## M65.4 Radial styloid tenosynovitis

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.

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.

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.

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.

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.

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

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 tendons 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.

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 axillary 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.

8. 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 OsteotomyUnder 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 Severe 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 Osteochondral 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 PlacementUnder 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 SynovitiProcedure: 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 extensor 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 Rupture 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 Tendons 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 Rupture 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. Wound 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 theposterior 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.

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.

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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. Adhesiolysis 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.