, and the infected bursa was excised. Thorough debridement of necrotic tissues and irrigation with antimicrobial solutions were performed. The wound was closed, and appropriate systemic antibiotics were initiated. Close postoperative monitoring and consultation with infectious disease specialists were arranged to ensure successful resolution of the severe joint infection.

6. Patient underwent trochanteric bursa surgical intervention for severe infection involving the extreme moving joint. The infected bursa was excised using a surgical approach, and extensive debridement of infected tissues was performed. The joint was irrigated with antimicrobial solutions to achieve thorough cleansing. The wound was closed, and intravenous antibiotics were administered. Frequent follow-up visits were scheduled to monitor infection control and joint function restoration.

7. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia due to a severe infection affecting the extreme moving joint. A lateral incision was made, and the infected bursa was excised. Thorough debridement of necrotic tissues and meticulous irrigation with antimicrobial solutions were performed. The wound was closed, and intravenous antibiotics were initiated. Close postoperative monitoring and collaboration with infectious disease specialists were planned to ensure successful resolution of the severe joint infection.

8. Patient underwent trochanteric bursa surgical intervention for severe infection involving the extreme moving joint. A surgical approach was utilized, and the infected bursa was excised. Extensive debridement of infected tissues was performed, and the joint was irrigated with antimicrobial solutions. The wound was closed, and appropriate intravenous antibiotics were administered. Regular follow-up visits were scheduled to monitor infection control and assess joint recovery.

9

. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia due to a severe infection affecting the extreme moving joint. A lateral incision was made, and the infected bursa was excised. Extensive debridement and irrigation with antimicrobial solutions were carried out to address the infection. The wound was closed, and systemic antibiotics were initiated. Close postoperative monitoring and infectious disease consultation were arranged to ensure successful resolution of the severe joint infection.

10. Patient underwent trochanteric bursa surgical intervention for severe infection involving the extreme moving joint. The infected bursa was excised using a surgical approach, and thorough debridement of infected tissues was performed. The joint was irrigated with antimicrobial solutions for effective cleansing. The wound was closed, and appropriate systemic antibiotics were started. Frequent follow-up visits were scheduled to monitor infection control and evaluate joint function recovery.

1. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia. The patient presented with severe inflammation in the extreme moving joint. A lateral approach was utilized, and the inflamed bursa was excised. Careful attention was given to address surrounding inflamed tissues. The wound was closed, and postoperative care instructions were provided. A follow-up visit was scheduled in six weeks to assess surgical site healing and inflammation reduction.

2. Patient underwent trochanteric bursa surgical intervention for severe inflammation affecting the extreme moving joint. A surgical approach was used to access the inflamed bursa. The bursa was excised, and meticulous debridement of inflamed tissues was performed. The wound was closed, and postoperative care, including anti-inflammatory measures, was initiated. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes and inflammation reduction.

3. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address severe inflammation in the extreme moving joint. A lateral incision was made, and the inflamed bursa was excised. Attention was given to address inflamed tissues and promote inflammation reduction. The wound was closed, and postoperative care instructions were provided. A follow-up appointment was scheduled in six weeks to evaluate surgical site healing and inflammation resolution.

4. Patient underwent trochanteric bursa surgical intervention for severe inflammation that affected the extreme moving joint. A surgical approach was used to access the inflamed bursa, followed by excision of the bursa and thorough debridement of inflamed tissues. The wound was closed, and postoperative care measures were initiated to reduce inflammation. The patient was advised to follow up in four weeks for a reassessment of surgical outcomes and inflammation reduction.

5. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address severe inflammation in the extreme moving joint. A lateral approach was employed, and the inflamed bursa was excised. Careful attention was given to address surrounding inflamed tissues and promote inflammation reduction. The incision was closed, and postoperative instructions were given. A follow-up visit was scheduled in six weeks to evaluate surgical site healing and inflammation resolution.

6. Patient underwent trochanteric bursa surgical intervention for severe inflammation affecting the extreme moving joint. An incision was made to access the inflamed bursa, followed by excision of the bursa and meticulous debridement of inflamed tissues. The surgical site was closed, and postoperative care measures, including anti-inflammatory interventions, were initiated. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes and inflammation reduction.

7. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address severe inflammation in the extreme moving joint. A lateral incision was made, and the inflamed bursa was excised. Attention was given to address inflamed tissues and promote inflammation reduction. The wound was closed, and postoperative care instructions were provided. A follow-up appointment was scheduled in six weeks to evaluate surgical site healing and inflammation resolution.

8. Patient underwent trochanteric bursa surgical intervention for severe inflammation that affected the extreme moving joint. A surgical approach was used to access the inflamed bursa, followed by excision of the bursa and thorough debridement of inflamed tissues. The wound was closed, and postoperative care measures were initiated to reduce inflammation. The patient was advised to follow up in four weeks for a reassessment of surgical outcomes and inflammation reduction.

9. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to

address severe inflammation in the extreme moving joint. A lateral approach was employed, and the inflamed bursa was excised. Careful attention was given to address surrounding inflamed tissues and promote inflammation reduction. The incision was closed, and postoperative instructions were given. A follow-up visit was scheduled in six weeks to evaluate surgical site healing and inflammation resolution.

10. Patient underwent trochanteric bursa surgical intervention for severe inflammation affecting the extreme moving joint. An incision was made to access the inflamed bursa, followed by excision of the bursa and meticulous debridement of inflamed tissues. The surgical site was closed, and postoperative care measures, including anti-inflammatory interventions, were initiated. The patient was scheduled for a follow-up visit in four weeks to assess surgical outcomes and inflammation reduction.

1. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia. The patient presented with a severe diagnosis of trochanteric bursitis. A lateral approach was utilized, and the bursa was excised. Careful attention was given to address any associated bone erosions. The wound was closed, and postoperative care instructions were provided. A follow-up visit was scheduled in two weeks for close monitoring and assessment of the severity of the diagnosis.

2. Patient underwent trochanteric bursa surgical intervention for a moderate diagnosis of trochanteric bursitis. A surgical approach was used to access the bursa, followed by excision of the bursa and meticulous debridement. The wound was closed, and postoperative care measures were initiated. The patient was advised to follow up in four weeks for a reassessment of the severity of the diagnosis and response to treatment.

3. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address a mild diagnosis of trochanteric bursitis. A lateral incision was made, and the bursa was excised. Attention was given to address any associated bone erosions. The wound was closed, and postoperative care instructions were provided. A follow-up appointment was scheduled in six weeks to assess the severity of the diagnosis and evaluate treatment outcomes.

4. Patient underwent trochanteric bursa surgical intervention for a severe diagnosis of trochanteric bursitis. A surgical approach was used to access the bursa, followed by excision of the bursa and thorough debridement. The wound was closed, and postoperative care measures, including pain management and physical therapy, were initiated. The patient was scheduled for a follow-up visit in two weeks to closely monitor the severity of the diagnosis and assess treatment response.

5. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address a moderate diagnosis of trochanteric bursitis. A lateral approach was employed, and the bursa was excised. Careful attention was given to address any associated bone erosions and inflammation. The incision was closed, and postoperative care instructions were provided. The patient's follow-up schedule was determined based on the severity of the diagnosis and individual treatment response.

6. Patient underwent trochanteric bursa surgical intervention for a mild diagnosis of trochanteric bursitis. An incision was made to access the bursa, followed by excision of the bursa and meticulous debridement. The surgical site was closed, and postoperative care measures were initiated. The patient's follow-up visits were planned based on the severity of the diagnosis and individual treatment response.

7. Operative note: Trochanteric bursa surgical intervention was performed under general anesthesia to address a severe diagnosis of trochanteric bursitis. A lateral incision was made, and the bursa was excised. Attention was given to address any associated bone erosions and inflammation. The wound was closed, and postoperative care instructions were provided. The patient's follow-up appointment was scheduled based on the severity of the diagnosis and treatment response.

8. Patient underwent trochanteric bursa surgical intervention for a moderate diagnosis of trochanteric bursitis. A surgical approach was used to access the bursa, followed by excision of the bursa and thorough debridement. The wound was closed, and postoperative care measures, including pain management and physical therapy, were initiated. The patient's follow-up visits were determined based on the severity of the diagnosis and individual treatment response.

9. Operative note: Trochanter

ic bursa surgical intervention was performed under general anesthesia to address a mild diagnosis of trochanteric bursitis. A lateral approach was employed, and the bursa was excised. Careful attention was given to address any associated bone erosions and inflammation. The incision was closed, and postoperative care instructions were provided. The patient's follow-up schedule was determined based on the severity of the diagnosis and individual treatment response.

10. Patient underwent trochanteric bursa surgical intervention for a severe diagnosis of trochanteric bursitis. An incision was made to access the bursa, followed by excision of the bursa and meticulous debridement. The surgical site was closed, and postoperative care measures, including pain management and physical therapy, were initiated. The patient's follow-up visits were planned based on the severity of the diagnosis and individual treatment response.

## M70.7 Other bursitis of hip

1. Operative Note: Patient underwent a surgical intervention for other bursitis of the hip. The affected bursa was accessed through a small incision, and meticulous dissection was performed. The inflamed bursa was excised completely, ensuring adequate margins. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were provided, including pain management and physical therapy. The patient tolerated the procedure well, and no immediate complications were noted.

2. Operative Note: A surgical procedure was performed to address other bursitis of the hip. An incision was made over the affected area, and careful dissection was carried out. The inflamed bursa was carefully excised, and meticulous hemostasis was achieved. The wound was closed using absorbable sutures, and a sterile dressing was applied. The patient was educated on postoperative care, including activity restrictions and medication usage. No intraoperative complications were encountered.

3. Operative Note: Surgical intervention was performed to address other bursitis of the hip. An incision was made, and the inflamed bursa was visualized. The bursa was meticulously excised, and the surrounding tissues were inspected for any signs of pathology. Hemostasis was achieved, and the wound was closed using sutures. The patient was advised regarding pain management and the importance of postoperative rehabilitation. The procedure was uneventful, and the patient tolerated it well.

4. Operative Note: The patient underwent surgery to address other bursitis of the hip. A small incision was made, and careful dissection was performed to access the inflamed bursa. The bursa was completely removed, ensuring clear margins. Hemostasis was obtained, and the wound was closed in layers. Postoperatively, the patient was provided with instructions for pain control and rehabilitation. The procedure was uneventful, and no complications were observed.

5. Operative Note: Surgery was performed to treat other bursitis of the hip. The affected bursa was accessed through a well-placed incision. Careful dissection allowed visualization of the inflamed bursa, which was excised completely. Hemostasis was achieved, and the wound was closed meticulously. Postoperatively, the patient was advised on pain management and referred for physical therapy. The procedure was uncomplicated, and the patient tolerated it well.

6. Operative Note: An operative procedure was performed to address other bursitis of the hip. A small incision was made over the affected area, and meticulous dissection was carried out to access the inflamed bursa. The bursa was excised completely, and meticulous hemostasis was achieved. The wound was closed using sutures, and a sterile dressing was applied. The patient was instructed on postoperative care, including pain management and activity restrictions. No intraoperative complications were encountered.

7. Operative Note: Surgical intervention was performed to address other bursitis of the hip. The inflamed bursa was accessed through a small incision, and careful dissection was performed. The bursa was excised completely, ensuring clear margins. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was educated on pain management and referred for physical therapy. The procedure was uneventful, and the patient's condition was stable.

8. Operative Note: The patient underwent surgery for other bursitis of the hip. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. The bursa was completely excised, and thorough hemostasis was achieved. The wound was closed in layers, and a sterile dressing

was applied. The patient was given postoperative instructions, including pain management and rehabilitation. The procedure was without complications, and the patient tolerated it well.

9. Operative Note: Surgical intervention was performed to address other bursitis of the hip. The affected bursa was accessed through a small incision, and meticulous dissection was carried out. The inflamed bursa was excised completely, ensuring adequate margins. Hemostasis was achieved, and the wound was closed using sutures. The patient was provided with postoperative care instructions, including pain management and activity modifications. The procedure was uneventful, and no immediate complications were noted.

10. Operative Note: A surgical procedure was performed to treat other bursitis of the hip. An incision was made, and careful dissection allowed access to the inflamed bursa. The bursa was completely excised, and meticulous hemostasis was obtained. The wound was closed using absorbable sutures, and appropriate wound care was provided. The patient was advised on postoperative pain management and referred for rehabilitation. The procedure was performed without any complications, and the patient's recovery was unremarkable.

1. Operative Note: The patient underwent a surgical procedure to address other bursitis of the hip. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. The bursa was completely excised, ensuring clear margins. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management and provided with a referral for physical therapy. The procedure was uneventful, and the patient tolerated it well.

2. Operative Note: Surgery was performed to address other bursitis of the hip. An incision was made, and careful dissection was performed to visualize the inflamed bursa. The bursa was excised completely, and meticulous hemostasis was achieved. The wound was closed using absorbable sutures, and a sterile dressing was applied. Postoperatively, the patient was advised on pain control and referred for rehabilitation. The procedure was uncomplicated, and the patient's condition was stable.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the hip. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, with attention to clear margins. Hemostasis was secured, and the wound was closed in layers. The patient was educated on postoperative care, including pain management and the importance of gradual return to activities. No intraoperative complications were encountered.

4. Operative Note: Surgical intervention was performed for other bursitis of the hip. An incision was made, and careful dissection was carried out to visualize the inflamed bursa. Complete excision of the bursa was performed, ensuring clear margins. Hemostasis was obtained, and the wound was closed using absorbable sutures. Postoperatively, the patient was provided with instructions for pain control and referred for physical therapy. The procedure was uneventful, and no complications were noted.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip. A small incision was made, and meticulous dissection was performed to access the inflamed bursa. Complete excision of the bursa was achieved, ensuring clear margins. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management and referred for rehabilitation. The procedure was uneventful, and the patient tolerated it well.

6. Operative Note: Surgical intervention was performed to treat other bursitis of the hip. An incision was made, and careful dissection allowed visualization of the inflamed bursa. Complete excision of the bursa was achieved, and meticulous hemostasis was ensured. The wound was closed using sutures, and a sterile dressing was applied. The patient was advised on postoperative care, including pain management and activity modifications. No intraoperative complications were encountered.

7. Operative Note: Surgery was performed to address other bursitis of the hip. The affected bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, ensuring adequate margins. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was educated on pain management and referred for physical therapy. The procedure was uneventful, and the patient's condition was stable.

8. Operative Note: A surgical procedure was performed to treat other bursitis of the hip. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was performed, and thorough hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient was given postoperative instructions, including pain management and rehabilitation. The procedure was without complications, and the patient tolerated it well.

9. Operative Note: Surgical intervention was performed to address other bursitis of the hip. The inflamed bursa was accessed through a small incision, and careful dissection was performed. Complete excision of the bursa was achieved, ensuring clear margins. Hemostasis was achieved, and the wound was closed using sutures. The patient was provided with postoperative care instructions, including pain management and activity restrictions. The procedure was uneventful, and no immediate complications were noted.

10. Operative Note: The patient underwent surgery for other bursitis of the hip. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was performed, and meticulous hemostasis was obtained. The wound was closed using absorbable sutures, and appropriate wound care was provided. The patient was advised on postoperative pain management and referred for rehabilitation. The procedure was performed without any complications, and the patient's recovery was unremarkable.

1. Operative Note: The patient underwent a surgical procedure to address other bursitis of the hip under general anesthesia. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, ensuring clear margins. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control and referred for physical therapy. The procedure was uneventful, and the patient tolerated it well.

2. Operative Note: Surgery was performed to address other bursitis of the hip under spinal anesthesia. An incision was made, and careful dissection was performed to visualize the inflamed bursa. Complete excision of the bursa was performed, ensuring clear margins. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was instructed on pain management and referred for rehabilitation. The procedure was uncomplicated, and the patient's condition was stable.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the hip under local anesthesia with sedation. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, ensuring adequate margins. Hemostasis was achieved, and the wound was closed using sutures. The patient was educated on postoperative care, including pain management and the importance of gradual return to activities. No intraoperative complications were encountered.

4. Operative Note: Surgical intervention was performed for other bursitis of the hip under regional anesthesia. An incision was made, and careful dissection allowed visualization of the inflamed bursa. Complete excision of the bursa was achieved, ensuring clear margins. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control and referred for physical therapy. The procedure was uneventful, and no complications were noted.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip under general anesthesia. A small incision was made, and meticulous dissection was performed to access the inflamed bursa. Complete excision of the bursa was achieved, ensuring clear margins. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management and referred for rehabilitation. The procedure was uneventful, and the patient tolerated it well.

6. Operative Note: Surgical intervention was performed to treat other bursitis of the hip under local anesthesia with sedation. An incision was made, and careful dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and meticulous hemostasis was ensured. The wound was closed using sutures, and a sterile dressing was applied. The patient was advised on postoperative care, including pain management and activity modifications. No intraoperative complications were encountered.

7. Operative Note: Surgery was performed to address other bursitis of the hip under spinal anesthesia. The affected bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, ensuring adequate margins. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was educated on pain management and referred for physical therapy. The procedure was uneventful, and the patient's condition was stable.

8. Operative Note: A surgical procedure was performed to treat other bursitis of the hip under regional anesthesia. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was performed, and thorough hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient was given postoperative instructions, including pain management and rehabilitation. The procedure was without complications, and the patient tolerated it well.

9. Operative Note: Surgical intervention was performed to address other bursitis of the hip under general anesthesia with lighter dosage. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, ensuring clear margins. Hemostasis was achieved, and the wound was closed using sutures. The patient was provided with postoperative care instructions, including pain management and activity restrictions. The procedure was uneventful, and no immediate complications were noted.

10. Operative Note: The patient underwent surgery for other bursitis of the hip under local anesthesia with sedation. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was performed, and meticulous hemostasis was obtained. The wound was closed using absorbable sutures, and appropriate wound care was provided. The patient was advised on postoperative pain management and referred for rehabilitation. The procedure was performed without any complications, and the patient's recovery was unremarkable.

1. Operative Note: The patient underwent a surgical procedure to address other bursitis of the hip with associated bone erosion. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa and the eroded bone. Complete excision of the bursa was achieved, and the eroded bone was debrided and smoothed. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control, weight-bearing restrictions, and rehabilitation. The procedure was uneventful, and the patient tolerated it well.

2. Operative Note: Surgery was performed to address other bursitis of the hip with underlying bone erosion. An incision was made, and careful dissection was performed to visualize the inflamed bursa and the eroded bone. Complete excision of the bursa was achieved, and bone grafting was performed to repair the eroded area. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was instructed on pain management, weight-bearing limitations, and referred for physical therapy. The procedure was uncomplicated, and the patient's condition was stable.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the hip with bone erosion. The inflamed bursa and the eroded bone were accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and the eroded bone was addressed with bone grafting and stabilization. Hemostasis was ensured, and the wound was closed in layers. The patient was educated on postoperative care, including pain management, restricted weight-bearing, and the need for follow-up imaging. No intraoperative complications were encountered.

4. Operative Note: Surgical intervention was performed for other bursitis of the hip with significant bone erosion. An incision was made, and careful dissection allowed visualization of the inflamed bursa and the eroded bone. Complete excision of the bursa was achieved, and bone augmentation was performed to address the erosion. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control, protected weight-bearing, and referred for rehabilitation. The procedure was uneventful, and no complications were noted.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip with extensive bone erosion. A small incision was made, and meticulous dissection was performed to access the inflamed bursa and the eroded bone. Complete excision of the bursa was achieved, and bone grafting was performed to reconstruct the eroded area. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management, non-weight-bearing precautions, and referred for rehabilitation. The procedure was uneventful, and the patient tolerated it well.

6. Operative Note: Surgical intervention was performed to treat other bursitis of the hip with underlying bone erosion. An incision was made, and careful dissection allowed access to the inflamed bursa and the eroded bone. Complete excision of the bursa was achieved, and bone debridement and contouring were performed to address the erosion. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient was provided with postoperative care instructions, including pain management, restricted weight-bearing, and the importance of follow-up imaging. The procedure was unevent

ful, and no immediate complications were noted.

7. Operative Note: Surgery was performed to address other bursitis of the hip with associated bone erosion. The affected bursa and the eroded bone were accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and bone grafting was performed to restore the eroded area. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was educated on pain management, protected weight-bearing, and referred for physical therapy. The procedure was uneventful, and the patient's condition was stable.

8. Operative Note: A surgical procedure was performed to treat other bursitis of the hip with significant bone erosion. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa and the eroded bone. Complete excision of the bursa was achieved, and bone grafting was performed to address the erosion and promote healing. Hemostasis was achieved, and the wound was closed in layers. The patient was given postoperative instructions, including pain management, restricted weight-bearing, and the need for close monitoring of bone healing. The procedure was without complications, and the patient tolerated it well.

9. Operative Note: Surgical intervention was performed to address other bursitis of the hip with bone erosion under general anesthesia. The inflamed bursa and the eroded bone were accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and the eroded bone was debrided and contoured to improve stability. Hemostasis was ensured, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control, restricted weight-bearing, and referred for rehabilitation. The procedure was uneventful, and no immediate complications were noted.

10. Operative Note: The patient underwent surgery for other bursitis of the hip with bone erosion under regional anesthesia. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa and the eroded bone. Complete excision of the bursa was achieved, and bone grafting was performed to restore the eroded area and promote healing. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management, weight-bearing precautions, and referred for physical therapy. The procedure was performed without any complications, and the patient's recovery was unremarkable.

1. Operative Note: The patient underwent a surgical procedure to address other bursitis of the hip with severe bone pain. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, providing relief from the underlying bone pain. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control, including the use of analgesic medications. The procedure was uneventful, and the patient tolerated it well.

2. Operative Note: Surgery was performed to address other bursitis of the hip with severe bone pain. An incision was made, and careful dissection was performed to visualize the inflamed bursa. Complete excision of the bursa was achieved, alleviating the severe bone pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was instructed on pain management techniques and referred for physical therapy. The procedure was uncomplicated, and the patient's condition was stable.

3. Operative Note: A surgical intervention was performed to treat other bursitis of the hip with associated severe bone pain. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, providing relief from the severe bone pain. Hemostasis was ensured, and the wound was closed in layers. The patient was educated on postoperative care, including pain management strategies and the importance of rehabilitation. No intraoperative complications were encountered.

4. Operative Note: Surgical intervention was performed for other bursitis of the hip with significant bone pain. An incision was made, and careful dissection allowed visualization of the inflamed bursa. Complete excision of the bursa was achieved, alleviating the severe bone pain. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control and referred for physical therapy. The procedure was uneventful, and no complications were noted.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip with severe bone pain. A small incision was made, and meticulous dissection was performed to access the inflamed bursa. Complete excision of the bursa was achieved, providing relief from the severe bone pain. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques, including the use of non-steroidal anti-inflammatory drugs. The procedure was uneventful, and the patient tolerated it well.

6. Operative Note: Surgical intervention was performed to treat other bursitis of the hip with underlying severe bone pain. An incision was made, and careful dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, relieving the severe bone pain. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient was provided with postoperative care instructions, including pain management strategies and the importance of gradual return to activities. No intraoperative complications were encountered.

7. Operative Note: Surgery was performed to address other bursitis of the hip with severe bone pain. The affected bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, providing relief from the severe bone pain. Hemostasis was achieved

, and the wound was closed using sutures. Postoperatively, the patient was educated on pain management techniques, including the use of heat therapy and analgesic medications. The procedure was uneventful, and the patient's condition was stable.

8. Operative Note: A surgical procedure was performed to treat other bursitis of the hip with significant bone pain. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, relieving the severe bone pain. Hemostasis was ensured, and the wound was closed in layers. The patient was given postoperative instructions, including pain management strategies and the importance of rest and elevation. The procedure was without complications, and the patient tolerated it well.

9. Operative Note: Surgical intervention was performed to address other bursitis of the hip with severe bone pain under general anesthesia. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, providing relief from the severe bone pain. Hemostasis was ensured, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control, including the use of prescribed analgesic medications. The procedure was uneventful, and no immediate complications were noted.

10. Operative Note: The patient underwent surgery for other bursitis of the hip with severe bone pain under regional anesthesia. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, providing relief from the severe bone pain. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques, including the use of ice packs and prescribed pain medications. The procedure was performed without any complications, and the patient's recovery was unremarkable.

1. Operative Note: A surgical intervention was performed to address other bursitis of the hip. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and thorough irrigation was performed to ensure proper cleansing. Hemostasis was obtained, and the wound was closed using sutures. The patient was provided with postoperative instructions, including pain management and the need for follow-up appointments. The procedure was uneventful, and the patient tolerated it well.

2. Operative Note: Surgery was performed to address other bursitis of the hip. An incision was made, and careful dissection was performed to visualize the inflamed bursa. Complete excision of the bursa was achieved, and meticulous debridement was carried out to remove any necrotic tissue. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was instructed on pain management, weight-bearing limitations, and referred for physical therapy. The procedure was uncomplicated, and the patient's condition was stable.

3. Operative Note: A surgical procedure was performed to treat other bursitis of the hip. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and additional debridement was performed to address any associated pathology. Hemostasis was ensured, and the wound was closed in layers. The patient was educated on postoperative care, including pain management, restricted weight-bearing, and the importance of rehabilitation. No intraoperative complications were encountered.

4. Operative Note: Surgical intervention was performed for other bursitis of the hip. An incision was made, and careful dissection allowed visualization of the inflamed bursa. Complete excision of the bursa was achieved, and meticulous debridement was performed to ensure removal of all affected tissue. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control and referred for physical therapy. The procedure was uneventful, and no complications were noted.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip. A small incision was made, and meticulous dissection was performed to access the inflamed bursa. Complete excision of the bursa was achieved, and thorough irrigation was performed to reduce the risk of infection. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management, non-weight-bearing precautions, and referred for rehabilitation. The procedure was uneventful, and the patient tolerated it well.

6. Operative Note: Surgical intervention was performed to treat other bursitis of the hip. An incision was made, and careful dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and additional procedures were performed to address associated pathology, including osteochondral defects. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient was provided with postoperative care instructions, including pain management, restricted weight-bearing, and the need for close monitoring. The procedure was without complications, and the patient tolerated it well.

7. Operative Note: Surgery was performed to address other bursitis of the hip with underlying pathology. The affected bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the

bursa was achieved, and concomitant procedures were performed to address bone erosion and repair soft tissue structures. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was educated on pain management, weight-bearing precautions, and referred for physical therapy. The procedure was uneventful, and the patient's condition was stable.

8. Operative Note: A surgical procedure was performed to treat other bursitis of the hip with associated pathology. The inflamed bursa was accessed through a well-placed incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and additional procedures were performed to address intra-articular pathology and restore joint function. Hemostasis was ensured, and the wound was closed in layers. The patient was given postoperative instructions, including pain management, restricted weight-bearing, and the need for close follow-up. The procedure was performed without any complications, and the patient's recovery was unremarkable.

9. Operative Note: Surgical intervention was performed to address other bursitis of the hip with underlying pathology. An incision was made, and careful dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and concurrent procedures were performed to address associated impingement and labral tears. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques, weight-bearing limitations, and referred for comprehensive rehabilitation. The procedure was uneventful, and no immediate complications were noted.

10. Operative Note: The patient underwent surgery for other bursitis of the hip with associated pathology. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and additional procedures were performed to address structural abnormalities and restore joint integrity. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management, weight-bearing precautions, and referred for an individualized rehabilitation program. The procedure was performed without any complications, and the patient's recovery was uneventful.

1. Operative Note: A surgical intervention was performed to address other bursitis of the hip. An incision was made, and meticulous dissection was performed to visualize the inflamed bursa. Complete excision of the bursa was achieved, and extensive debridement was performed to remove any necrotic tissue. Hemostasis was obtained, and the wound was closed using absorbable sutures. Postoperatively, the patient was provided with instructions for pain management and referred for physical therapy. The procedure was uneventful, and the patient's condition was stable.

2. Operative Note: Surgery was performed to treat other bursitis of the hip. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and thorough irrigation was performed to reduce the risk of infection. Hemostasis was ensured, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques and referred for rehabilitation. The procedure was uncomplicated, and the patient tolerated it well.

3. Operative Note: A surgical procedure was performed to address other bursitis of the hip. The affected bursa was accessed through a well-placed incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and additional procedures were performed to address any associated labral tears. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control, weight-bearing restrictions, and referred for physical therapy. The procedure was uneventful, and the patient's condition was stable.

4. Operative Note: Surgical intervention was performed for other bursitis of the hip. An incision was made, and careful dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and meticulous debridement was performed to remove any damaged tissue. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management, weight-bearing limitations, and referred for rehabilitation. The procedure was without complications, and the patient's recovery was unremarkable.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip. A small incision was made, and meticulous dissection was performed to access the inflamed bursa. Complete excision of the bursa was achieved, and additional procedures were performed to address any associated impingement. Hemostasis was obtained, and the wound was closed using absorbable sutures. Postoperatively, the patient was educated on pain management techniques, restricted weight-bearing, and the importance of rehabilitation. No intraoperative complications were encountered.

6. Operative Note: Surgical intervention was performed to treat other bursitis of the hip. An incision was made, and careful dissection allowed visualization of the inflamed bursa. Complete excision of the bursa was achieved, and meticulous debridement was performed to remove any necrotic tissue. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control and referred for physical therapy. The procedure was uneventful, and no complications were noted.

7. Operative Note: Surgery was performed to address other bursitis of the hip with underlying pathology. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and

additional procedures were performed to address bone erosion and restore joint function. Hemostasis was ensured, and the wound was closed in layers. The patient was given postoperative instructions, including pain management, restricted weight-bearing, and the need for close monitoring. The procedure was performed without any complications, and the patient's recovery was unremarkable.

8. Operative Note: A surgical procedure was performed to treat other bursitis of the hip with associated pathology. An incision was made, and careful dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and additional procedures were performed to address intra-articular pathology and repair soft tissue structures. Hemostasis was ensured, and the wound was closed using sutures. The patient was provided with postoperative instructions, including pain management, restricted weight-bearing, and the need for close follow-up. The procedure was without complications, and the patient tolerated it well.

9. Operative Note: Surgical intervention was performed to address other bursitis of the hip with underlying pathology. The affected bursa was accessed through a well-placed incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and additional procedures were performed to address structural abnormalities and restore joint integrity. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques, weight-bearing precautions, and referred for comprehensive rehabilitation. The procedure was uneventful, and no immediate complications were noted.

10. Operative Note: The patient underwent surgery for other bursitis of the hip with associated pathology. A well-placed incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and additional procedures were performed to address impingement and repair labral tears. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management, weight-bearing precautions, and referred for an individualized rehabilitation program. The procedure was performed without any complications, and the patient's recovery was uneventful.

1. Operative Note: A surgical intervention was performed to address other bursitis of the hip with severe infection on the extremely moving joint. An incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the infected bursa was achieved, and extensive irrigation with antimicrobial solution was performed. Debridement of necrotic tissue was carried out, and cultures were obtained for further evaluation. Hemostasis was achieved, and a drain was placed. The wound was closed using sutures. The patient was started on broad-spectrum antibiotics and closely monitored postoperatively. The procedure was challenging due to the severe infection, but adequate control was achieved.

2. Operative Note: Surgery was performed to treat other bursitis of the hip with severe infection on the extremely moving joint. An incision was made, and meticulous dissection allowed visualization of the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and thorough debridement was performed to remove infected tissue and promote wound healing. Copious irrigation with antibiotic solution was done. Hemostasis was ensured, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on appropriate intravenous antibiotics and closely monitored for signs of systemic infection. The procedure was challenging due to the extent of the infection, but adequate control was achieved.

3. Operative Note: A surgical procedure was performed to address other bursitis of the hip with severe infection on the extremely moving joint. The inflamed and infected bursa was accessed through a well-placed incision, and meticulous dissection was carried out. Complete excision of the infected bursa was achieved, and extensive debridement was performed to remove necrotic and infected tissue. The joint was thoroughly irrigated with antimicrobial solution. Hemostasis was obtained, and a closed suction drain was placed. The wound was closed in layers. The patient was started on intravenous antibiotics, and appropriate wound care was instituted. The procedure was technically demanding due to the severe infection, but successfully managed.

4. Operative Note: Surgical intervention was performed to address other bursitis of the hip with severe infection involving the extremely moving joint. An incision was made, and meticulous dissection allowed access to the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and thorough debridement was performed to remove necrotic tissue and control the infection. Copious irrigation with antimicrobial solution was carried out. Hemostasis was ensured, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on intravenous antibiotics and closely monitored for signs of systemic infection. The procedure was technically challenging due to the severe infection, but managed effectively.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip with severe infection on the extremely moving joint. A carefully planned incision was made, and meticulous dissection was performed to access the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and extensive debridement was performed to remove infected tissue and promote healing. Copious irrigation with antimicrobial solution was performed. Hemostasis was achieved, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on intravenous antibiotics and closely monitored for signs of sepsis. The procedure was technically demanding due to the severity of the infection, but managed effectively.

6. Operative Note: Surgical intervention was performed for other bursitis

of the hip with severe infection involving the extremely moving joint. An incision was made, and meticulous dissection was performed to access the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and extensive debridement was performed to remove necrotic and infected tissue. The joint was thoroughly irrigated with antimicrobial solution. Hemostasis was obtained, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on intravenous antibiotics and closely monitored for signs of systemic infection. The procedure was technically challenging due to the severe infection, but managed effectively.

7. Operative Note: A surgical procedure was performed to treat other bursitis of the hip with severe infection on the extremely moving joint. An incision was made, and meticulous dissection allowed access to the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and thorough debridement was performed to remove infected tissue and control the infection. The joint was lavaged with antimicrobial solution. Hemostasis was achieved, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on intravenous antibiotics and closely monitored for signs of systemic infection. The procedure was technically demanding due to the severity of the infection, but managed effectively.

8. Operative Note: Surgery was performed to address other bursitis of the hip with severe infection on the extremely moving joint. An incision was made, and meticulous dissection was performed to access the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and extensive debridement was performed to remove necrotic tissue and control the infection. The joint was thoroughly irrigated with antimicrobial solution. Hemostasis was ensured, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on intravenous antibiotics and closely monitored for signs of systemic infection. The procedure was technically challenging due to the severe infection, but managed effectively.

9. Operative Note: A surgical intervention was performed to address other bursitis of the hip with severe infection on the extremely moving joint. An incision was made, and meticulous dissection allowed access to the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and extensive debridement was performed to remove necrotic tissue and control the infection. Copious irrigation with antimicrobial solution was carried out. Hemostasis was achieved, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on intravenous antibiotics and closely monitored for signs of systemic infection. The procedure was technically demanding due to the severity of the infection, but managed effectively.

10. Operative Note: Surgical intervention was performed to address other bursitis of the hip with severe infection involving the extremely moving joint. An incision was made, and meticulous dissection was performed to access the inflamed and infected bursa. Complete excision of the infected bursa was achieved, and thorough debridement was performed to remove necrotic tissue and control the infection. The joint was thoroughly irrigated with antimicrobial solution. Hemostasis was obtained, and a closed suction drain was placed. The wound was closed using sutures. The patient was started on intravenous antibiotics and closely monitored for signs of systemic infection. The procedure was technically challenging due to the severe infection, but managed effectively.

1. Operative Note: A surgical intervention was performed to address other bursitis of the hip with severe inflammation. An incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and thorough debridement was performed to remove necrotic tissue. Hemostasis was ensured, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain management and referred for physical therapy. The procedure was uneventful, and the patient's condition improved following surgery.

2. Operative Note: Surgery was performed to treat other bursitis of the hip with moderate inflammation. The inflamed bursa was accessed through a small incision, and meticulous dissection was carried out. Partial excision of the bursa was achieved, and careful debridement was performed to remove inflamed tissue. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques and referred for rehabilitation. The procedure was successful in reducing inflammation and relieving symptoms.

3. Operative Note: A surgical procedure was performed to address other bursitis of the hip with mild inflammation. The affected bursa was accessed through a well-placed incision, and careful dissection was carried out. Partial excision of the bursa was achieved, and minimal debridement was performed to address the inflamed tissue. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain control and referred for physical therapy. The procedure was successful in reducing inflammation and improving the patient's condition.

4. Operative Note: Surgical intervention was performed to address other bursitis of the hip with severe inflammation. An incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and extensive debridement was performed to remove necrotic tissue. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain management, weight-bearing restrictions, and referred for physical therapy. The procedure successfully addressed the severe inflammation, and the patient experienced symptomatic relief.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip with moderate inflammation. A small incision was made, and meticulous dissection was performed to access the inflamed bursa. Partial excision of the bursa was achieved, and careful debridement was performed to remove inflamed tissue. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperatively, the patient was educated on pain management techniques, restricted weight-bearing, and the importance of rehabilitation. The procedure successfully reduced inflammation and improved the patient's symptoms.

6. Operative Note: Surgical intervention was performed to address other bursitis of the hip with mild inflammation. An incision was made, and careful dissection allowed access to the inflamed bursa. Partial excision of the bursa was achieved, and minimal debridement was performed to address the inflamed tissue. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques, weight-bearing precautions, and referred for physical therapy. The procedure successfully reduced inflammation and improved the patient's condition.

7. Operative Note: A surgical procedure was performed to treat other bursitis of the hip with severe inflammation. The inflamed bursa was

accessed through a well-placed incision, and meticulous dissection was carried out. Complete excision of the bursa was achieved, and extensive debridement was performed to remove inflamed tissue. Hemostasis was ensured, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain management techniques, weight-bearing restrictions, and referred for rehabilitation. The procedure successfully addressed the severe inflammation, resulting in improved symptoms.

8. Operative Note: Surgery was performed to address other bursitis of the hip with moderate inflammation. An incision was made, and meticulous dissection allowed access to the inflamed bursa. Partial excision of the bursa was achieved, and careful debridement was performed to remove inflamed tissue. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain management and referred for physical therapy. The procedure effectively reduced inflammation and improved the patient's condition.

9. Operative Note: A surgical intervention was performed to address other bursitis of the hip with mild inflammation. The affected bursa was accessed through a well-placed incision, and careful dissection was carried out. Partial excision of the bursa was achieved, and minimal debridement was performed to address the inflamed tissue. Hemostasis was obtained, and the wound was closed using sutures. Postoperatively, the patient was instructed on pain control techniques and referred for rehabilitation. The procedure successfully reduced inflammation and improved the patient's condition.

10. Operative Note: Surgical intervention was performed to address other bursitis of the hip with severe inflammation. An incision was made, and meticulous dissection allowed access to the inflamed bursa. Complete excision of the bursa was achieved, and extensive debridement was performed to remove inflamed tissue. Hemostasis was achieved, and the wound was closed using sutures. Postoperatively, the patient was provided with instructions for pain management, weight-bearing restrictions, and referred for physical therapy. The procedure successfully addressed the severe inflammation, resulting in significant symptomatic relief.

1. Operative Note: A surgical intervention was performed to address other bursitis of the hip. The inflamed bursa was excised, and meticulous debridement was performed. Hemostasis was achieved, and the wound was closed. Follow-up appointments were scheduled at one week and one month to monitor the patient's progress, assess pain levels, and evaluate the need for physical therapy. The patient was advised to continue pain management strategies and adhere to weight-bearing restrictions.

2. Operative Note: Surgery was performed to treat other bursitis of the hip. Complete excision of the inflamed bursa was achieved, followed by thorough debridement. Hemostasis was ensured, and the wound was closed. Postoperative care included scheduled follow-up appointments at two weeks and six weeks for wound evaluation, pain assessment, and consideration of further imaging studies if required. The patient was instructed to adhere to a rehabilitation program and continue pain management as prescribed.

3. Operative Note: A surgical procedure was performed to address other bursitis of the hip. The affected bursa was excised, and extensive debridement was carried out. Hemostasis was obtained, and the wound was closed. The patient was scheduled for follow-up visits at two weeks, six weeks, and three months to monitor healing progress, assess pain levels, and determine the need for physical therapy or further interventions. Pain management strategies and weight-bearing restrictions were emphasized during postoperative care.

4. Operative Note: Surgical intervention was performed to address other bursitis of the hip. Complete excision of the inflamed bursa was achieved, followed by meticulous debridement. Hemostasis was achieved, and the wound was closed. The patient's postoperative follow-up plan included appointments at one week, four weeks, and three months to evaluate wound healing, assess pain levels, and discuss the need for additional interventions such as injections or physical therapy. Pain management strategies and weight-bearing restrictions were reviewed.

5. Operative Note: The patient underwent surgery to address other bursitis of the hip. The inflamed bursa was excised, and thorough debridement was performed. Hemostasis was ensured, and the wound was closed. Follow-up visits were scheduled at two weeks and six weeks to assess wound healing, evaluate pain levels, and determine the need for further interventions or imaging studies. The patient was instructed to adhere to pain management techniques and adhere to weight-bearing restrictions during the recovery period.

6. Operative Note: Surgical intervention was performed for other bursitis of the hip. Complete excision of the inflamed bursa was achieved, followed by meticulous debridement. Hemostasis was obtained, and the wound was closed. Postoperative care included follow-up appointments at one week, four weeks, and three months to assess wound healing, monitor pain levels, and discuss the need for additional interventions such as injections or physical therapy. Pain management strategies and weight-bearing restrictions were emphasized during the recovery period.

7. Operative Note: A surgical procedure was performed to treat other bursitis of the hip. The affected bursa was excised, and extensive debridement was performed. Hemostasis was achieved, and the wound was closed. The patient's postoperative follow-up plan included appointments at two weeks, six weeks, and three months to evaluate wound healing, assess pain levels, and discuss the need for further interventions or imaging studies. Pain management strategies and weight-bearing restrictions were reviewed.

8. Operative Note: Surgery was performed to address other bursitis of the hip. Complete excision of the inflamed bursa was achieved, followed by meticulous debridement. Hemostasis was ensured, and the wound was closed. The patient's postoperative follow-up plan included appointments at one week, four weeks, and three months to assess wound healing, monitor pain levels, and determine the need for additional interventions such as injections or physical therapy. Pain management strategies and weight-bearing restrictions were emphasized during the recovery period.

9. Operative Note: Surgical intervention was performed for other bursitis of the hip. The inflamed bursa was excised, and thorough debridement was performed. Hemostasis was obtained, and the wound was closed. Follow-up visits were scheduled at two weeks and six weeks to assess wound healing, evaluate pain levels, and determine the need for further interventions or imaging studies. The patient was instructed to adhere to pain management techniques and weight-bearing restrictions during the recovery period.

10. Operative Note: The patient underwent surgery to address other bursitis of the hip. Complete excision of the inflamed bursa was achieved, followed by meticulous debridement. Hemostasis was achieved, and the wound was closed. The patient's postoperative follow-up plan included appointments at one week, four weeks, and three months to evaluate wound healing, monitor pain levels, and discuss the need for additional interventions such as injections or physical therapy. Pain management strategies and weight-bearing restrictions were emphasized during the recovery period.

## M70.8 Other soft tissue disorders related to use, overuse and pressure

1. Operative Note - Soft Tissue Biopsy: A 2 cm incision was made over the affected area. Soft tissue was carefully dissected, and a biopsy sample was obtained. Hemostasis was achieved using electrocautery. The incision was closed with absorbable sutures. Specimen was sent for histopathological analysis.

2. Operative Note - Lipoma Excision: A 3 cm elliptical incision was made over the lipoma. Subcutaneous tissue was dissected, and the lipoma was identified and excised with surrounding capsule. Hemostasis was achieved with bipolar electrocautery. Closure was performed in layers using absorbable sutures.

3. Operative Note - Ganglion Cyst Removal: A 2 cm incision was made over the cyst. The cyst wall was identified, dissected, and excised in its entirety. Hemostasis was ensured with bipolar electrocautery. The wound was closed using absorbable sutures. The excised cyst was sent for pathological examination.

4. Operative Note - Soft Tissue Debridement: A 4 cm incision was made to access the necrotic soft tissue. Careful debridement was performed, removing all devitalized tissue. Copious irrigation with sterile saline was done. Hemostasis was achieved using electrocautery. The wound was dressed and a sterile bandage was applied.

5. Operative Note - Dupuytren's Contracture Release: A zigzag incision was made over the contracted area of the hand. The contracted palmar fascia was identified, dissected, and released. Full extension of the finger was achieved. The wound was closed with absorbable sutures. A bulky dressing and splint were applied for immobilization.

6. Operative Note - Soft Tissue Abscess Drainage: A 2 cm incision was made over the fluctuant abscess. Pus was drained under aseptic conditions. The abscess cavity was thoroughly irrigated with antiseptic solution. A drain was inserted and secured. The wound was packed with sterile gauze. Antibiotics were administered per protocol.

7. Operative Note - Soft Tissue Foreign Body Removal: A 1 cm incision was made over the suspected foreign body site. Soft tissue was dissected, and a foreign body (wood splinter) was located and carefully removed. Hemostasis was achieved using electrocautery. The wound was closed with non-absorbable sutures. Postoperative wound care instructions were given.

8. Operative Note - Soft Tissue Hematoma Evacuation: A 3 cm incision was made over the hematoma. The hematoma was evacuated, and active bleeding vessels were ligated. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated and closed in layers with absorbable sutures. A sterile dressing was applied.

9. Operative Note - Soft Tissue Sarcoma Resection: A wide excision was performed, encompassing the tumor with adequate margins. The tumor was carefully dissected, ensuring preservation of nearby structures. Hemostasis was achieved using a combination of bipolar electrocautery and ligatures. Closure was performed in layers with absorbable sutures. Specimen was sent for histopathological examination.

10. Operative Note - Soft Tissue Reconstruction: A 6 cm defect was reconstructed using a local advancement flap. The flap was designed, elevated, and transposed to cover the defect. Hemostasis was achieved using electrocautery. Closure was performed with absorbable sutures. A pressure dressing was applied. Postoperative care included immobilization and regular wound monitoring.

1. Operative Note - Soft Tissue Hemorrhage Control: A 4 cm incision was made to access the site of active bleeding. The bleeding vessel was identified, isolated, and ligated. Hemostasis was confirmed. The wound was irrigated with saline and closed in layers using absorbable sutures. A sterile dressing was applied.

2. Operative Note - Soft Tissue Scar Revision: A 3 cm incision was made along the scar line. The scar tissue was carefully excised, and healthy tissue edges were approximated. Closure was performed using meticulous suturing technique. The wound was dressed with sterile strips and a non-adherent dressing.

3. Operative Note - Soft Tissue Seroma Drainage: A 2 cm incision was made over the seroma. The seroma cavity was identified and drained under sterile conditions. A drain was inserted and secured. The wound was closed with absorbable sutures. Appropriate dressing and compression were applied.

4. Operative Note - Soft Tissue Hemangioma Resection: A 4 cm elliptical incision was made encompassing the hemangioma. The lesion was carefully dissected and excised, ensuring complete removal. Hemostasis was achieved using bipolar electrocautery. The wound was closed in layers using absorbable sutures. Postoperative wound care instructions were provided.

5. Operative Note - Soft Tissue Lymphedema Reduction: Multiple small incisions were made in the affected area. Liposuction was performed to remove excess fatty tissue and reduce lymphedema. Hemostasis was achieved using electrocautery. The incisions were closed with absorbable sutures. Compression garments were applied postoperatively.

6. Operative Note - Soft Tissue Necrotizing Fasciitis Debridement: Extensive debridement was performed to remove necrotic fascial tissue. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and ligatures. The wound was packed with sterile dressings. Broad-spectrum antibiotics were administered.

7. Operative Note - Soft Tissue Dermoid Cyst Excision: A 3 cm incision was made over the cyst. The cyst wall was carefully dissected and excised, ensuring complete removal. Hemostasis was achieved using bipolar electrocautery. The wound was closed in layers with absorbable sutures. Postoperative care instructions were provided.

8. Operative Note - Soft Tissue Hematoma Evacuation and Vessel Repair: A 5 cm incision was made over the hematoma. The hematoma was evacuated, and the injured vessel was identified and repaired. Hemostasis was confirmed. The wound was irrigated and closed in layers with absorbable sutures. A sterile dressing was applied.

9. Operative Note - Soft Tissue Granuloma Excision: A 2 cm incision was made over the granuloma. The lesion was carefully dissected and excised with surrounding healthy tissue. Hemostasis was achieved using electrocautery. The wound was closed with absorbable sutures. Postoperative wound care instructions were given.

10. Operative Note - Soft Tissue Synovial Cyst Excision: A 4 cm incision was made over the synovial cyst. The cyst was identified, dissected, and excised, ensuring complete removal. Hemostasis was achieved with bipolar electrocautery. The wound was closed in layers using absorbable sutures. Postoperative care included immobilization and regular follow-up.

1. Operative Note - Soft Tissue Biopsy under Local Anesthesia: A 2 cm incision was made over the affected area after administering local anesthesia with lidocaine. Soft tissue was carefully dissected, and a biopsy sample was obtained. Hemostasis was achieved using electrocautery. The incision was closed with absorbable sutures. Specimen was sent for histopathological analysis. Patient tolerated the procedure well under local anesthesia.

2. Operative Note - Lipoma Excision under Regional Anesthesia: After administering regional anesthesia with a brachial plexus block, a 3 cm elliptical incision was made over the lipoma. Subcutaneous tissue was dissected, and the lipoma was identified and excised with surrounding capsule. Hemostasis was achieved with bipolar electrocautery. Closure was performed in layers using absorbable sutures. The patient remained comfortable throughout the procedure under regional anesthesia.

3. Operative Note - Ganglion Cyst Removal under General Anesthesia: After induction of general anesthesia, a 2 cm incision was made over the cyst. The cyst wall was identified, dissected, and excised in its entirety. Hemostasis was ensured with bipolar electrocautery. The wound was closed using absorbable sutures. The patient was safely maintained under general anesthesia throughout the procedure.

4. Operative Note - Soft Tissue Debridement under Moderate Sedation: Following administration of moderate sedation with a combination of intravenous medications, a 4 cm incision was made to access the necrotic soft tissue. Careful debridement was performed, removing all devitalized tissue. Copious irrigation with sterile saline was done. Hemostasis was achieved using electrocautery. The patient remained calm and comfortable under moderate sedation.

5. Operative Note - Dupuytren's Contracture Release under Local Anesthesia with Sedation: A zigzag incision was made over the contracted area of the hand after administering local anesthesia with lidocaine. The contracted palmar fascia was identified, dissected, and released. Full extension of the finger was achieved. The wound was closed with absorbable sutures. The patient was kept comfortable under local anesthesia with sedation.

6. Operative Note - Soft Tissue Abscess Drainage under Local Anesthesia: Following administration of local anesthesia with lidocaine, a 2 cm incision was made over the fluctuant abscess. Pus was drained under aseptic conditions. The abscess cavity was thoroughly irrigated with antiseptic solution. A drain was inserted and secured. The wound was packed with sterile gauze. The patient experienced minimal discomfort under local anesthesia.

7. Operative Note - Soft Tissue Foreign Body Removal under General Anesthesia: After induction of general anesthesia, a 1 cm incision was made over the suspected foreign body site. Soft tissue was dissected, and a foreign body (wood splinter) was located and carefully removed. Hemostasis was achieved using electrocautery. The wound was closed with non-absorbable sutures. The procedure was safely performed under general anesthesia.

8. Operative Note - Soft Tissue Hematoma Evacuation under Spinal Anesthesia: After administering spinal anesthesia, a 3 cm incision was made over the hematoma. The hematoma was evacuated, and active bleeding vessels were ligated. Hemostasis was achieved using bipolar electrocautery. The wound was irrigated and closed in layers with absorbable sutures. The patient remained comfortable under spinal anesthesia.

9. Operative Note - Soft Tissue Sarcoma Resection under General Anesthesia with Epidural Analgesia: Following induction of general anesthesia and placement of an epidural cath

eter, a wide excision was performed, encompassing the tumor with adequate margins. The tumor was carefully dissected, ensuring preservation of nearby structures. Hemostasis was achieved using a combination of bipolar electrocautery and ligatures. Closure was performed in layers with absorbable sutures. The patient received effective pain control through epidural analgesia.

10. Operative Note - Soft Tissue Reconstruction under Local Anesthesia with Intravenous Sedation: After administering local anesthesia with lidocaine and providing intravenous sedation, a 6 cm defect was reconstructed using a local advancement flap. The flap was designed, elevated, and transposed to cover the defect. Hemostasis was achieved using electrocautery. Closure was performed with absorbable sutures. The patient was comfortable and relaxed throughout the procedure.

1. Operative Note - Soft Tissue Biopsy with Bone Erosion: A 2 cm incision was made over the area of suspected soft tissue pathology with associated bone erosion. Soft tissue was carefully dissected, and a biopsy sample was obtained. Hemostasis was achieved using electrocautery. The incision was closed with absorbable sutures. Specimen was sent for histopathological analysis, and imaging was obtained to evaluate the extent of bone erosion.

2. Operative Note - Soft Tissue Infection with Adjacent Bone Erosion Debridement: A 4 cm incision was made to access the infected soft tissue and underlying bone erosion. Extensive debridement was performed to remove necrotic tissue and clear the infection. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and bone wax for any bleeding from the eroded bone. The wound was closed in layers using absorbable sutures.

3. Operative Note - Soft Tissue Tumor Excision with Bone Erosion: A wide excision was performed to remove the soft tissue tumor, including the involved area of bone erosion. The tumor was carefully dissected, ensuring clear margins. Hemostasis was achieved using bipolar electrocautery and bone wax. The wound was closed in layers with absorbable sutures. The excised specimen and bone samples were sent for further analysis.

4. Operative Note - Soft Tissue Sarcoma Resection with Bone Erosion: A comprehensive resection was carried out to remove the soft tissue sarcoma, which extended into the adjacent bone causing erosion. The tumor was meticulously dissected, preserving critical structures. Hemostasis was achieved using a combination of bipolar electrocautery, ligatures, and bone wax. Closure was performed in layers with absorbable sutures. The patient's bone erosion and soft tissue tumor were successfully addressed.

5. Operative Note - Soft Tissue Abscess Drainage with Adjacent Bone Erosion: Following administration of local anesthesia, a 3 cm incision was made over the fluctuant abscess with associated bone erosion. Pus was drained under aseptic conditions, and the abscess cavity was thoroughly irrigated. Bone erosion was carefully inspected and any exposed bone was covered with soft tissue flaps. The wound was packed with sterile gauze. Appropriate antibiotics were administered.

6. Operative Note - Soft Tissue Inflammatory Disorder Excision with Bone Erosion: A 4 cm incision was made over the affected area with associated bone erosion. The inflamed soft tissue was excised, and meticulous care was taken to address the underlying bone erosion. Hemostasis was achieved using electrocautery and bone wax. The wound was closed in layers using absorbable sutures. The patient's bone erosion and inflammatory disorder were managed effectively.

7. Operative Note - Soft Tissue Hematoma Evacuation with Bone Erosion: Following administration of local anesthesia, a 3 cm incision was made over the hematoma with associated bone erosion. The hematoma was evacuated, and active bleeding vessels were controlled. The eroded bone was carefully inspected, and hemostasis was achieved using bone wax and pressure dressing. The wound was closed in layers using absorbable sutures.

8. Operative Note - Soft Tissue Granuloma Excision with Adjacent Bone Erosion: A 2 cm incision was made over the granuloma with associated bone erosion. The granuloma was meticulously excised, and bone erosion was addressed with careful debridement and bone wax application. Hemostasis was achieved using electrocautery. The wound was closed with absorbable sutures. Postoperative imaging confirmed successful resolution

of the granuloma and bone erosion.

9. Operative Note - Soft Tissue Rheumatoid Nodule Excision with Bone Erosion: A 2 cm incision was made over the rheumatoid nodule with associated bone erosion. The nodule was excised, ensuring complete removal. Bone erosion was carefully evaluated and addressed with bone grafting and stabilization. Hemostasis was achieved using electrocautery. The wound was closed in layers with absorbable sutures. The patient's rheumatoid nodule and bone erosion were effectively managed.

10. Operative Note - Soft Tissue Infection Debridement with Bone Erosion: A 4 cm incision was made to access the infected soft tissue and underlying bone erosion. Extensive debridement was performed to remove necrotic tissue and clear the infection. Bone erosion was carefully evaluated and addressed with debridement, bone grafting, and application of antibiotic-impregnated bone cement. Hemostasis was achieved using electrocautery. The wound was closed in layers using absorbable sutures.

1. Operative Note - Soft Tissue Tumor Resection with Severe Bone Pain: A wide excision was performed to remove the soft tissue tumor causing severe bone pain. The tumor was carefully dissected, ensuring clear margins. Adjacent bone involvement was noted and addressed with meticulous bone debridement. Hemostasis was achieved using bipolar electrocautery and bone wax. The wound was closed in layers with absorbable sutures. Postoperatively, the patient reported significant relief from the severe bone pain.

2. Operative Note - Soft Tissue Infection Debridement with Severe Bone Pain: A 5 cm incision was made to access the infected soft tissue with severe bone pain. Extensive debridement was performed to remove necrotic tissue and clear the infection. Severe bone pain was managed by addressing any underlying bone involvement, including debridement and bone stabilization. The wound was irrigated and closed in layers using absorbable sutures. The patient experienced notable improvement in severe bone pain postoperatively.

3. Operative Note - Soft Tissue Hematoma Evacuation with Severe Bone Pain: Following administration of local anesthesia, a 3 cm incision was made over the hematoma with severe bone pain. The hematoma was evacuated, and active bleeding vessels were controlled. Severe bone pain was managed through careful evaluation of the underlying bone involvement and appropriate bone stabilization. The wound was closed in layers using absorbable sutures. The patient reported relief from severe bone pain after the procedure.

4. Operative Note - Soft Tissue Biopsy with Severe Bone Pain: A 2 cm incision was made over the area of suspected soft tissue pathology with severe bone pain. Soft tissue was carefully dissected, and a biopsy sample was obtained. Evaluation of the bone involvement was conducted to identify the cause of severe bone pain. Hemostasis was achieved using electrocautery. The incision was closed with absorbable sutures. Postoperatively, the patient's severe bone pain was further investigated.

5. Operative Note - Soft Tissue Foreign Body Removal with Severe Bone Pain: Following administration of local anesthesia, a 2 cm incision was made over the site of suspected soft tissue foreign body with severe bone pain. Soft tissue was dissected, and the foreign body (metal fragment) was located and carefully removed. Evaluation of the adjacent bone involvement was performed to address the severe bone pain. The wound was closed with non-absorbable sutures. The patient experienced relief from severe bone pain postoperatively.

6. Operative Note - Soft Tissue Synovial Cyst Excision with Severe Bone Pain: A 4 cm incision was made over the synovial cyst with severe bone pain. The cyst was identified, dissected, and excised, ensuring complete removal. Evaluation of the adjacent bone involvement was conducted to address the severe bone pain. Hemostasis was achieved with bipolar electrocautery. The wound was closed in layers using absorbable sutures. The patient reported significant improvement in severe bone pain after the procedure.

7. Operative Note - Soft Tissue Necrotizing Fasciitis Debridement with Severe Bone Pain: Extensive debridement was performed to remove necrotic fascial tissue causing severe bone pain. Evaluation of the underlying bone involvement was conducted, including debridement and bone stabilization to address the severe bone pain. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and ligatures. The wound was packed with sterile dressings. Postoperatively, the patient experienced relief from severe bone pain.

8. Operative Note - Soft Tissue Scar Revision with Severe Bone Pain: A 3 cm incision was made

over the scarred soft tissue with severe bone pain. Scar tissue was carefully excised and revised. Evaluation of the underlying bone involvement was performed, addressing any contributing factors to the severe bone pain. Hemostasis was achieved using electrocautery. The wound was closed in layers with absorbable sutures. The patient reported significant reduction in severe bone pain postoperatively.

9. Operative Note - Soft Tissue Osteomyelitis Debridement with Severe Bone Pain: Following administration of local anesthesia, a 4 cm incision was made over the infected soft tissue with severe bone pain. Extensive debridement was performed to remove infected tissue and address the underlying osteomyelitis causing severe bone pain. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and bone wax. The wound was closed in layers using absorbable sutures. The patient experienced relief from severe bone pain postoperatively.

10. Operative Note - Soft Tissue Neuroma Excision with Severe Bone Pain: A 2 cm incision was made over the neuroma with severe bone pain. The neuroma was identified, dissected, and excised, ensuring complete removal. Evaluation of the adjacent bone involvement was conducted to address the severe bone pain. Hemostasis was achieved using bipolar electrocautery. The wound was closed with absorbable sutures. The patient reported notable improvement in severe bone pain after the procedure.

1. Operative Note - Soft Tissue Tumor Resection with Surgical Intervention: A wide excision was performed to remove the soft tissue tumor. Surgical intervention involved meticulous dissection to ensure complete tumor removal and clear margins. Hemostasis was achieved using bipolar electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue tumor was successfully managed through surgical intervention.

2. Operative Note - Soft Tissue Infection Debridement with Surgical Intervention: A 6 cm incision was made to access the infected soft tissue. Surgical intervention involved extensive debridement to remove necrotic tissue and clear the infection. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers using absorbable sutures. The patient's soft tissue infection was effectively addressed through surgical intervention.

3. Operative Note - Soft Tissue Reconstruction with Surgical Intervention: Following trauma, a 10 cm defect in the soft tissue required surgical intervention for reconstruction. A local flap was designed and elevated to cover the defect. Vascular anastomosis was performed to ensure adequate blood supply. The flap was sutured into place, and hemostasis was achieved using electrocautery and ligatures. The patient's soft tissue defect was successfully reconstructed through surgical intervention.

4. Operative Note - Soft Tissue Abscess Drainage with Surgical Intervention: Following administration of local anesthesia, a 4 cm incision was made to access the fluctuant abscess. Surgical intervention involved careful drainage of the abscess under aseptic conditions. Copious irrigation with antiseptic solution was done. A drain was inserted and secured. The wound was closed with non-absorbable sutures. The patient's soft tissue abscess was effectively managed through surgical intervention.

5. Operative Note - Soft Tissue Hematoma Evacuation with Surgical Intervention: After administering local anesthesia, a 5 cm incision was made to access the hematoma. Surgical intervention involved careful evacuation of the hematoma, ensuring complete removal. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers using absorbable sutures. The patient's soft tissue hematoma was successfully addressed through surgical intervention.

6. Operative Note - Soft Tissue Sarcoma Resection with Surgical Intervention: A comprehensive resection was performed to remove the soft tissue sarcoma. Surgical intervention involved meticulous dissection to achieve clear margins. Adjacent structures were carefully preserved. Hemostasis was achieved using bipolar electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue sarcoma was effectively managed through surgical intervention.

7. Operative Note - Soft Tissue Biopsy with Surgical Intervention: A 3 cm incision was made over the area of suspected soft tissue pathology. Surgical intervention involved obtaining a biopsy sample for further analysis. Hemostasis was achieved using electrocautery and ligatures. The incision was closed with absorbable sutures. The patient's soft tissue pathology was investigated through surgical intervention.

8. Operative Note - Soft Tissue Reconstruction with Flap Surgery: Following trauma, a large soft tissue defect required flap surgery for reconstruction. A pedicled flap was harvested from the nearby region and transferred to cover the defect. Vascular anastomosis was performed to ensure flap viability. The flap was sutured into place, and hemostasis was achieved using electrocautery and ligatures. The patient's soft tissue defect was successfully reconstructed through flap surgery.

9. Operative Note - Soft Tissue Foreign Body Removal with Surgical Intervention: Following administration of local anesthesia, a 2 cm incision was

made over the site of suspected soft tissue foreign body. Surgical intervention involved careful dissection and removal of the foreign body. Hemostasis was achieved using electrocautery and ligatures. The wound was closed with non-absorbable sutures. The patient's soft tissue foreign body was effectively managed through surgical intervention.

10. Operative Note - Soft Tissue Inflammatory Disorder Excision with Surgical Intervention: A 4 cm incision was made over the area affected by the inflammatory disorder. Surgical intervention involved excising the inflamed soft tissue. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers using absorbable sutures. The patient's soft tissue inflammatory disorder was successfully managed through surgical intervention.

1. Operative Note - Soft Tissue Revision Surgery: A 5 cm incision was made over the previously operated soft tissue site. Surgical intervention involved revising the previous surgical procedure to address persistent symptoms and complications. Extensive dissection and tissue rearrangement were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue was successfully revised through surgical intervention.

2. Operative Note - Soft Tissue Augmentation with Surgical Intervention: A 3 cm incision was made over the area requiring soft tissue augmentation. Surgical intervention involved the placement of a soft tissue implant to enhance volume and contour. The implant was carefully positioned and secured. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue augmentation was successfully performed through surgical intervention.

3. Operative Note - Soft Tissue Flap Reconstruction Surgery: Following a traumatic injury resulting in soft tissue loss, surgical intervention involved flap reconstruction. A local or regional flap was designed and elevated to cover the defect. Vascular anastomosis was performed to ensure adequate blood supply. The flap was meticulously sutured into place. Hemostasis was achieved using electrocautery and ligatures. The patient's soft tissue defect was effectively reconstructed through flap surgery.

4. Operative Note - Soft Tissue Release Surgery: A 4 cm incision was made over the area with restricted soft tissue mobility. Surgical intervention involved releasing the tight soft tissue structures to improve range of motion. Meticulous dissection and careful release of adhesions were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue mobility was successfully improved through surgical intervention.

5. Operative Note - Soft Tissue Excision and Resurfacing Surgery: A 6 cm incision was made over the area of soft tissue abnormality. Surgical intervention involved the excision of the abnormal tissue followed by resurfacing with healthy tissue. Meticulous dissection and excision were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue abnormality was successfully addressed through surgical excision and resurfacing.

6. Operative Note - Soft Tissue Repair with Surgical Intervention: Following a traumatic injury, a 3 cm laceration in the soft tissue required surgical intervention for repair. Surgical intervention involved meticulous wound exploration, debridement, and layered closure using non-absorbable sutures. Hemostasis was achieved using electrocautery and ligatures. The wound was dressed with sterile dressings. The patient's soft tissue laceration was successfully repaired through surgical intervention.

7. Operative Note - Soft Tissue Recession Surgery: A 2 cm incision was made over the area with excessive soft tissue bulk. Surgical intervention involved the removal of excess tissue to achieve a more balanced contour. Meticulous dissection and tissue excision were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue recession was successfully achieved through surgical intervention.

8. Operative Note - Soft Tissue Suture Removal: Following a previous surgical procedure, surgical intervention involved the removal of non-absorbable sutures from the soft tissue. The sutures were carefully located and removed using sterile instruments. Hemostasis was ensured, and the wound was inspected for any signs of infection or complications. The patient's soft tissue sutures were successfully removed through surgical intervention.

9. Operative Note

- Soft Tissue Scar Revision Surgery: A 4 cm incision was made over the scarred soft tissue. Surgical intervention involved revising the scar to improve its appearance and functionality. Meticulous dissection and scar tissue excision were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue scar was successfully revised through surgical intervention.

10. Operative Note - Soft Tissue Reduction Surgery: Following a diagnosis of soft tissue hypertrophy, surgical intervention involved reducing the excessive tissue volume. Meticulous dissection and tissue excision were performed to achieve the desired reduction. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's soft tissue hypertrophy was successfully managed through surgical reduction.

1. Operative Note - Soft Tissue Debridement for Severe Joint Infection: A 5 cm incision was made to access the soft tissue surrounding the extreme moving joint with severe infection. Surgical intervention involved extensive debridement of necrotic and infected tissue, ensuring thorough cleansing of the joint space. Copious irrigation with antiseptic solution was performed. The wound was left open for subsequent wound care. The patient's severe joint infection was addressed through surgical debridement.

2. Operative Note - Soft Tissue Abscess Drainage with Severe Joint Infection: Following administration of local anesthesia, a 4 cm incision was made over the area of soft tissue abscess adjacent to the extreme moving joint with severe infection. Surgical intervention involved careful drainage of the abscess, ensuring complete removal of purulent material. Copious irrigation with antiseptic solution was done. A drain was inserted and secured. The wound was left open for further management. The patient's severe joint infection and abscess were effectively addressed through surgical drainage.

3. Operative Note - Soft Tissue Necrotizing Fasciitis Debridement with Severe Joint Infection: Extensive debridement was performed to remove necrotic fascial tissue surrounding the extreme moving joint with severe infection. Surgical intervention involved meticulous dissection and removal of infected tissue, including exploration of the joint space. Copious irrigation with antiseptic solution was performed. Hemostasis was achieved using electrocautery and ligatures. The wound was left open for subsequent wound care. The patient's severe joint infection and necrotizing fasciitis were managed through surgical debridement.

4. Operative Note - Soft Tissue Sinus Tract Excision with Severe Joint Infection: A sinus tract was identified over the soft tissue near the extreme moving joint with severe infection. Surgical intervention involved excising the sinus tract, ensuring complete removal and exploration of the underlying joint structures. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and ligatures. The wound was left open for further management. The patient's severe joint infection and sinus tract were successfully addressed through surgical excision.

5. Operative Note - Soft Tissue Flap Reconstruction for Severe Joint Infection: Following a severe joint infection resulting in soft tissue loss, surgical intervention involved flap reconstruction. A regional or microvascular flap was designed and elevated to cover the defect, including the joint area. Vascular anastomosis was performed to ensure adequate blood supply. The flap was meticulously sutured into place. Hemostasis was achieved using electrocautery and ligatures. The patient's severe joint infection and soft tissue defect were effectively managed through surgical flap reconstruction.

6. Operative Note - Soft Tissue Biopsy for Severe Joint Infection: A 3 cm incision was made over the soft tissue adjacent to the extreme moving joint with severe infection. Surgical intervention involved obtaining a biopsy sample for culture and sensitivity analysis. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and ligatures. The incision was closed with absorbable sutures. The patient's severe joint infection was further investigated through surgical biopsy.

7. Operative Note - Soft Tissue Elevation and Drainage for Severe Joint Infection: A 6 cm incision was made to access the soft tissue with severe infection surrounding the extreme moving joint. Surgical intervention involved careful elevation of the affected soft tissue and subsequent drainage of purulent material. Copious irrigation with antiseptic solution was performed. Hemostasis was achieved using electrocautery and ligatures. The wound was left open for subsequent wound care. The patient's severe joint infection and soft tissue abs

cess were addressed through surgical elevation and drainage.

8. Operative Note - Soft Tissue Cyst Excision with Severe Joint Infection: A cyst was identified over the soft tissue near the extreme moving joint with severe infection. Surgical intervention involved excising the cyst, ensuring complete removal and exploration of the joint space. Copious irrigation with antiseptic solution was done. Hemostasis was achieved using electrocautery and ligatures. The wound was left open for further management. The patient's severe joint infection and cyst were successfully addressed through surgical excision.

9. Operative Note - Soft Tissue Washout for Severe Joint Infection: Following administration of local anesthesia, a 4 cm incision was made over the soft tissue surrounding the extreme moving joint with severe infection. Surgical intervention involved thorough washout of the infected soft tissue and joint space using a sterile solution. Copious irrigation was performed to flush out debris and bacteria. Hemostasis was achieved using electrocautery and ligatures. The wound was left open for subsequent wound care. The patient's severe joint infection was managed through surgical washout.

10. Operative Note - Soft Tissue Reconstruction with Severe Joint Infection: After controlling the severe joint infection, surgical intervention involved soft tissue reconstruction. A local or regional flap was designed and elevated to cover the defect, including the joint area. Vascular anastomosis was performed to ensure adequate blood supply. The flap was meticulously sutured into place. Hemostasis was achieved using electrocautery and ligatures. The patient's severe joint infection and soft tissue defect were successfully managed through surgical reconstruction.

1. Operative Note - Soft Tissue Debridement for Inflammatory Lesion: A 5 cm incision was made to access the inflamed soft tissue lesion. Surgical intervention involved meticulous debridement of necrotic and inflamed tissue, ensuring complete removal. Copious irrigation with sterile saline was performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's inflammatory lesion was effectively addressed through surgical debridement.

2. Operative Note - Soft Tissue Biopsy for Inflammatory Disorder: A 3 cm incision was made over the area affected by the inflammatory disorder. Surgical intervention involved obtaining a biopsy sample for histopathological analysis. Hemostasis was achieved using electrocautery and ligatures. The incision was closed with absorbable sutures. The patient's inflammatory disorder was investigated through surgical biopsy.

3. Operative Note - Soft Tissue Excision for Severe Inflammation: A 6 cm incision was made to access the soft tissue with severe inflammation. Surgical intervention involved excising the inflamed tissue, ensuring clear margins. Hemostasis was achieved using bipolar electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's severe inflammation was effectively managed through surgical excision.

4. Operative Note - Soft Tissue Flap Reconstruction for Inflammatory Defect: Following inflammation-induced tissue loss, surgical intervention involved flap reconstruction. A local or regional flap was designed and elevated to cover the defect caused by inflammation. The flap was meticulously sutured into place, and hemostasis was achieved using electrocautery and ligatures. The patient's inflammatory defect was successfully addressed through surgical flap reconstruction.

5. Operative Note - Soft Tissue Release for Inflammatory Contracture: A 4 cm incision was made over the area with inflammatory contracture. Surgical intervention involved releasing the tight soft tissue structures to restore mobility. Meticulous dissection and careful release of adhesions were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's inflammatory contracture was successfully managed through surgical release.

6. Operative Note - Soft Tissue Washout for Acute Inflammation: Following administration of local anesthesia, a 4 cm incision was made over the acutely inflamed soft tissue. Surgical intervention involved thorough washout of the inflamed tissue using a sterile solution. Copious irrigation was performed to reduce inflammation and remove debris. Hemostasis was achieved using electrocautery and ligatures. The wound was left open for subsequent wound care. The patient's acute inflammation was managed through surgical washout.

7. Operative Note - Soft Tissue Reduction Surgery for Chronic Inflammation: A 5 cm incision was made over the area affected by chronic inflammation. Surgical intervention involved reducing the excessive soft tissue bulk to alleviate chronic inflammatory symptoms. Meticulous dissection and tissue excision were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's chronic inflammation was successfully addressed through surgical reduction.

8. Operative Note - Soft Tissue Resurfacing for Inflammatory Ulcer: Following inflammation-induced ulceration, surgical intervention involved resurfacing the ulcerated soft tissue. Debridement of necrotic tissue was performed, and the healthy tissue was prepared for resurfacing. A graft or flap was meticulously sutured into place, ensuring adequate blood supply. Hemostasis was achieved using electrocautery and ligatures. The patient's inflammatory ulcer was effectively managed through surgical resurfacing.

9.

Operative Note - Soft Tissue Revision Surgery for Inflammatory Scarring: A 3 cm incision was made over the area of inflammatory scarring. Surgical intervention involved revising the scar to improve its appearance and functionality. Meticulous dissection and scar tissue excision were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's inflammatory scarring was successfully revised through surgical intervention.

10. Operative Note - Soft Tissue Repair for Inflammatory Laceration: Following a traumatic injury with associated inflammation, surgical intervention involved repairing the soft tissue laceration. Meticulous wound exploration, debridement, and layered closure using non-absorbable sutures were performed. Hemostasis was achieved using electrocautery and ligatures. The wound was dressed with sterile dressings. The patient's inflammatory laceration was successfully repaired through surgical intervention.

1. Operative Note - Soft Tissue Excision for Severe Lesion: A 5 cm incision was made over the site of the severe soft tissue lesion. Surgical intervention involved meticulous excision of the lesion, ensuring clear margins. Hemostasis was achieved using electrocautery and ligatures. The wound was closed in layers with absorbable sutures. The patient's postoperative follow-up will depend on the histopathological analysis of the excised tissue and the severity of the diagnosis.

2. Operative Note - Soft Tissue Debridement for Extensive Infection: Following a thorough debridement of extensive soft tissue infection, the wound was irrigated with antiseptic solution and left open for further management. The patient's postoperative follow-up will depend on the response to the debridement, resolution of infection, and the severity of any underlying conditions.

3. Operative Note - Soft Tissue Reconstruction for Severe Defect: A regional or microvascular flap was used to reconstruct the severe soft tissue defect. The flap was meticulously sutured into place, ensuring adequate blood supply. The patient's postoperative follow-up will depend on the successful integration of the flap, wound healing progress, and the severity of any associated complications.

4. Operative Note - Soft Tissue Biopsy for Suspicious Malignancy: A biopsy sample was obtained from the soft tissue suspected of malignancy. The patient's postoperative follow-up will depend on the histopathological analysis results, which will determine the severity of the diagnosis and guide further management and treatment options.

5. Operative Note - Soft Tissue Reduction for Chronic Overuse Syndrome: Surgical intervention involved reducing the excessive soft tissue bulk caused by chronic overuse syndrome. The patient's postoperative follow-up will depend on the resolution of symptoms, functional improvement, and the severity of any residual symptoms or complications.

6. Operative Note - Soft Tissue Revision for Recurrent Hernia: Surgical intervention involved revising the recurrent soft tissue hernia. The patient's postoperative follow-up will depend on the successful repair, resolution of symptoms, and the severity of any complications or recurrences.

7. Operative Note - Soft Tissue Release for Severe Contracture: Surgical intervention involved releasing the severe soft tissue contracture. The patient's postoperative follow-up will depend on the restoration of range of motion, functional improvement, and the severity of any residual contracture or complications.

8. Operative Note - Soft Tissue Repair for Traumatic Avulsion: Surgical intervention involved repairing the traumatic soft tissue avulsion. The patient's postoperative follow-up will depend on the successful reattachment of the avulsed tissue, wound healing progress, and the severity of any associated injuries or complications.

9. Operative Note - Soft Tissue Reconstruction for Extensive Skin Loss: Surgical intervention involved reconstructing the soft tissue with extensive skin loss. The patient's postoperative follow-up will depend on the successful integration of the reconstruction, wound healing progress, and the severity of any complications or additional treatments required.

10. Operative Note - Soft Tissue Resurfacing for Chronic Ulcer: Surgical intervention involved resurfacing the chronic soft tissue ulcer. The patient's postoperative follow-up will depend on the successful healing of the ulcer, resolution of symptoms, and the severity of any residual ulceration or complications.

## M70.9 Unspecified soft tissue disorder related to use, overuse and pressure

Operative Note 1:

Patient underwent exploratory surgery for an unspecified soft tissue disorder. A midline incision was made, and the soft tissue was dissected to expose the affected area. The diseased tissue was excised, and hemostasis was achieved. The wound was irrigated and closed in layers. The specimen was sent for histopathological analysis. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 2:

Surgical intervention was performed for an unspecified soft tissue disorder. A lateral approach was used to access the affected site. The diseased tissue was meticulously excised, ensuring clear margins. Hemostasis was achieved using electrocautery. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for further evaluation. The patient's postoperative recovery was uneventful.

Operative Note 3:

An unspecified soft tissue disorder necessitated surgical intervention. An oblique incision was made to expose the affected area. The diseased tissue was excised, and meticulous hemostasis was obtained. Closure was performed in layers after thorough irrigation. A drain was placed to prevent fluid accumulation. The excised tissue was sent for pathological analysis. The patient's postoperative course was uncomplicated.

Operative Note 4:

For an unspecified soft tissue disorder, the patient underwent surgical treatment. A transverse incision was made to access the affected site. Careful dissection allowed exposure of the diseased tissue. The affected tissue was excised, ensuring clear margins. Hemostasis was achieved using sutures and electrocautery. The wound was closed layer by layer and dressed appropriately. The patient's recovery was satisfactory without any immediate complications.

Operative Note 5:

Surgical intervention was performed to address an unspecified soft tissue disorder. A vertical incision was made to gain access to the affected area. The diseased tissue was excised meticulously, ensuring complete removal. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated and closed in layers. The specimen was submitted for histopathological analysis. The patient tolerated the procedure well, and no immediate postoperative issues were noted.

Operative Note 6:

An unspecified soft tissue disorder prompted surgical intervention. A curvilinear incision was made to expose the affected region. The diseased tissue was excised with clear margins. Hemostasis was achieved using electrocautery and local hemostatic agents. The wound was irrigated thoroughly and closed meticulously in layers. The excised tissue was sent for pathological examination. The patient's recovery was uneventful without any immediate complications.

Operative Note 7:

Patient underwent surgical intervention for an unspecified soft tissue disorder. An elliptical incision was made, allowing exposure of the affected area. The diseased tissue was meticulously excised, ensuring complete removal. Hemostasis was achieved using sutures and hemostatic agents. The wound was irrigated and closed layer by layer. The specimen was sent for histopathological evaluation. The patient's immediate postoperative period was unremarkable.

Operative Note 8:

For an unspecified soft tissue disorder, surgical intervention was performed. A longitudinal incision was made, providing access to the affected region. The diseased tissue was excised with clear margins, ensuring complete removal. Hemostasis was achieved using sutures and bipolar cautery. The wound was thoroughly irrigated and closed in layers. The excised tissue was submitted for further analysis. The patient's recovery was smooth without any immediate complications.

Operative Note 9:

Surgical intervention was performed to address an unspecified soft tissue disorder. A transverse curved incision was made to expose the affected area. The diseased tissue was meticulously excised, ensuring complete clearance. Hemost

asis was achieved using bipolar cautery and sutures. The wound was irrigated and closed in layers. The excised tissue was sent for histopathological examination. The patient tolerated the procedure well, with no immediate postoperative issues.

Operative Note 10:

An unspecified soft tissue disorder necessitated surgical intervention. A paramedian incision was made to access the affected region. The diseased tissue was excised meticulously, ensuring clear margins. Hemostasis was achieved using electrocautery and sutures. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for further analysis. The patient's immediate postoperative course was uneventful.

Operative Note 11:

Patient underwent surgical intervention for an unspecified soft tissue disorder. A curvilinear incision was made to expose the affected area. The diseased tissue was excised meticulously, ensuring complete removal. Hemostasis was achieved using electrocautery and ligatures. The wound was irrigated and closed in layers. The excised tissue was sent for histopathological analysis. The patient's immediate postoperative recovery was uncomplicated, with no signs of complications.

Operative Note 12:

Surgical treatment was performed for an unspecified soft tissue disorder. An oblique incision was made to access the affected site. The diseased tissue was carefully excised, ensuring negative margins. Hemostasis was achieved using bipolar cautery and sutures. The wound was irrigated and closed layer by layer. The excised tissue was sent for pathological examination. The patient tolerated the procedure well, and no immediate postoperative issues were observed.

Operative Note 13:

An unspecified soft tissue disorder required surgical intervention. A midline vertical incision was made to expose the affected area. The diseased tissue was meticulously excised with clear margins. Hemostasis was achieved using electrocautery and hemostatic agents. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for histopathological evaluation. The patient's immediate recovery was uneventful, without any complications.

Operative Note 14:

Surgical intervention was performed for an unspecified soft tissue disorder. A transverse curved incision was made, providing access to the affected region. The diseased tissue was excised meticulously, ensuring complete removal. Hemostasis was achieved using bipolar cautery and sutures. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was smooth without any immediate complications.

Operative Note 15:

For an unspecified soft tissue disorder, surgical intervention was performed. A medial incision was made to access the affected site. The diseased tissue was excised meticulously with clear margins. Hemostasis was achieved using bipolar cautery and ligatures. The wound was irrigated and closed layer by layer. The excised tissue was submitted for histopathological examination. The patient's immediate postoperative period was unremarkable.

Operative Note 16:

An unspecified soft tissue disorder necessitated surgical intervention. A transverse incision was made, allowing exposure of the affected area. The diseased tissue was meticulously excised, ensuring complete removal. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated and closed in layers. The excised tissue was sent for histopathological evaluation. The patient's immediate postoperative course was uneventful.

Operative Note 17:

Patient underwent surgical intervention for an unspecified soft tissue disorder. A paramedian incision was made to access the affected region. The diseased tissue was meticulously excised with clear margins. Hemostasis was achieved using bipolar cautery and ligatures. The wound was thoroughly irrigated and closed layer by layer. The excised tissue was sent for histopathological analysis. The patient tolerated the procedure well, with no immediate postoperative complications.

Operative Note 18:

Surgical intervention was performed to address an unspecified soft tissue disorder. A curvilinear incision was made to expose the affected area. The diseased tissue was excised meticulously, ensuring complete removal. Hemostasis was achieved using sutures and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for pathological examination. The patient's recovery was uneventful without any immediate complications.

Operative Note 19:

For an unspecified soft tissue disorder, surgical intervention was performed. An oblique

incision was made to gain access to the affected site. The diseased tissue was meticulously excised, ensuring clear margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was thoroughly irrigated and closed layer by layer. The excised tissue was submitted for further analysis. The patient's recovery was satisfactory without any immediate complications.

Operative Note 20:

Surgical intervention was performed to address an unspecified soft tissue disorder. A longitudinal incision was made, providing access to the affected region. The diseased tissue was excised with clear margins, ensuring complete removal. Hemostasis was achieved using sutures and electrocautery. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for histopathological examination. The patient tolerated the procedure well, and no immediate postoperative issues were noted.

Operative Note 21:

Patient underwent surgical intervention for an unspecified soft tissue disorder. Under general anesthesia with endotracheal intubation, a midline incision was made to expose the affected area. The diseased tissue was meticulously excised, ensuring clear margins. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated and closed in layers. The excised tissue was sent for histopathological analysis. The patient's postoperative recovery was uneventful with appropriate anesthesia dosage.

Operative Note 22:

Surgical treatment was performed for an unspecified soft tissue disorder. The patient received regional anesthesia via a nerve block. A curvilinear incision was made to access the affected site. The diseased tissue was carefully excised with clear margins. Hemostasis was achieved using bipolar cautery and sutures. The wound was irrigated and closed layer by layer. The excised tissue was sent for pathological examination. The patient's immediate postoperative course was uneventful with the appropriate anesthesia dosage.

Operative Note 23:

An unspecified soft tissue disorder required surgical intervention. The patient received conscious sedation and local anesthesia. An oblique incision was made to expose the affected region. The diseased tissue was meticulously excised, ensuring complete removal. Hemostasis was achieved using electrocautery and local hemostatic agents. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for histopathological evaluation. The patient's recovery was uneventful with appropriate anesthesia dosage.

Operative Note 24:

Surgical intervention was performed for an unspecified soft tissue disorder. The patient received general anesthesia with balanced anesthesia techniques. A transverse incision was made, providing access to the affected region. The diseased tissue was excised meticulously, ensuring complete removal. Hemostasis was achieved using bipolar cautery and sutures. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was smooth without any immediate complications and appropriate anesthesia dosage.

Operative Note 25:

For an unspecified soft tissue disorder, surgical intervention was performed. The patient received spinal anesthesia. A medial incision was made to access the affected site. The diseased tissue was excised meticulously with clear margins. Hemostasis was achieved using bipolar cautery and ligatures. The wound was irrigated and closed layer by layer. The excised tissue was submitted for histopathological examination. The patient's immediate postoperative period was unremarkable with appropriate anesthesia dosage.

Operative Note 26:

An unspecified soft tissue disorder necessitated surgical intervention. The patient received local anesthesia with sedation. A paramedian incision was made to access the affected region. The diseased tissue was meticulously excised with clear margins. Hemostasis was achieved using bipolar cautery and ligatures. The wound was thoroughly irrigated and closed layer by layer. The excised tissue was sent for histopathological analysis. The patient tolerated the procedure well, with no immediate postoperative complications and appropriate anesthesia dosage.

Operative Note 27:

Patient underwent surgical intervention for an unspecified soft tissue disorder. General anesthesia was administered via inhalation. A curvilinear incision was made to expose the affected area. The diseased tissue was excised meticulously, ensuring complete removal. Hemostasis was achieved using sutures and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for histopathological evaluation. The patient's recovery was uneventful without any immediate complications and appropriate anesthesia dosage.

Operative Note 28:

Surgical intervention was performed to address an unspecified soft tissue disorder. The patient received regional anesthesia via epidural block. A transverse curved incision was

made to expose the affected area. The diseased tissue was meticulously excised, ensuring complete clearance. Hemostasis was achieved using bipolar cautery and sutures. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was satisfactory without any immediate complications and appropriate anesthesia dosage.

Operative Note 29:

For an unspecified soft tissue disorder, surgical intervention was performed. The patient received local anesthesia with intravenous sedation. An oblique incision was made to gain access to the affected site. The diseased tissue was excised meticulously, ensuring clear margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated and closed in layers. The excised tissue was sent for pathological examination. The patient's recovery was smooth without any immediate complications and appropriate anesthesia dosage.

Operative Note 30:

Surgical intervention was performed to address an unspecified soft tissue disorder. The patient received general anesthesia with total intravenous anesthesia (TIVA). A longitudinal incision was made, providing access to the affected region. The diseased tissue was excised with clear margins, ensuring complete removal. Hemostasis was achieved using sutures and electrocautery. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for histopathological examination. The patient tolerated the procedure well, and no immediate postoperative issues were noted with appropriate anesthesia dosage.

Operative Note 31:

Patient underwent surgical intervention for an unspecified soft tissue disorder with associated bone erosion. A midline incision was made to expose the affected area. Significant bone erosion was noted, and thorough debridement of the affected bone was performed. The diseased soft tissue was excised, ensuring clear margins. Hemostasis was achieved using electrocautery and bone wax. The wound was irrigated and closed in layers. The excised tissue and bone fragments were sent for histopathological analysis. The patient's immediate postoperative course was uneventful.

Operative Note 32:

Surgical treatment was performed for an unspecified soft tissue disorder with bone erosion. Under general anesthesia, a lateral approach was used to access the affected site. Extensive bone erosion was observed, requiring meticulous debridement. The diseased tissue was excised with clear margins, and the affected bone was smoothed. Hemostasis was achieved using electrocautery and bone substitutes. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for pathological examination. The patient's recovery was satisfactory without any immediate complications.

Operative Note 33:

An unspecified soft tissue disorder with bone erosion necessitated surgical intervention. A transverse incision was made to expose the affected region. Extensive bone erosion was noted, requiring careful debridement. The diseased tissue was excised meticulously, ensuring clear margins. Hemostasis was achieved using bone wax and electrocautery. The wound was irrigated thoroughly and closed layer by layer. The excised tissue and bone fragments were sent for histopathological evaluation. The patient tolerated the procedure well, with appropriate measures taken for bone erosion.

Operative Note 34:

Surgical intervention was performed to address an unspecified soft tissue disorder with bone erosion. A paramedian incision was made to access the affected area. Severe bone erosion was observed, necessitating meticulous debridement. The diseased tissue was excised with clear margins, and the eroded bone surfaces were smoothed. Hemostasis was achieved using bone substitutes and sutures. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for further analysis. The patient's recovery was uneventful with appropriate measures taken for bone erosion.

Operative Note 35:

For an unspecified soft tissue disorder with bone erosion, surgical intervention was performed. A curvilinear incision was made to expose the affected area. Extensive bone erosion was noted, necessitating thorough debridement. The diseased tissue was meticulously excised with clear margins, and the eroded bone was reshaped and smoothed. Hemostasis was achieved using bone wax and electrocautery. The wound was irrigated and closed layer by layer. The excised tissue and bone fragments were submitted for histopathological examination. The patient's immediate postoperative course was unremarkable, with appropriate measures taken for bone erosion.

Operative Note 36:

An unspecified soft tissue disorder with bone erosion prompted surgical intervention. Under general anesthesia, a vertical incision was made to access the affected region. Significant bone erosion was observed and thoroughly debrided. The diseased tissue was excised meticulously, ensuring negative margins. Hemostasis was achieved using bone substitutes and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for pathological analysis. The patient tolerated the procedure well, with appropriate management of bone erosion.

Operative Note 37:

Patient underwent surgical intervention for an unspecified soft tissue disorder with associated bone erosion. The surgical approach involved a transverse curved incision to expose the affected area. Extensive bone erosion was encountered, necessitating meticulous debridement. The diseased tissue was excised

with clear margins, and the eroded bone surfaces were smoothed. Hemostasis was achieved using bone wax and sutures. The wound was thoroughly irrigated and closed in layers. The excised tissue and bone fragments were sent for further analysis. The patient's recovery was uneventful, with appropriate measures taken for bone erosion.

Operative Note 38:

Surgical intervention was performed to address an unspecified soft tissue disorder with bone erosion. The patient received general anesthesia. A medial incision was made to access the affected site. Severe bone erosion was observed, necessitating meticulous debridement. The diseased tissue was excised with clear margins, and the eroded bone surfaces were reshaped. Hemostasis was achieved using bone substitutes and electrocautery. The wound was irrigated and closed layer by layer. The excised tissue and bone fragments were sent for histopathological examination. The patient's immediate postoperative course was unremarkable, with appropriate management of bone erosion.

Operative Note 39:

For an unspecified soft tissue disorder with bone erosion, surgical intervention was performed. The patient received regional anesthesia via nerve block. An oblique incision was made to expose the affected region. Extensive bone erosion was noted, necessitating thorough debridement. The diseased tissue was meticulously excised with clear margins, and the eroded bone surfaces were smoothed. Hemostasis was achieved using bone wax and bipolar cautery. The wound was irrigated and closed in layers. The excised tissue and bone fragments were submitted for histopathological evaluation. The patient's recovery was uneventful, with appropriate measures taken for bone erosion.

Operative Note 40:

An unspecified soft tissue disorder with bone erosion necessitated surgical intervention. The patient received general anesthesia with endotracheal intubation. A paramedian incision was made to access the affected region. Significant bone erosion was observed, requiring meticulous debridement. The diseased tissue was excised with clear margins, and the eroded bone was reshaped. Hemostasis was achieved using bone substitutes and sutures. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for further analysis. The patient's recovery was satisfactory, with appropriate measures taken for bone erosion.

Operative Note 41:

Patient underwent surgical intervention for an unspecified soft tissue disorder with severe bone pain. A midline incision was made to expose the affected area. Extensive bone erosion and necrosis were noted, contributing to the severe pain. Thorough debridement of the diseased tissue and eroded bone was performed. Hemostasis was achieved using bone wax and electrocautery. The wound was irrigated and closed in layers. The excised tissue and bone fragments were sent for histopathological analysis. The patient's immediate postoperative course showed relief from severe bone pain.

Operative Note 42:

Surgical treatment was performed for an unspecified soft tissue disorder with severe bone pain. Under general anesthesia, a lateral approach was used to access the affected site. Severe bone erosion and inflammation were observed, contributing to the patient's pain. Meticulous debridement of the diseased tissue and eroded bone was carried out. Hemostasis was achieved using bone substitutes and sutures. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for pathological examination. The patient experienced significant relief from severe bone pain postoperatively.

Operative Note 43:

An unspecified soft tissue disorder with severe bone pain necessitated surgical intervention. A transverse incision was made to expose the affected region. Extensive bone erosion and associated nerve compression were noted, contributing to the severe pain. The diseased tissue was meticulously excised with clear margins, and the eroded bone surfaces were smoothed. Hemostasis was achieved using bone wax and bipolar cautery. The wound was irrigated and closed layer by layer. The excised tissue and bone fragments were sent for histopathological evaluation. The patient's recovery was satisfactory, with significant relief from severe bone pain.

Operative Note 44:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe bone pain. A paramedian incision was made to access the affected area. Severe bone erosion and inflammation were observed, causing debilitating pain for the patient. Thorough debridement of the diseased tissue and eroded bone was performed. Hemostasis was achieved using bone substitutes and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for further analysis. The patient experienced significant relief from severe bone pain postoperatively.

Operative Note 45:

For an unspecified soft tissue disorder with severe bone pain, surgical intervention was performed. A curvilinear incision was made to expose the affected area. Severe bone erosion and necrosis were noted, contributing to the intense pain experienced by the patient. Meticulous debridement of the diseased tissue and eroded bone was carried out. Hemostasis was achieved using bone wax and sutures. The wound was irrigated and closed layer by layer. The excised tissue and bone fragments were submitted for histopathological examination. The patient reported significant relief from severe bone pain following the surgery.

Operative Note 46:

An unspecified soft tissue disorder with severe bone pain prompted surgical intervention. The patient received general anesthesia with total intravenous anesthesia (TIVA). A longitudinal incision was made to access the affected region. Severe bone erosion and associated nerve compression were observed, contributing to the severe pain. The diseased tissue was excised with clear margins, and the eroded bone was reshaped. Hemostasis was achieved using bone substitutes and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for histopathological examination. The patient's immediate postoperative course showed significant relief from severe bone pain.

Operative Note 47:

Patient underwent surgical intervention for an unspecified soft tissue disorder with severe

bone pain. General anesthesia was administered via inhalation. A vertical incision was made to expose the affected area. Severe bone erosion and necrosis were noted, causing significant pain for the patient. Thorough debridement of the diseased tissue and eroded bone was performed. Hemostasis was achieved using bone wax and sutures. The wound was irrigated thoroughly and closed in layers. The excised tissue and bone fragments were sent for further analysis. The patient experienced substantial relief from severe bone pain following the surgery.

Operative Note 48:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe bone pain. The patient received regional anesthesia via epidural block. An oblique incision was made to expose the affected region. Severe bone erosion and associated nerve compression were observed, contributing to the severe pain. The diseased tissue was meticulously excised with clear margins, and the eroded bone surfaces were smoothed. Hemostasis was achieved using bone wax and bipolar cautery. The wound was irrigated and closed in layers. The excised tissue and bone fragments were sent for histopathological evaluation. The patient experienced significant relief from severe bone pain postoperatively.

Operative Note 49:

For an unspecified soft tissue disorder with severe bone pain, surgical intervention was performed. The patient received local anesthesia with intravenous sedation. A medial incision was made to access the affected region. Severe bone erosion and inflammation were noted, causing intense pain for the patient. Meticulous debridement of the diseased tissue and eroded bone was carried out. Hemostasis was achieved using bone substitutes and sutures. The wound was irrigated and closed in layers. The excised tissue and bone fragments were sent for pathological examination. The patient reported substantial relief from severe bone pain following the surgery.

Operative Note 50:

An unspecified soft tissue disorder with severe bone pain necessitated surgical intervention. The patient received general anesthesia with endotracheal intubation. A transverse curved incision was made to expose the affected area. Severe bone erosion and necrosis were observed, contributing to the severe pain experienced by the patient. The diseased tissue was excised with clear margins, and the eroded bone surfaces were reshaped. Hemostasis was achieved using bone wax and electrocautery. The wound was irrigated and closed layer by layer. The excised tissue and bone fragments were sent for further analysis. The patient's immediate postoperative course showed significant relief from severe bone pain.

Operative Note 51:

A surgical intervention was performed for the management of an unspecified soft tissue disorder. The patient received general anesthesia. A midline incision was made to access the affected area. Thorough exploration revealed extensive soft tissue involvement. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated and closed in layers. The excised tissue was sent for pathological examination. The patient's immediate postoperative course was unremarkable with appropriate measures taken during the surgical intervention.

Operative Note 52:

Surgical intervention was undertaken to address an unspecified soft tissue disorder. The patient received regional anesthesia. A longitudinal incision was made to expose the affected region. The diseased soft tissue was meticulously excised, ensuring negative margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was satisfactory without any immediate complications, and the surgical intervention was successful in addressing the soft tissue disorder.

Operative Note 53:

For the treatment of an unspecified soft tissue disorder, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. An oblique incision was made to expose the affected area. Thorough exploration revealed extensive involvement of the soft tissue. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for histopathological examination. The patient's immediate postoperative course was uneventful, and the surgical intervention effectively addressed the soft tissue disorder.

Operative Note 54:

Surgical intervention was carried out to address an unspecified soft tissue disorder. The patient received local anesthesia with intravenous sedation. A transverse incision was made to access the affected region. Thorough exploration revealed extensive involvement of the soft tissue. The diseased tissue was meticulously excised with clear margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was thoroughly irrigated and closed layer by layer. The excised tissue was sent for pathological examination. The patient tolerated the procedure well, and the surgical intervention successfully treated the soft tissue disorder.

Operative Note 55:

An unspecified soft tissue disorder necessitated a surgical intervention. The patient received general anesthesia with total intravenous anesthesia (TIVA). A paramedian incision was made to expose the affected area. Thorough exploration revealed extensive involvement of the soft tissue. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using sutures and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was unremarkable, and the surgical intervention effectively addressed the soft tissue disorder.

Operative Note 56:

For the management of an unspecified soft tissue disorder, a surgical intervention was performed. The patient received general anesthesia. A curvilinear incision was made to access the affected region. Thorough exploration revealed extensive involvement of the soft tissue. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated thoroughly and closed layer by layer. The excised tissue was sent for histopathological examination. The patient's immediate postoperative course was uncomplicated, and the surgical intervention effectively treated the soft tissue disorder.

Operative Note 57:

Surgical intervention was performed for the treatment of an unspecified soft tissue disorder. The patient received

regional anesthesia via nerve block. A medial incision was made to expose the affected area. Thorough exploration revealed extensive involvement of the soft tissue. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated and closed in layers. The excised tissue was sent for pathological examination. The patient's recovery was uneventful, and the surgical intervention successfully managed the soft tissue disorder.

Operative Note 58:

An unspecified soft tissue disorder necessitated a surgical intervention. The patient received general anesthesia with endotracheal intubation. A transverse curved incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for further analysis. The patient's immediate postoperative course was unremarkable, and the surgical intervention effectively treated the soft tissue disorder.

Operative Note 59:

For the management of an unspecified soft tissue disorder, a surgical intervention was performed. The patient received general anesthesia. A paramedian incision was made to access the affected region. Thorough exploration revealed extensive involvement of the soft tissue. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using sutures and electrocautery. The wound was irrigated thoroughly and closed layer by layer. The excised tissue was sent for histopathological examination. The patient's recovery was satisfactory, and the surgical intervention effectively addressed the soft tissue disorder.

Operative Note 60:

Surgical intervention was performed to address an unspecified soft tissue disorder. The patient received local anesthesia with intravenous sedation. An oblique incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for pathological examination. The patient's immediate postoperative course was uneventful, and the surgical intervention successfully treated the soft tissue disorder.

Operative Note 61:

A surgical intervention was performed to address an unspecified soft tissue disorder. The patient received general anesthesia. A midline incision was made to access the affected area. Thorough exploration revealed extensive involvement of the soft tissue with deep-seated structures. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using electrocautery and sutures. The wound was thoroughly irrigated and closed in layers. The excised tissue was sent for histopathological examination. The patient's immediate postoperative course was uneventful, and the surgical intervention effectively managed the soft tissue disorder.

Operative Note 62:

Surgical intervention was undertaken for the treatment of an unspecified soft tissue disorder. The patient received regional anesthesia. A longitudinal incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue with adjacent structures. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was satisfactory without any immediate complications, and the surgical intervention successfully addressed the soft tissue disorder.

Operative Note 63:

For the management of an unspecified soft tissue disorder, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. An oblique incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue with underlying structures. Meticulous excision of the diseased tissue was carried out, ensuring clear margins. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated thoroughly and closed layer by layer. The excised tissue was sent for histopathological examination. The patient's immediate postoperative course was unremarkable, and the surgical intervention effectively treated the soft tissue disorder.

Operative Note 64:

Surgical intervention was performed to address an unspecified soft tissue disorder. The patient received local anesthesia with intravenous sedation. A transverse incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue with surrounding structures. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for pathological examination. The patient tolerated the procedure well, and the surgical intervention successfully managed the soft tissue disorder.

Operative Note 65:

An unspecified soft tissue disorder necessitated a surgical intervention. The patient received general anesthesia with total intravenous anesthesia (TIVA). A paramedian incision was made to access the affected area. Thorough exploration revealed extensive involvement of the soft tissue with deep-seated structures. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using sutures and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was unremarkable, and the surgical intervention effectively addressed the soft tissue disorder.

Operative Note 66:

For the management of an unspecified soft tissue disorder, a surgical intervention was performed. The patient received regional anesthesia via nerve block. A medial incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue with adjacent structures. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated and closed in layers. The excised tissue was sent for histopathological examination. The

patient's recovery was uneventful, and the surgical intervention effectively managed the soft tissue disorder.

Operative Note 67:

Surgical intervention was performed to address an unspecified soft tissue disorder. The patient received general anesthesia. A curvilinear incision was made to access the affected area. Thorough exploration revealed extensive involvement of the soft tissue with underlying structures. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using electrocautery and sutures. The wound was irrigated thoroughly and closed layer by layer. The excised tissue was sent for further analysis. The patient's immediate postoperative course was uncomplicated, and the surgical intervention effectively treated the soft tissue disorder.

Operative Note 68:

An unspecified soft tissue disorder necessitated a surgical intervention. The patient received local anesthesia with intravenous sedation. A transverse curved incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue with adjacent structures. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for pathological examination. The patient's immediate postoperative course was unremarkable, and the surgical intervention effectively treated the soft tissue disorder.

Operative Note 69:

Surgical intervention was performed for the treatment of an unspecified soft tissue disorder. The patient received general anesthesia with endotracheal intubation. A paramedian incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue with deep-seated structures. Meticulous excision of the diseased tissue was performed, ensuring clear margins. Hemostasis was achieved using sutures and electrocautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for histopathological examination. The patient's recovery was satisfactory, and the surgical intervention effectively addressed the soft tissue disorder.

Operative Note 70:

For the management of an unspecified soft tissue disorder, a surgical intervention was performed. The patient received regional anesthesia. A longitudinal incision was made to expose the affected region. Thorough exploration revealed extensive involvement of the soft tissue with surrounding structures. Meticulous excision of the diseased tissue was performed, ensuring negative margins. Hemostasis was achieved using sutures and bipolar cautery. The wound was irrigated thoroughly and closed in layers. The excised tissue was sent for further analysis. The patient's recovery was uneventful, and the surgical intervention effectively managed the soft tissue disorder.

Operative Note 71:

A surgical intervention was performed for the management of an unspecified soft tissue disorder with severe infection involving the extreme moving joint. The patient received general anesthesia. An extended longitudinal incision was made to access the affected joint. Thorough exploration revealed severe infection with extensive soft tissue involvement. Meticulous debridement of the infected tissue was carried out, followed by irrigation with antibiotic solution. The joint was stabilized, and a drain was placed. The wound was closed in layers. The excised tissue was sent for microbiological analysis. Postoperatively, appropriate antibiotic therapy was initiated to manage the severe infection.

Operative Note 72:

Surgical intervention was undertaken to address an unspecified soft tissue disorder with severe infection on the extreme moving joint. The patient received regional anesthesia. A modified hockey stick incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement and purulent discharge. Extensive debridement of the infected tissue was performed, ensuring clear margins. Copious irrigation with antibiotic solution was done. The joint was stabilized, and a drain was placed. The wound was closed layer by layer. The excised tissue and drain fluid were sent for culture and sensitivity testing. The patient was started on appropriate antibiotic therapy postoperatively to manage the severe infection.

Operative Note 73:

For the management of an unspecified soft tissue disorder with severe infection on the extreme moving joint, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with abscess formation. Meticulous debridement of the infected tissue was performed, ensuring negative margins. The joint was irrigated with antibiotic solution. Drainage was achieved, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for microbiological analysis. The patient received appropriate antibiotic therapy to manage the severe infection.

Operative Note 74:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe infection on the extreme moving joint. The patient received local anesthesia with intravenous sedation. An oblique incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with pus formation. Meticulous debridement of the infected tissue was performed, ensuring clear margins. Copious irrigation with antibiotic solution was carried out. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for culture and sensitivity testing. Postoperatively, the patient received appropriate antibiotic therapy to manage the severe infection.

Operative Note 75:

An unspecified soft tissue disorder with severe infection on the extreme moving joint necessitated a surgical intervention. The patient received general anesthesia with total intravenous anesthesia (TIVA). A transverse incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement with purulent discharge. Meticulous debridement of the infected tissue was performed, ensuring negative margins. The joint was irrigated with antibiotic solution. A drain was placed to facilitate drainage. The wound was closed layer by layer. The excised tissue and drain fluid were sent for microbiological analysis. The patient was started on appropriate antibiotic therapy postoperatively to manage the severe infection.

Operative Note 76:

For the management of an unspecified soft tissue disorder with severe infection on the extreme moving joint, a surgical intervention was performed. The patient received regional anesthesia via nerve block. A medial incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with abscess formation. Meticulous debridement of the infected tissue was carried out, ensuring clear margins. The joint was thoroughly irrigated

with antibiotic solution. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for culture and sensitivity testing. The patient received appropriate antibiotic therapy to manage the severe infection.

Operative Note 77:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe infection on the extreme moving joint. The patient received general anesthesia. A paramedian incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with purulent discharge. Meticulous debridement of the infected tissue was performed, ensuring negative margins. The joint was irrigated thoroughly with antibiotic solution. A drain was placed for drainage. The wound was closed layer by layer. The excised tissue and drain fluid were sent for microbiological analysis. The patient was started on appropriate antibiotic therapy postoperatively to manage the severe infection.

Operative Note 78:

An unspecified soft tissue disorder with severe infection on the extreme moving joint necessitated a surgical intervention. The patient received local anesthesia with intravenous sedation. A transverse curved incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with pus formation. Meticulous debridement of the infected tissue was performed, ensuring clear margins. The joint was irrigated with antibiotic solution. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for culture and sensitivity testing. Postoperatively, the patient received appropriate antibiotic therapy to manage the severe infection.

Operative Note 79:

For the management of an unspecified soft tissue disorder with severe infection on the extreme moving joint, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. An oblique incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with abscess formation. Meticulous debridement of the infected tissue was performed, ensuring negative margins. The joint was thoroughly irrigated with antibiotic solution. A drain was placed to facilitate drainage. The wound was closed in layers. The excised tissue and drain fluid were sent for culture and sensitivity testing. The patient was started on appropriate antibiotic therapy postoperatively to manage the severe infection.

Operative Note 80:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe infection on the extreme moving joint. The patient received local anesthesia with intravenous sedation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with purulent discharge. Meticulous debridement of the infected tissue was performed, ensuring clear margins. The joint was irrigated thoroughly with antibiotic solution. A drain was placed for adequate drainage. The wound was closed in layers. The excised tissue and drain fluid were sent for microbiological analysis. The patient received appropriate antibiotic therapy to manage the severe infection.

Operative Note 81:

A surgical intervention was performed for the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received general anesthesia. An extended longitudinal incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was carried out, followed by irrigation with anti-inflammatory solution. The joint was stabilized, and a drain was placed. The wound was closed in layers. The excised tissue was sent for further analysis. Postoperatively, appropriate anti-inflammatory therapy was initiated to manage the severe inflammation.

Operative Note 82:

Surgical intervention was undertaken to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received regional anesthesia. A modified hockey stick incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with significant inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. Copious irrigation with anti-inflammatory solution was done. The joint was stabilized, and a drain was placed. The wound was closed layer by layer. The excised tissue and drain fluid were sent for further analysis. The patient was started on appropriate anti-inflammatory therapy postoperatively to manage the severe inflammation.

Operative Note 83:

For the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring negative margins. The joint was irrigated with anti-inflammatory solution. Drainage was achieved, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient received appropriate anti-inflammatory therapy to manage the severe inflammation.

Operative Note 84:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received local anesthesia with intravenous sedation. An oblique incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with significant inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. Copious irrigation with anti-inflammatory solution was carried out. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. Postoperatively, the patient received appropriate anti-inflammatory therapy to manage the severe inflammation.

Operative Note 85:

An unspecified soft tissue disorder with severe inflammation on the extreme moving joint necessitated a surgical intervention. The patient received general anesthesia with total intravenous anesthesia (TIVA). A transverse incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. The joint was irrigated with anti-inflammatory solution. A drain was placed to facilitate drainage. The wound was closed layer by layer. The excised tissue and drain fluid were sent for further analysis. The patient was started on appropriate anti-inflammatory therapy postoperatively to manage the severe inflammation.

Operative Note 86:

For the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint, a surgical intervention was performed. The patient received regional anesthesia via nerve block. A medial incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with significant inflammation. Meticulous debridement of the inflamed tissue was carried out, ensuring clear margins.

The joint was thoroughly irrigated with anti-inflammatory solution. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient received appropriate anti-inflammatory therapy to manage the severe inflammation.

Operative Note 87:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received general anesthesia. A paramedian incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring negative margins. The joint was irrigated thoroughly with anti-inflammatory solution. A drain was placed for adequate drainage. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient received appropriate anti-inflammatory therapy to manage the severe inflammation.

Operative Note 88:

An unspecified soft tissue disorder with severe inflammation on the extreme moving joint necessitated a surgical intervention. The patient received local anesthesia with intravenous sedation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with significant inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. The joint was irrigated thoroughly with anti-inflammatory solution. A drain was placed for adequate drainage. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient received appropriate anti-inflammatory therapy to manage the severe inflammation.

Operative Note 89:

For the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. An oblique incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring negative margins. The joint was irrigated with anti-inflammatory solution. Drainage was achieved, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient received appropriate anti-inflammatory therapy to manage the severe inflammation.

Operative Note 90:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received local anesthesia with intravenous sedation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. The joint was irrigated thoroughly with anti-inflammatory solution. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. Postoperatively, the patient received appropriate anti-inflammatory therapy to manage the severe inflammation.

Operative Note 91:

A surgical intervention was performed for the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received general anesthesia. An extended longitudinal incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was carried out, followed by irrigation with anti-inflammatory solution. The joint was stabilized, and a drain was placed. The wound was closed in layers. The excised tissue was sent for further analysis. Postoperatively, the patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 92:

Surgical intervention was undertaken to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received regional anesthesia. A modified hockey stick incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with significant inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. Copious irrigation with anti-inflammatory solution was done. The joint was stabilized, and a drain was placed. The wound was closed layer by layer. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 93:

For the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring negative margins. The joint was irrigated with anti-inflammatory solution. Drainage was achieved, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 94:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received local anesthesia with intravenous sedation. An oblique incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with significant inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. Copious irrigation with anti-inflammatory solution was carried out. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 95:

An unspecified soft tissue disorder with severe inflammation on the extreme moving joint necessitated a surgical intervention. The patient received general anesthesia with total intravenous anesthesia (TIVA). A transverse incision was made to access the affected joint. Thorough exploration revealed significant soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. The joint was irrigated with anti-inflammatory solution. A drain was placed to facilitate drainage. The wound was closed layer by layer. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 96:

For the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint, a surgical intervention was performed. The patient received regional anesthesia via nerve block. A medial incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with significant inflammation. Meticulous debridement of

the inflamed tissue was carried out, ensuring clear margins. The joint was thoroughly irrigated with anti-inflammatory solution. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 97:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received local anesthesia with intravenous sedation. A paramedian incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring negative margins. The joint was irrigated thoroughly with anti-inflammatory solution. A drain was placed for adequate drainage. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 98:

An unspecified soft tissue disorder with severe inflammation on the extreme moving joint necessitated a surgical intervention. The patient received local anesthesia with intravenous sedation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. The joint was irrigated thoroughly with anti-inflammatory solution. A drain was placed for adequate drainage. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 99:

For the management of an unspecified soft tissue disorder with severe inflammation on the extreme moving joint, a surgical intervention was performed. The patient received general anesthesia with endotracheal intubation. An oblique incision was made to expose the affected joint. Thorough exploration revealed extensive soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring negative margins. The joint was irrigated with anti-inflammatory solution. Drainage was achieved, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. The patient's follow-up will depend on the severity of the diagnosis and response to treatment.

Operative Note 100:

Surgical intervention was performed to address an unspecified soft tissue disorder with severe inflammation on the extreme moving joint. The patient received local anesthesia with intravenous sedation. A curvilinear incision was made to access the affected joint. Thorough exploration revealed extensive soft tissue involvement with marked inflammation. Meticulous debridement of the inflamed tissue was performed, ensuring clear margins. The joint was irrigated thoroughly with anti-inflammatory solution. Drainage was established, and a drain was placed. The wound was closed in layers. The excised tissue and drain fluid were sent for further analysis. Postoperatively, the patient's follow-up will depend on the severity of the diagnosis and response to treatment.

## M71.0 Abscess of bursa

Operative Note 1:

Patient presented with a bursa abscess in the left elbow. After administration of general anesthesia, a curvilinear incision was made over the affected area. The abscess cavity was identified, drained, and thoroughly irrigated with sterile saline. Necrotic tissue was debrided, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. Postoperative instructions regarding wound care and antibiotic therapy were provided to the patient.

Operative Note 2:

An abscess of the prepatellar bursa was diagnosed in the right knee. Under sterile conditions, a midline incision was made, and the abscess cavity was identified. Pus was drained, and copious irrigation with normal saline was performed. Any necrotic tissue was meticulously debrided, and a closed suction drain was inserted. The wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and advised on wound care and follow-up appointments.

Operative Note 3:

A bursa abscess was identified in the left shoulder region. After appropriate anesthesia was administered, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Debridement of necrotic tissue was performed, and a closed suction drain was inserted. The wound was closed using absorbable sutures in layers. The patient received postoperative instructions regarding wound care and was prescribed a course of antibiotics.

Operative Note 4:

The patient presented with a bursa abscess in the right hip. After obtaining informed consent and administering anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Necrotic tissue was debrided, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care and prescribed a suitable antibiotic regimen.

Operative Note 5:

A bursa abscess was diagnosed in the left ankle region. Under sterile conditions and adequate anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Debridement of necrotic tissue was carried out, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care and provided with a prescription for antibiotics.

Operative Note 6:

A bursa abscess was identified in the right hand. After administering anesthesia, a transverse incision was made over the abscess site. Pus was drained, and the cavity was irrigated using sterile saline. Necrotic tissue was debrided, and a closed suction drain was inserted. The wound was closed meticulously using absorbable sutures. Postoperative instructions regarding wound care and a course of antibiotics were provided to the patient.

Operative Note 7:

Patient presented with a bursa abscess in the left heel. After appropriate anesthesia was administered, an elliptical incision was made over the abscess. The abscess was drained, and the cavity was thoroughly irrigated with sterile saline. Debridement of necrotic tissue was performed, and a closed suction drain was inserted. The wound was closed in layers using absorbable sutures. The patient was advised on postoperative wound care and prescribed antibiotics.

Operative Note 8:

An abscess of the olecranon bursa was diagnosed in the right elbow. Under sterile conditions, a curved incision was made, and the abscess was identified. Pus was drained, and extensive irrigation with normal saline was

performed. Debridement of necrotic tissue was carried out, and a closed suction drain was inserted. The wound was closed in layers using interrupted non-absorbable sutures. The patient was given instructions on postoperative wound care and prescribed antibiotics.

Operative Note 9:

A bursa abscess was found in the right knee. After appropriate anesthesia, a vertical incision was made over the abscess. Drainage of pus was achieved, and the abscess cavity was irrigated with sterile saline. Necrotic tissue was debrided, and a closed suction drain was placed. The wound was meticulously closed in layers using absorbable sutures. The patient was provided with postoperative instructions regarding wound care and prescribed a suitable antibiotic regimen.

Operative Note 10:

Patient presented with a bursa abscess in the left wrist. After administration of anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was debrided, and a closed suction drain was inserted. The wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care and prescribed a course of antibiotics.

Operative Note 11:

A bursa abscess was diagnosed in the right scapular region. After obtaining informed consent and administering anesthesia, an incision was made over the abscess. Pus was drained, and thorough irrigation with sterile saline was carried out. Necrotic tissue was debrided, and a closed suction drain was placed. The wound was closed meticulously using absorbable sutures. The patient received postoperative instructions regarding wound care and was prescribed a suitable antibiotic regimen.

Operative Note 12:

A bursa abscess was identified in the left thigh. Under sterile conditions and adequate anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Debridement of necrotic tissue was carried out, and a closed suction drain was inserted. The wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care and provided with a prescription for antibiotics.

Operative Note 13:

Patient presented with a bursa abscess in the right shoulder region. After appropriate anesthesia was administered, a curvilinear incision was made over the abscess. The abscess was drained, and the cavity was thoroughly irrigated with sterile saline. Debridement of necrotic tissue was performed, and a closed suction drain was inserted. The wound was closed meticulously using absorbable sutures. Postoperatively, the patient was given instructions on wound care and prescribed antibiotics.

Operative Note 14:

An abscess of the ischial bursa was diagnosed in the left buttock. Under sterile conditions, an incision was made, and the abscess was identified. Pus was drained, and extensive irrigation with normal saline was performed. Necrotic tissue was debrided, and a closed suction drain was inserted. The wound was closed in layers using interrupted non-absorbable sutures. The patient was given instructions on postoperative wound care and prescribed antibiotics.

Operative Note 15:

A bursa abscess was identified in the right ankle region. After obtaining informed consent and administering anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Necrotic tissue was meticulously debrided, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care and prescribed a course of antibiotics.

Operative Note 16:

A bursa abscess was diagnosed in the left hip. After appropriate anesthesia was administered, a transverse incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Debridement of necrotic tissue was performed, and a closed suction drain was inserted. The wound was closed using absorbable sutures in layers. Postoperative instructions regarding wound care and a course of antibiotics were provided to the patient.

Operative Note 17:

Patient presented with a bursa abscess in the right wrist. After administering anesthesia, an elliptical incision was made over the abscess. The abscess was drained, and the cavity was thoroughly irrigated with sterile saline. Debridement of necrotic tissue was performed, and a closed suction drain was inserted. The wound was closed in layers using absorbable sutures. The patient was advised on postoperative wound care and prescribed antibiotics.

Operative Note 18:

An abscess of the subacromial bursa was diagnosed in the left shoulder. Under sterile conditions, a curved incision was made, and the abscess was identified. Pus was drained, and extensive irrigation with normal saline was performed. Necrotic tissue

was debrided, and a closed suction drain was inserted. The wound was closed in layers using interrupted non-absorbable sutures. The patient was given instructions on postoperative wound care and prescribed antibiotics.

Operative Note 19:

A bursa abscess was identified in the right hand. After obtaining informed consent and administering anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Debridement of necrotic tissue was carried out, and a closed suction drain was inserted. The wound was closed meticulously using absorbable sutures. The patient received postoperative instructions regarding wound care and was prescribed a suitable antibiotic regimen.

Operative Note 20:

Patient presented with a bursa abscess in the left patellar region. After appropriate anesthesia was administered, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was debrided, and a closed suction drain was inserted. The wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care and prescribed a course of antibiotics.

Operative Note 21:

Patient presented with a bursa abscess in the left elbow. After administering local anesthesia, a curvilinear incision was made over the affected area. The abscess cavity was identified, drained, and thoroughly irrigated with sterile saline. Necrotic tissue was debrided, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. Postoperative instructions regarding wound care and antibiotic therapy were provided to the patient.

Operative Note 22:

An abscess of the prepatellar bursa was diagnosed in the right knee. Under regional anesthesia, a midline incision was made, and the abscess cavity was identified. Pus was drained, and copious irrigation with normal saline was performed. Any necrotic tissue was meticulously debrided, and a closed suction drain was inserted. The wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and advised on wound care and follow-up appointments.

Operative Note 23:

A bursa abscess was identified in the left shoulder region. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Debridement of necrotic tissue was performed, and a closed suction drain was inserted. The wound was closed using absorbable sutures in layers. The patient received postoperative instructions regarding wound care and was prescribed a suitable antibiotic regimen.

Operative Note 24:

The patient presented with a bursa abscess in the right hip. After obtaining informed consent and administering general anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Necrotic tissue was debrided, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care and prescribed a suitable antibiotic regimen.

Operative Note 25:

A bursa abscess was diagnosed in the left ankle region. Under local anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Debridement of necrotic tissue was carried out, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care and provided with a prescription for antibiotics.

Operative Note 26:

A bursa abscess was found in the right hand. After administering regional anesthesia, a transverse incision was made over the abscess site. Pus was drained, and the cavity was irrigated using sterile saline. Necrotic tissue was debrided, and a closed suction drain was inserted. The wound was closed meticulously using absorbable sutures. Postoperative instructions regarding wound care and a course of antibiotics were provided to the patient.

Operative Note 27:

Patient presented with a bursa abscess in the left heel. After administering local anesthesia, an elliptical incision was made over the abscess. The abscess was drained, and the cavity was thoroughly irrigated with sterile saline. Debridement of necrotic tissue was performed, and a closed suction drain was inserted. The wound was closed in layers using absorbable sutures. The patient was advised on postoperative wound care and prescribed antibiotics.

Operative Note 28:

An abscess of the olecranon bursa was diagnosed in the right elbow. Under regional anesthesia, a curved incision was made, and the abscess was identified. Pus was drained, and extensive irrigation with normal saline was performed. Necrot

ic tissue was debrided, and a closed suction drain was inserted. The wound was closed in layers using interrupted non-absorbable sutures. The patient was given instructions on postoperative wound care and prescribed antibiotics.

Operative Note 29:

A bursa abscess was identified in the right knee. After obtaining informed consent and administering general anesthesia, a vertical incision was made over the abscess. Drainage of pus was achieved, and the abscess cavity was irrigated with sterile saline. Necrotic tissue was meticulously debrided, and a closed suction drain was placed. The wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care and prescribed a suitable antibiotic regimen.

Operative Note 30:

Patient presented with a bursa abscess in the left wrist. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was performed. Necrotic tissue was debrided, and a closed suction drain was inserted. The wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care and prescribed a course of antibiotics.

Operative Note 31:

A bursa abscess with bone erosion was identified in the left shoulder region. After administering general anesthesia, a curvilinear incision was made over the affected area. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue and bone erosion was carried out. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. Postoperative instructions regarding wound care, antibiotic therapy, and appropriate management of bone erosion were provided to the patient.

Operative Note 32:

An abscess of the prepatellar bursa with bone erosion was diagnosed in the right knee. Under regional anesthesia, a midline incision was made, and the abscess cavity was identified. Pus was drained, and copious irrigation with normal saline was performed. Extensive debridement of necrotic tissue and bone erosion was carried out. A closed suction drain was inserted, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and advised on wound care, as well as appropriate measures for managing bone erosion.

Operative Note 33:

A bursa abscess with bone erosion was identified in the left elbow. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Extensive debridement of necrotic tissue and bone erosion was performed. A closed suction drain was inserted, and the wound was closed using absorbable sutures in layers. The patient received postoperative instructions regarding wound care, antibiotic therapy, and management of bone erosion.

Operative Note 34:

The patient presented with a bursa abscess with bone erosion in the right hip. After obtaining informed consent and administering general anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Extensive debridement of necrotic tissue and bone erosion was performed. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care, prescribed a suitable antibiotic regimen, and provided with appropriate measures for managing bone erosion.

Operative Note 35:

A bursa abscess with bone erosion was diagnosed in the left ankle region. Under local anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue and bone erosion was carried out. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care, prescribed antibiotics, and provided with appropriate measures for managing bone erosion.

Operative Note 36:

A bursa abscess with bone erosion was found in the right hand. After administering regional anesthesia, a transverse incision was made over the abscess site. Pus was drained, and the cavity was irrigated using sterile saline. Extensive debridement of necrotic tissue and bone erosion was performed. A closed suction drain was inserted, and the wound was closed meticulously using absorbable sutures. Postoperative instructions regarding wound care, antibiotic therapy, and management of bone erosion were provided to the patient.

Operative Note 37:

Patient presented with a bursa abscess with bone erosion in the left heel. After administering local anesthesia, an elliptical incision was made over the abscess. The abscess was drained, and the cavity was thoroughly irrigated with sterile saline. Extensive debridement of necrotic tissue

and bone erosion was performed. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. The patient was advised on postoperative wound care, prescribed antibiotics, and provided with appropriate measures for managing bone erosion.

Operative Note 38:

An abscess of the olecranon bursa with bone erosion was diagnosed in the right elbow. Under regional anesthesia, a curved incision was made, and the abscess was identified. Pus was drained, and extensive irrigation with normal saline was performed. Extensive debridement of necrotic tissue and bone erosion was carried out. A closed suction drain was inserted, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was given instructions on postoperative wound care, prescribed antibiotics, and provided with appropriate measures for managing bone erosion.

Operative Note 39:

A bursa abscess with bone erosion was identified in the right knee. After obtaining informed consent and administering general anesthesia, a vertical incision was made over the abscess. Drainage of pus was achieved, and the abscess cavity was irrigated with sterile saline. Extensive debridement of necrotic tissue and bone erosion was performed. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care, prescribed a suitable antibiotic regimen, and provided with appropriate measures for managing bone erosion.

Operative Note 40:

Patient presented with a bursa abscess with bone erosion in the left wrist. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue and bone erosion was carried out. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care, prescribed a course of antibiotics, and provided with appropriate measures for managing bone erosion.

Operative Note 41:

A bursa abscess with severe bone pain was identified in the left shoulder region. After administering general anesthesia, a curvilinear incision was made over the affected area. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was managed intraoperatively with appropriate analgesics. Postoperative instructions regarding wound care, antibiotic therapy, and pain management were provided.

Operative Note 42:

An abscess of the prepatellar bursa with severe bone pain was diagnosed in the right knee. Under regional anesthesia, a midline incision was made, and the abscess cavity was identified. Pus was drained, and copious irrigation with normal saline was performed. Extensive debridement of necrotic tissue was carried out. A closed suction drain was inserted, and the wound was closed in layers using interrupted non-absorbable sutures. Intraoperative measures were taken to manage the patient's severe bone pain. The patient was prescribed postoperative antibiotics and given instructions on wound care and pain management.

Operative Note 43:

A bursa abscess with severe bone pain was identified in the left elbow. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Extensive debridement of necrotic tissue was performed. A closed suction drain was inserted, and the wound was closed using absorbable sutures in layers. The patient's severe bone pain was effectively managed with appropriate analgesics during the procedure. Postoperative instructions regarding wound care, antibiotic therapy, and pain management were provided.

Operative Note 44:

The patient presented with a bursa abscess with severe bone pain in the right hip. After obtaining informed consent and administering general anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Extensive debridement of necrotic tissue was performed. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. Intraoperative measures were taken to manage the patient's severe bone pain. Postoperatively, the patient was given instructions on wound care, prescribed a suitable antibiotic regimen, and provided with appropriate pain management options.

Operative Note 45:

A bursa abscess with severe bone pain was diagnosed in the left ankle region. Under local anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics during the procedure. Postoperatively, the patient was given instructions on wound care, prescribed antibiotics, and provided with pain management strategies.

Operative Note 46:

A bursa abscess with severe bone pain was found in the right hand. After administering regional anesthesia, a transverse incision was made over the abscess site. Pus was drained, and the cavity was irrigated using sterile saline. Extensive debridement of necrotic tissue was performed. A closed suction drain was inserted, and the wound was closed meticulously using absorbable sutures. Intraoperatively, measures were taken to manage the patient's severe bone pain. Postoperative instructions regarding wound care, antibiotic therapy, and pain management were provided to the patient

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Operative Note 47:

Patient presented with a bursa abscess with severe bone pain in the left heel. After administering local anesthesia, an elliptical incision was made over the abscess. The abscess was drained, and the cavity was thoroughly irrigated with sterile saline. Extensive debridement of necrotic tissue was performed. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics intraoperatively. Postoperatively, the patient received instructions on wound care, prescribed antibiotics, and provided with pain management options.

Operative Note 48:

An abscess of the olecranon bursa with severe bone pain was diagnosed in the right elbow. Under regional anesthesia, a curved incision was made, and the abscess was identified. Pus was drained, and extensive irrigation with normal saline was performed. Extensive debridement of necrotic tissue was carried out. A closed suction drain was inserted, and the wound was closed in layers using interrupted non-absorbable sutures. Intraoperative measures were taken to manage the patient's severe bone pain. The patient was given instructions on postoperative wound care, prescribed antibiotics, and provided with pain management strategies.

Operative Note 49:

A bursa abscess with severe bone pain was identified in the right knee. After obtaining informed consent and administering general anesthesia, a vertical incision was made over the abscess. Drainage of pus was achieved, and the abscess cavity was irrigated with sterile saline. Extensive debridement of necrotic tissue was performed. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. Intraoperative measures were taken to manage the patient's severe bone pain. The patient was given postoperative instructions on wound care, prescribed a suitable antibiotic regimen, and provided with pain management options.

Operative Note 50:

Patient presented with a bursa abscess with severe bone pain in the left wrist. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. Intraoperatively, the patient's severe bone pain was effectively managed with appropriate analgesics. Postoperatively, the patient was given instructions on wound care, prescribed a course of antibiotics, and provided with pain management strategies.

Operative Note 51:

A bursa abscess with severe bone pain was identified in the left shoulder region. After administering general anesthesia, a curvilinear incision was made over the affected area. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics. Postoperative instructions regarding wound care, antibiotic therapy, and pain management were provided.

Operative Note 52:

An abscess of the prepatellar bursa with severe bone pain was diagnosed in the right knee. Under regional anesthesia, a midline incision was made, and the abscess cavity was identified. Pus was drained, and copious irrigation with normal saline was performed. Extensive debridement of necrotic tissue was carried out. During the procedure, a surgical intervention was performed to address the underlying cause of the abscess and alleviate the severe bone pain. A closed suction drain was inserted, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 53:

A bursa abscess with severe bone pain was identified in the left elbow. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and alleviate the severe bone pain. A closed suction drain was inserted, and the wound was closed using absorbable sutures in layers. The patient received postoperative instructions regarding wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 54:

The patient presented with a bursa abscess with severe bone pain in the right hip. After obtaining informed consent and administering general anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was undertaken to address the underlying cause of the abscess and relieve the severe bone pain. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care, prescribed a suitable antibiotic regimen, and provided with pain management options and rehabilitation plan.

Operative Note 55:

A bursa abscess with severe bone pain was diagnosed in the left ankle region. Under local anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and alleviate the severe bone pain. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics. Postoperatively, the patient was given instructions on wound care, prescribed antibiotics, and provided with pain management strategies and rehabilitation guidance.

Operative Note 56:

A bursa abscess with severe bone pain was found in the right hand. After administering regional anesthesia, a transverse incision was made over the abscess site. Pus was drained, and the cavity was irrigated using sterile saline. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and alleviate the severe bone pain. A closed suction drain was inserted, and the wound was closed meticulously using absorbable sutures. Postoperatively, the patient received instructions on wound care, antibiotic therapy, pain management, and rehabilitation to ensure optimal recovery.

Operative Note 57:

A bursa abscess with severe bone pain was identified in the right knee. Under regional anesthesia, a vertical incision was made over the abscess. Pus was drained, and extensive irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and alleviate the severe bone pain. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. The patient was given postoperative instructions on wound care, prescribed a suitable antibiotic regimen, and provided with pain management options and rehabilitation recommendations.

Operative Note 58:

Patient presented with a bursa abscess with severe bone pain in the left wrist. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and alleviate the severe bone pain. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. Intraoperative measures were taken to ensure adequate pain control. Postoperatively, the patient was given instructions on wound care, prescribed a course of antibiotics, and provided with pain management strategies and rehabilitation guidance.

Operative Note 59:

A bursa abscess with severe bone pain was identified in the right hip joint. After obtaining informed consent and administering general anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was undertaken to address the underlying cause of the abscess and relieve the severe bone pain. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. The patient was provided with postoperative instructions regarding wound care, prescribed appropriate antibiotic therapy, and given pain management strategies and rehabilitation recommendations.

Operative Note 60:

A bursa abscess with severe bone pain was diagnosed in the left ankle. After administering regional anesthesia, an incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and alleviate the severe bone pain. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics. Postoperatively, the patient was given instructions on wound care, prescribed antibiotics, and provided with pain management strategies and rehabilitation guidance.

Operative Note 61:

A bursa abscess with severe bone pain was identified in the right shoulder region. After obtaining informed consent and administering general anesthesia, a curvilinear incision was made over the affected area. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess. Bone erosion was observed and addressed during the procedure. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics. Postoperative instructions regarding wound care, antibiotic therapy, and pain management were provided.

Operative Note 62:

An abscess of the prepatellar bursa with severe bone pain was diagnosed in the left knee. Under regional anesthesia, a midline incision was made, and the abscess cavity was identified. Pus was drained, and copious irrigation with normal saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and manage the bone erosion. A closed suction drain was inserted, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 63:

A bursa abscess with severe bone pain was identified in the left elbow. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess and manage the bone erosion. A closed suction drain was inserted, and the wound was closed using absorbable sutures in layers. The patient received postoperative instructions regarding wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 64:

The patient presented with a bursa abscess with severe bone pain and significant bone erosion in the right hip. After obtaining informed consent and administering general anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was undertaken to address the underlying cause of the abscess, manage the bone erosion, and restore stability. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care, prescribed a suitable antibiotic regimen, and provided with pain management options and rehabilitation plan.

Operative Note 65:

A bursa abscess with severe bone pain was diagnosed in the left ankle region. Under local anesthesia, an incision was made to access the abscess. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess, manage the bone erosion, and stabilize the joint. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics. Postoperatively, the patient was given instructions on wound care, prescribed antibiotics, and provided with pain management strategies and rehabilitation guidance.

Operative Note 66:

A bursa abscess with severe bone pain was found in the right hand. After administering regional anesthesia, a transverse incision was made over the abscess site. Pus was drained, and the cavity was irrigated using sterile saline. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess, manage the bone erosion, and restore normal hand function. A closed suction drain was inserted, and the wound was closed meticulously using absorbable sutures. Postoperatively, the patient received instructions on wound care, antibiotic therapy, pain management, and rehabilitation to ensure optimal recovery.

Operative Note 67:

A bursa abscess with severe bone pain was identified in the left shoulder region. Under regional anesthesia, a curvilinear incision was made over the affected area. The abscess cavity was drained, and thorough irrigation with sterile saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess, manage the bone erosion, and restore stability and range of motion. A closed suction drain was inserted, and the wound was closed in layers using absorbable sutures. The patient's severe bone pain was effectively managed with appropriate analgesics. Postoperative instructions regarding wound care, antibiotic therapy, pain management, and rehabilitation were provided.

Operative Note 68:

An abscess of the prepatellar bursa with severe bone pain was diagnosed in the right knee. Under regional anesthesia, a midline incision was made, and the abscess cavity was identified. Pus was drained, and copious irrigation with normal saline was performed. Extensive debridement of necrotic tissue was carried out. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess, manage the bone erosion, and reconstruct the damaged structures. A closed suction drain was inserted, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 69:

A bursa abscess with severe bone pain was identified in the left elbow. After administering regional anesthesia, an oblique incision was made over the abscess. The abscess was drained, and thorough irrigation with sterile saline was carried out. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the underlying cause of the abscess, manage the bone erosion, and restore normal joint function. A closed suction drain was inserted, and the wound was closed using absorbable sutures in layers. The patient received postoperative instructions regarding wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 70:

The patient presented with a bursa abscess with severe bone pain and significant bone erosion in the right hip. After obtaining informed consent and administering general anesthesia, an incision was made over the abscess. Drainage of pus was achieved, followed by extensive irrigation with sterile saline. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was undertaken to address the underlying cause of the abscess, manage the bone erosion, and restore stability. A closed suction drain was placed, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was given instructions on wound care, prescribed a suitable antibiotic regimen, and provided with pain management options and rehabilitation plan.

Operative Note 71:

The patient presented with a severe infection in the right shoulder joint, causing extreme pain and limited range of motion. After obtaining informed consent and administering general anesthesia, a curvilinear incision was made over the affected area. The infected joint was thoroughly irrigated with antimicrobial solution, and the abscess was drained. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the underlying infection and restore joint function. Antibiotic beads were placed, and the wound was closed in layers using absorbable sutures. Postoperative instructions were provided, including wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 72:

A severe infection with extreme joint involvement was identified in the left knee. Under regional anesthesia, a midline incision was made, and the infected joint was exposed. The joint was thoroughly irrigated with antibiotic solution, and pus was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint stability. Antibiotic-impregnated cement was used, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 73:

The patient presented with a severe infection in the right elbow joint, causing extreme pain and restricted movement. After administering regional anesthesia, an oblique incision was made over the infected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed using absorbable sutures in layers. Postoperative instructions were provided, including wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 74:

A severe infection with extreme joint involvement was diagnosed in the right hip joint. After obtaining informed consent and administering general anesthesia, an incision was made over the infected joint. Thorough irrigation with antimicrobial solution was performed, and pus was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was undertaken to address the severe infection and restore joint stability. Antibiotic-impregnated cement was utilized, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was prescribed antibiotics and provided with instructions on wound care, pain management, and rehabilitation.

Operative Note 75:

A severe infection with extreme joint involvement was identified in the left ankle joint. Under regional anesthesia, an incision was made to access the infected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient received instructions on wound care, prescribed antibiotics, and provided with pain management strategies and rehabilitation guidance.

Operative Note 76:

A severe infection with extreme joint involvement was diagnosed in the right wrist joint. After administering regional anesthesia, a transverse incision was made over the infected joint. The joint was thoroughly irrigated with antimicrobial solution, and pus was drained. Extensive debridement of necrotic tissue and infected b

ursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint stability. Antibiotic-impregnated cement was used, and the wound was closed meticulously using absorbable sutures. Postoperatively, the patient received instructions on wound care, antibiotic therapy, pain management, and rehabilitation to ensure optimal recovery.

Operative Note 77:

A severe infection with extreme joint involvement was identified in the left shoulder joint. After obtaining informed consent and administering general anesthesia, a curvilinear incision was made over the affected area. The infected joint was thoroughly irrigated with antimicrobial solution, and the abscess was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed in layers using absorbable sutures. The patient's extreme pain was effectively managed with appropriate analgesics. Postoperative instructions regarding wound care, antibiotic therapy, pain management, and rehabilitation were provided.

Operative Note 78:

A severe infection with extreme joint involvement was diagnosed in the right knee joint. Under regional anesthesia, a midline incision was made, and the infected joint was exposed. The joint was thoroughly irrigated with antibiotic solution, and pus was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint stability. Antibiotic-impregnated cement was used, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 79:

The patient presented with a severe infection in the right elbow joint, causing extreme pain and limited mobility. After administering regional anesthesia, an oblique incision was made over the infected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed using absorbable sutures in layers. The patient received postoperative instructions regarding wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 80:

A severe infection with extreme joint involvement was identified in the left hip joint. After obtaining informed consent and administering general anesthesia, an incision was made over the infected joint. Thorough irrigation with antimicrobial solution was performed, and pus was drained. Extensive debridement of necrotic tissue and infected bursa were carried out. Intraoperatively, a surgical intervention was undertaken to address the severe infection and restore joint stability. Antibiotic-impregnated cement was utilized, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was prescribed antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 81:

The patient presented with a severe infection and intense inflammatory response in the right shoulder joint, causing extreme pain and limited range of motion. After obtaining informed consent and administering general anesthesia, a curvilinear incision was made over the affected area. The inflamed joint was thoroughly irrigated with anti-inflammatory solution, and the abscess was drained. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed in layers using absorbable sutures. Postoperative instructions were provided, including wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 82:

A severe infection with intense inflammatory response was identified in the left knee joint. Under regional anesthesia, a midline incision was made, and the inflamed joint was exposed. The joint was thoroughly irrigated with anti-inflammatory solution, and pus was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint stability. Antibiotic-impregnated cement was used, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 83:

The patient presented with a severe infection and significant inflammation in the right elbow joint. After administering regional anesthesia, an oblique incision was made over the inflamed joint. Thorough irrigation with anti-inflammatory solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed using absorbable sutures in layers. Postoperative instructions were provided, including wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 84:

A severe infection with intense inflammation was diagnosed in the left hip joint. After obtaining informed consent and administering general anesthesia, an incision was made over the inflamed joint. Thorough irrigation with anti-inflammatory solution was performed, and pus was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was undertaken to address the severe infection, manage the inflammation, and restore joint stability. Antibiotic-impregnated cement was utilized, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was prescribed antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 85:

A severe infection with intense inflammatory response was identified in the left ankle joint. Under regional anesthesia, an incision was made to access the inflamed joint. Thorough irrigation with anti-inflammatory solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient received instructions on wound care, prescribed antibiotics, and provided with pain management strategies and rehabilitation guidance.

Operative Note 86:

A severe infection with intense inflammation was identified in the right wrist joint. After administering regional anesthesia, a transverse inc

ision was made over the inflamed joint. The joint was thoroughly irrigated with anti-inflammatory solution, and pus was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint stability. Antibiotic-impregnated cement was used, and the wound was closed meticulously using absorbable sutures. Postoperatively, the patient received instructions on wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 87:

The patient presented with a severe infection and intense inflammatory response in the right shoulder joint, causing extreme pain and limited mobility. After obtaining informed consent and administering general anesthesia, a curvilinear incision was made over the affected area. The inflamed joint was thoroughly irrigated with anti-inflammatory solution, and the abscess was drained. Extensive debridement of necrotic tissue was performed. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed in layers using absorbable sutures. The patient's extreme pain was effectively managed with appropriate analgesics. Postoperative instructions regarding wound care, antibiotic therapy, pain management, and rehabilitation were provided.

Operative Note 88:

A severe infection with intense inflammatory response was diagnosed in the left knee joint. Under regional anesthesia, a midline incision was made, and the inflamed joint was exposed. The joint was thoroughly irrigated with anti-inflammatory solution, and pus was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint stability. Antibiotic-impregnated cement was used, and the wound was closed in layers using interrupted non-absorbable sutures. The patient was prescribed postoperative antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 89:

The patient presented with a severe infection and significant inflammation in the right elbow joint. After administering regional anesthesia, an oblique incision was made over the inflamed joint. Thorough irrigation with anti-inflammatory solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, manage the inflammation, and restore joint function. Antibiotic-impregnated beads were placed, and the wound was closed using absorbable sutures in layers. Postoperative instructions were provided, including wound care, antibiotic therapy, pain management, and rehabilitation.

Operative Note 90:

A severe infection with intense inflammation was identified in the left hip joint. After obtaining informed consent and administering general anesthesia, an incision was made over the inflamed joint. Thorough irrigation with anti-inflammatory solution was performed, and pus was drained. Extensive debridement of necrotic tissue and inflamed bursa were carried out. Intraoperatively, a surgical intervention was undertaken to address the severe infection, manage the inflammation, and restore joint stability. Antibiotic-impregnated cement was utilized, and the wound was closed in layers using absorbable sutures. Postoperatively, the patient was prescribed antibiotics and given instructions on wound care, pain management, and rehabilitation.

Operative Note 91:

A severe infection with extensive necrotic tissue was diagnosed in the right knee joint. Under general anesthesia, a midline incision was made, and the infected joint was exposed. Thorough irrigation with antimicrobial solution was performed, and the necrotic tissue and infected bursa were debrided. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint stability. Antibiotic-impregnated cement was used, and the wound was closed in layers using absorbable sutures. The patient was closely monitored postoperatively, and follow-up visits were scheduled based on the severity of the infection and the patient's response to treatment.

Operative Note 92:

The patient presented with a severe infection and extensive bone erosion in the left hip joint. After obtaining informed consent and administering general anesthesia, an incision was made over the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection and restore joint stability. Antibiotic-impregnated beads were placed, and the wound was closed meticulously using absorbable sutures. Postoperatively, the patient's follow-up plan was determined based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 93:

A severe infection with significant bone erosion was identified in the right shoulder joint. After obtaining informed consent and administering general anesthesia, a curvilinear incision was made over the affected area. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated cement and bone grafting were utilized, and the wound was closed meticulously using absorbable sutures. The patient's postoperative follow-up plan was determined based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 94:

A severe infection with extensive bone erosion was diagnosed in the left ankle joint. Under regional anesthesia, an incision was made to access the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated cement and bone grafting were utilized, and the wound was closed using absorbable sutures. The patient's postoperative follow-up plan was tailored based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 95:

A severe infection with extensive bone erosion was identified in the right elbow joint. After administering regional anesthesia, an oblique incision was made over the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated beads and bone grafting were utilized, and the wound was closed meticulously using absorbable sutures. The patient's postoperative follow-up plan was determined based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 96:

The patient presented with a severe infection and extensive bone erosion in the left wrist joint. After administering regional anesthesia, a transverse incision was made over the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated cement and bone grafting were utilized, and the wound was closed meticulously using absorbable sutures. The patient's postoperative follow-up plan was tailored based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 97:

A severe infection with extensive bone erosion was diagnosed in the right hip joint. After obtaining informed consent and administering general anesthesia, an incision was made over the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated cement and bone grafting were utilized, and the wound was closed in layers using absorbable sutures. The patient's postoperative follow-up plan was determined based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 98:

A severe infection with extensive bone erosion was identified in the left shoulder joint. After obtaining informed consent and administering general anesthesia, a curvilinear incision was made over the affected area. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated cement and bone grafting were utilized, and the wound was closed meticulously using absorbable sutures. The patient's postoperative follow-up plan was determined based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 99:

A severe infection with significant bone erosion was diagnosed in the right ankle joint. Under regional anesthesia, an incision was made to access the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated cement and bone grafting were utilized, and the wound was closed using absorbable sutures. The patient's postoperative follow-up plan was tailored based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 100:

A severe infection with extensive bone erosion was identified in the left elbow joint. After administering regional anesthesia, an oblique incision was made over the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated beads and bone grafting were utilized, and the wound was closed meticulously using absorbable sutures. The patient's postoperative follow-up plan was determined based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

Operative Note 103:

The patient presented with a severe infection and extensive bone erosion in the right wrist joint. After administering regional anesthesia, a transverse incision was made over the affected joint. Thorough irrigation with antimicrobial solution was performed, and the abscess was drained. Extensive debridement of necrotic tissue, infected bursa, and eroded bone was carried out. Intraoperatively, a surgical intervention was performed to address the severe infection, stabilize the joint, and address the bone erosion. Antibiotic-impregnated cement and bone grafting were utilized, and the wound was closed meticulously using absorbable sutures. The patient's postoperative follow-up plan was tailored based on the severity of the infection, the extent of bone erosion, and the need for further interventions or rehabilitation.

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