## M67.2 Synovial hypertrophy, not elsewhere classified

1. Patient underwent arthroscopic examination revealing synovial hypertrophy in the right knee. Following meticulous debridement and synovectomy, the hypertrophic synovium was excised. Hemostasis achieved. Postoperative X-rays confirmed optimal joint alignment. Patient tolerated the procedure well without complications.

2. Operative findings included significant synovial hypertrophy in the left shoulder joint. An arthroscopic approach was employed for synovectomy and removal of hypertrophic tissue. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion. The patient experienced an uneventful recovery.

3. During open joint exploration, synovial hypertrophy was identified in the right hip. A synovectomy was performed, excising the hypertrophic tissue. Hemostasis was obtained, and the joint was stabilized. The patient's pain and discomfort improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Arthroscopic examination revealed extensive synovial hypertrophy in the right ankle joint. A synovectomy was carried out, removing the hypertrophic synovium. The procedure was uneventful, and the patient reported reduced pain and improved mobility during the postoperative period.

5. Intraoperative evaluation revealed synovial hypertrophy in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient's symptoms significantly improved after the procedure, and there were no postoperative complications.

6. Open exploration of the left wrist joint revealed synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion and decreased pain postoperatively, without any notable complications.

7. Arthroscopic examination demonstrated synovial hypertrophy in the right temporomandibular joint. A thorough synovectomy was performed, excising the hypertrophic synovium. Hemostasis was ensured, and the joint was stabilized. The patient experienced relief from jaw pain and improved mouth opening following the procedure, with no complications observed.

8. During arthroscopic examination of the left hip joint, synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced hip pain and improved function after the procedure, without any postoperative issues.

9. Open joint exploration revealed synovial hypertrophy in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient experienced decreased shoulder pain and improved range of motion postoperatively, with no complications encountered.

10. Arthroscopic examination demonstrated synovial hypertrophy in the left knee joint. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced knee pain and increased stability after the procedure, without any significant postoperative complications.

1. Intraoperative evaluation revealed synovial hypertrophy in the right wrist joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced improved grip strength and reduced wrist pain postoperatively, without any notable complications.

2. Open exploration of the left ankle joint revealed synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported decreased swelling and enhanced joint mobility after the procedure, with no postoperative issues.

3. Arthroscopic examination demonstrated synovial hypertrophy in the right temporomandibular joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced relief from jaw pain and improved chewing ability following the procedure, without any complications observed.

4. During open joint exploration, synovial hypertrophy was identified in the left hip. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient's hip pain significantly improved postoperatively, with progressive restoration of hip function. No complications were noted.

5. Operative findings included synovial hypertrophy in the right shoulder joint. An arthroscopic approach was employed for synovectomy and removal of hypertrophic tissue. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion and reduced shoulder pain. The patient had an uneventful recovery.

6. Intraoperative examination revealed synovial hypertrophy in the left knee joint. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced reduced knee pain and increased stability postoperatively, without any notable complications.

7. Arthroscopic examination demonstrated extensive synovial hypertrophy in the right elbow joint. A thorough synovectomy was performed, excising the hypertrophic synovium. Hemostasis was ensured, and the joint was stabilized. The patient reported relief from elbow pain and improved range of motion following the procedure, with no complications observed.

8. Open exploration of the left temporomandibular joint revealed synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient experienced decreased jaw pain and improved mouth opening after the procedure, without any significant postoperative issues.

9. During arthroscopic examination of the right ankle joint, synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced ankle pain and enhanced mobility after the procedure, without any notable complications.

10. Operative findings included synovial hypertrophy in the left shoulder joint. An arthroscopic approach was employed for synovectomy and removal of hypertrophic tissue. Adequate hemostasis was achieved, and the joint was stabilized. Postoperatively, the patient experienced improved shoulder function and reduced pain, with an uneventful recovery.

1. Under general anesthesia, the patient underwent arthroscopic examination revealing synovial hypertrophy in the right knee. Following meticulous debridement and synovectomy, the hypertrophic synovium was excised. Hemostasis achieved. Postoperative X-rays confirmed optimal joint alignment. The patient tolerated the procedure well without complications.

2. Local anesthesia with sedation was administered as the patient underwent arthroscopic examination of the left shoulder joint. Synovial hypertrophy was identified, and a synovectomy was performed to excise the hypertrophic synovium. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion. The patient experienced an uneventful recovery.

3. Spinal anesthesia was administered for open joint exploration, revealing synovial hypertrophy in the right hip. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient's pain and discomfort improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Regional anesthesia with a peripheral nerve block was performed for arthroscopic examination of the right ankle joint. Synovial hypertrophy was identified, and a synovectomy was carried out to remove the hypertrophic tissue. The procedure was uneventful, and the patient reported reduced pain and improved mobility during the postoperative period.

5. General anesthesia was administered during intraoperative evaluation, revealing synovial hypertrophy in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient's symptoms significantly improved after the procedure, and there were no postoperative complications.

6. Local anesthesia with sedation was utilized for open exploration of the left wrist joint, where synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion and decreased pain postoperatively, without any notable complications.

7. Regional anesthesia with a nerve block was administered for arthroscopic examination of the right temporomandibular joint. Synovial hypertrophy was identified, and a thorough synovectomy was performed, excising the hypertrophic synovium. Hemostasis was ensured, and the joint was stabilized. The patient experienced relief from jaw pain and improved mouth opening following the procedure, with no complications observed.

8. Spinal anesthesia was administered for open joint exploration of the left hip, revealing synovial hypertrophy. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced hip pain and improved function after the procedure, without any postoperative issues.

9. General anesthesia was administered during arthroscopic examination of the left knee joint, where synovial hypertrophy was identified. A synovectomy was performed, excising the hypertrophic synovium. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced knee pain and increased stability after the procedure, without any significant postoperative complications.

10. Regional anesthesia with a peripheral nerve block was utilized for open joint exploration, revealing synovial hypertrophy in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. Hemostasis was obtained, and the joint was stabilized. The patient experienced decreased shoulder pain and improved range of motion postoperatively, with no complications encountered.

1. Under general anesthesia, arthroscopic examination revealed synovial hypertrophy and bone erosion in the right knee joint. Extensive synovectomy and debridement were performed, and the eroded bone surfaces were smoothed. Hemostasis achieved. Postoperative imaging showed improved joint alignment. The patient tolerated the procedure well without complications.

2. Local anesthesia with sedation was administered as the patient underwent arthroscopic examination of the left shoulder joint. Synovial hypertrophy and bone erosion were identified. A synovectomy was performed, and the eroded bone surfaces were debrided. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion. The patient experienced an uneventful recovery.

3. Spinal anesthesia was administered for open joint exploration, revealing synovial hypertrophy and significant bone erosion in the right hip. A synovectomy was performed, excising the hypertrophic synovium. Bone grafting was performed to restore the eroded areas. Hemostasis was obtained, and the joint was stabilized. The patient's pain and discomfort improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Regional anesthesia with a peripheral nerve block was performed for arthroscopic examination of the right ankle joint. Synovial hypertrophy and bone erosion were identified. A synovectomy was carried out, removing the hypertrophic tissue. The eroded bone surfaces were debrided and treated. The procedure was uneventful, and the patient reported reduced pain and improved mobility during the postoperative period.

5. General anesthesia was administered during intraoperative evaluation, revealing synovial hypertrophy and bone erosion in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and smoothed. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient's symptoms significantly improved after the procedure, and there were no postoperative complications.

6. Local anesthesia with sedation was utilized for open exploration of the left wrist joint, where synovial hypertrophy and bone erosion were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and repaired. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion and decreased pain postoperatively, without any notable complications.

7. Regional anesthesia with a nerve block was administered for arthroscopic examination of the right temporomandibular joint. Synovial hypertrophy and bone erosion were identified. A thorough synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and reconstructed. Hemostasis was ensured, and the joint was stabilized. The patient experienced relief from jaw pain and improved mouth opening following the procedure, with no complications observed.

8. Spinal anesthesia was administered for open joint exploration of the left hip, revealing synovial hypertrophy and significant bone erosion. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and reinforced with bone grafts. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced hip pain and improved function after the procedure, without any postoperative issues.

9. General anesthesia was administered during arthroscopic examination of the left knee joint, where synovial hypertrophy and bone erosion were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and reconstructed. Hemostasis was achieved, and the joint was stabilized. The patient reported reduced knee pain and increased stability after the procedure, without any significant postoperative complications.

10. Regional anesthesia with a peripheral nerve block was utilized for open joint exploration, revealing synovial hypertrophy and bone erosion in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. The eroded bone surfaces were debrided and treated. Hemostasis was obtained, and the joint was stabilized. The patient experienced decreased shoulder pain and improved range of motion postoperatively, with no complications encountered.

1. Under general anesthesia, arthroscopic examination revealed synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right knee joint. Extensive synovectomy, debridement, and bone grafting were performed to address the pathology. Hemostasis achieved. Postoperative imaging showed improved joint alignment and reduced bone pain. The patient tolerated the procedure well without complications.

2. Local anesthesia with sedation was administered as the patient underwent arthroscopic examination of the left shoulder joint. Synovial hypertrophy, severe bone erosion, and excruciating bone pain were identified. A synovectomy was performed, and the eroded bone surfaces were debrided. Adequate hemostasis was achieved, and the joint was stabilized. Postoperative evaluation showed improved range of motion and significant relief from bone pain. The patient experienced an uneventful recovery.

3. Spinal anesthesia was administered for open joint exploration, revealing synovial hypertrophy, extensive bone erosion, and severe bone pain in the right hip. A synovectomy was performed, excising the hypertrophic synovium. Bone grafting and stabilization procedures were implemented to alleviate the bone pain. Hemostasis was obtained, and the joint was stabilized. The patient's bone pain and discomfort significantly improved postoperatively, with progressive restoration of hip function. No complications were noted.

4. Regional anesthesia with a peripheral nerve block was performed for arthroscopic examination of the right ankle joint. Synovial hypertrophy, severe bone erosion, and debilitating bone pain were identified. A synovectomy was carried out, removing the hypertrophic tissue. The eroded bone surfaces were debrided and treated to alleviate the bone pain. The procedure was uneventful, and the patient reported a remarkable reduction in bone pain and improved mobility during the postoperative period.

5. General anesthesia was administered during intraoperative evaluation, revealing synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left elbow joint. A meticulous synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided and stabilized to alleviate the bone pain. The joint was stabilized, and postoperative X-rays confirmed satisfactory alignment. The patient experienced significant relief from bone pain, improved range of motion, and there were no postoperative complications.

6. Local anesthesia with sedation was utilized for open exploration of the left wrist joint, where synovial hypertrophy, severe bone erosion, and debilitating bone pain were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, stabilized, and treated to alleviate the bone pain. Hemostasis was achieved, and the joint was stabilized. The patient showed improved range of motion, a substantial reduction in bone pain, and decreased discomfort postoperatively, without any notable complications.

7. Regional anesthesia with a nerve block was administered for arthroscopic examination of the right temporomandibular joint. Synovial hypertrophy, severe bone erosion, and excruciating bone pain were identified. A thorough synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, reconstructed, and treated to alleviate the bone pain. Hemostasis was ensured, and the joint was stabilized. The patient experienced significant relief from jaw pain, improved mouth opening, and a remarkable reduction in bone pain following the procedure, with no complications observed.

8. Spinal anesthesia was administered for open joint exploration of the left hip, revealing synovial hypertrophy, severe bone erosion, and debilitating bone pain. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, reconstructed, and treated to alleviate the bone pain. Hemostasis was achieved, and the joint was stabilized. The patient reported a substantial reduction in hip pain, improved function, and significant relief from bone pain after the procedure, without any postoperative issues.

9. General anesthesia was administered during arthroscopic examination of the left knee joint, where synovial hypertrophy, severe bone erosion, and excruciating bone pain were identified. A synovectomy was performed, excising the hypertrophic synovium. The eroded bone surfaces were debrided, stabilized, and treated to alleviate the bone pain. Hemostasis was achieved, and the joint was stabilized. The patient reported a significant reduction in bone pain, increased stability, and improved mobility after the procedure, without any significant postoperative complications.

10. Regional anesthesia with a peripheral nerve block was utilized for open joint exploration, revealing synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right shoulder joint. A meticulous synovectomy was performed, removing the hypertrophic synovium. The eroded bone surfaces were debrided, reconstructed, and treated to alleviate the bone pain. Hemostasis was obtained, and the joint was stabilized. The patient experienced a remarkable reduction in shoulder pain, improved range of motion, and significant relief from bone pain postoperatively, with no complications encountered.

1. Surgical intervention was performed under general anesthesia for synovial hypertrophy with severe bone erosion and intractable bone pain in the right knee joint. A comprehensive synovectomy and debridement were carried out, followed by bone grafting and stabilization. The procedure successfully alleviated the bone pain and restored joint function. The patient had a smooth recovery without any postoperative complications.

2. The patient underwent surgical intervention with local anesthesia and sedation for synovial hypertrophy, extensive bone erosion, and excruciating bone pain in the left shoulder joint. A thorough synovectomy was performed, accompanied by meticulous debridement and repair of the eroded bone surfaces. The procedure significantly reduced the bone pain, resulting in improved shoulder mobility and function. The patient experienced an uneventful postoperative course.

3. Open joint surgery was performed under spinal anesthesia to address synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right hip joint. The surgical intervention involved a synovectomy, extensive debridement, and bone reconstruction. The procedure successfully relieved the bone pain and restored hip joint stability. The patient achieved a favorable postoperative recovery without any complications.

4. Arthroscopic surgical intervention was performed with regional anesthesia for synovial hypertrophy, significant bone erosion, and severe bone pain in the right ankle joint. The procedure included synovectomy, meticulous debridement, and bone smoothing. The surgical intervention effectively alleviated the bone pain, resulting in improved ankle joint function and reduced discomfort during the recovery period.

5. The patient underwent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left elbow joint. The procedure involved a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored elbow joint stability, and improved range of motion. The patient had a smooth postoperative course without complications.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left wrist joint. The surgical intervention included a synovectomy, meticulous debridement, and bone grafting. The procedure significantly reduced the bone pain and improved wrist joint mobility. The patient had a satisfactory recovery without any postoperative issues.

7. Surgical intervention was performed with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the right temporomandibular joint. The procedure included a thorough synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention effectively alleviated the bone pain, resulting in improved jaw function and reduced discomfort. The patient had an uneventful postoperative course.

8. A surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left hip joint. The procedure involved a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored hip joint stability, and improved the patient's mobility. The postoperative period was uneventful without any complications.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left knee joint. The procedure included a thorough synovectomy, meticulous bone debridement, and stabilization. The surgical intervention effectively reduced the bone pain, resulting in improved knee joint function and decreased discomfort during the recovery phase. The patient had a smooth postoperative course.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the right shoulder joint. The procedure involved a comprehensive synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored shoulder joint stability, and improved range of motion. The patient experienced an uneventful postoperative recovery without complications.

1. The patient underwent surgical intervention under general anesthesia to address severe synovial hypertrophy, extensive bone erosion, and debilitating bone pain in the right knee joint. A comprehensive synovectomy and bone reconstruction procedure were performed, leading to significant relief of bone pain and improved joint function. The patient experienced a smooth recovery without any postoperative complications.

2. Surgical intervention was performed with local anesthesia and sedation for the treatment of synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left ankle joint. The procedure involved a synovectomy, meticulous debridement, and bone grafting. The surgical intervention successfully alleviated the bone pain, resulting in improved ankle joint mobility and reduced discomfort during the recovery period.

3. Open joint surgery was performed under spinal anesthesia to address synovial hypertrophy, significant bone erosion, and severe bone pain in the right shoulder joint. The surgical intervention included a synovectomy, extensive debridement, and reconstruction of the eroded bone surfaces. The procedure effectively relieved the bone pain and restored shoulder joint stability. The patient had a favorable postoperative recovery without any complications.

4. Arthroscopic surgical intervention was performed with regional anesthesia for synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left hip joint. The procedure involved a synovectomy, meticulous debridement, and bone smoothing. The surgical intervention successfully alleviated the bone pain, resulting in improved hip joint function and reduced discomfort during the recovery period.

5. The patient underwent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the right elbow joint. The procedure included a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention effectively relieved the bone pain, restored elbow joint stability, and improved range of motion. The patient had a smooth postoperative course without complications.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and debilitating bone pain in the left temporomandibular joint. The surgical intervention involved a synovectomy, meticulous debridement, and bone grafting. The procedure significantly reduced the bone pain and improved jaw joint function. The patient had a satisfactory recovery without any postoperative issues.

7. Surgical intervention was performed with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the right wrist joint. The procedure included a thorough synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention effectively alleviated the bone pain, resulting in improved wrist joint mobility and reduced discomfort. The patient had an uneventful postoperative course.

8. A surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and excruciating bone pain in the left temporomandibular joint. The procedure involved a comprehensive synovectomy, extensive bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored jaw joint stability, and improved the patient's ability to chew and speak. The postoperative period was uneventful without any complications.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and debilitating bone pain in the right hip joint. The procedure included a thorough synovectomy, meticulous bone debridement, and stabilization. The surgical intervention effectively reduced the bone pain, resulting in improved hip joint function and decreased discomfort during the recovery phase. The patient had a smooth postoperative course.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and intractable bone pain in the left shoulder joint. The procedure involved a comprehensive synovectomy, meticulous bone debridement, and reconstruction. The surgical intervention successfully relieved the bone pain, restored shoulder joint stability, and improved range of motion. The patient experienced an uneventful postoperative recovery without complications.

1. Urgent surgical intervention was performed under general anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection involving the extreme moving joint of the right knee. A thorough synovectomy, aggressive debridement, and extensive irrigation were carried out to address the infection. Antibiotic therapy was initiated, and the joint was stabilized. The patient's condition improved with reduced infection, relieved bone pain, and enhanced joint function postoperatively.

2. The patient underwent immediate surgical intervention with local anesthesia and sedation to manage synovial hypertrophy, extensive bone erosion, and a severe infection affecting the extreme moving joint of the left shoulder. A comprehensive synovectomy, meticulous debridement, and intensive irrigation were performed to control the infection. Postoperatively, the patient showed significant improvement with reduced infection, diminished bone pain, and improved shoulder mobility.

3. Open joint surgery was conducted under spinal anesthesia to address synovial hypertrophy, severe bone erosion, and a severe infection in the extreme moving joint of the right hip. The surgical intervention involved a thorough synovectomy, extensive debridement of infected tissues, and thorough irrigation. The joint was stabilized, and appropriate antibiotic treatment was initiated. The patient's condition improved postoperatively with reduced infection, relieved bone pain, and restored hip joint function.

4. Surgical intervention was performed with regional anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection affecting the extreme moving joint of the left ankle. A synovectomy, meticulous debridement, and intensive irrigation were carried out to address the infection. The joint was stabilized, and systemic antibiotics were administered. The patient demonstrated a positive response, with reduced infection, alleviated bone pain, and improved mobility during the postoperative period.

5. The patient underwent urgent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection involving the extreme moving joint of the right elbow. A comprehensive synovectomy, thorough debridement, and meticulous irrigation were performed to eradicate the infection. Antibiotic therapy was initiated, and the joint was stabilized. The patient's condition improved postoperatively with reduced infection, relieved bone pain, and restored elbow joint function.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and a severe infection affecting the extreme moving joint of the left wrist. A synovectomy, extensive debridement, and intensive irrigation were carried out to control the infection. The joint was stabilized, and appropriate antibiotic treatment was administered. The patient experienced improved symptoms postoperatively with reduced infection, diminished bone pain, and enhanced wrist joint mobility.

7. Surgical intervention was conducted with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and a severe infection involving the extreme moving joint of the right temporomandibular joint. A thorough synovectomy, meticulous debridement, and extensive irrigation were performed to eradicate the infection. The joint was stabilized, and systemic antibiotics were administered. The patient showed significant improvement with reduced infection, relieved bone pain, and improved jaw function after the surgery.

8. Urgent surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection affecting the extreme moving joint of the left hip. The surgical procedure involved a comprehensive synovectomy, thorough debridement, and extensive irrigation to control the infection. The joint was stabilized, and appropriate antibiotic therapy was initiated. The patient experienced improved symptoms postoperatively with reduced infection, relieved bone pain, and restored hip joint function.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and a severe infection involving the extreme moving joint of the right knee. A thorough synovectomy, meticulous debridement, and intensive irrigation were carried out to address the infection. The joint was stabilized, and systemic antibiotics were administered. The patient demonstrated significant improvement with reduced infection, relieved bone pain, and improved knee joint function postoperatively.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and a severe infection affecting the extreme moving joint of the left shoulder. A comprehensive synovectomy, meticulous debridement, and extensive irrigation were performed to control the infection. The joint was stabilized, and appropriate antibiotic treatment was administered. The patient showed notable improvement with reduced infection, relieved bone pain, and enhanced shoulder mobility after the surgery.

1. Urgent surgical intervention was performed under general anesthesia for severe synovial hypertrophy, extensive bone erosion, and intense inflammation in the extreme moving joint of the right knee. A thorough synovectomy, meticulous debridement, and anti-inflammatory measures were implemented to address the inflammation. The joint was stabilized, and the patient experienced a significant reduction in inflammation, relieved bone pain, and improved joint function postoperatively.

2. The patient underwent immediate surgical intervention with local anesthesia and sedation to manage synovial hypertrophy, significant bone erosion, and severe inflammation in the extreme moving joint of the left shoulder. A comprehensive synovectomy, aggressive debridement, and anti-inflammatory treatment were carried out to control the inflammation. Postoperatively, the patient showed remarkable improvement with reduced inflammation, diminished bone pain, and improved shoulder mobility.

3. Open joint surgery was conducted under spinal anesthesia to address synovial hypertrophy, severe bone erosion, and intense inflammation in the extreme moving joint of the right hip. The surgical intervention involved a thorough synovectomy, extensive debridement, and anti-inflammatory measures. The joint was stabilized, and appropriate anti-inflammatory medications were administered. The patient's condition improved postoperatively with reduced inflammation, relieved bone pain, and restored hip joint function.

4. Surgical intervention was performed with regional anesthesia for synovial hypertrophy, severe bone erosion, and severe inflammation affecting the extreme moving joint of the left ankle. A synovectomy, meticulous debridement, and anti-inflammatory interventions were carried out to address the inflammation. The joint was stabilized, and systemic anti-inflammatory treatment was initiated. The patient demonstrated a positive response, with reduced inflammation, alleviated bone pain, and improved mobility during the postoperative period.

5. The patient underwent urgent surgical intervention under general anesthesia for synovial hypertrophy, severe bone erosion, and intense inflammation involving the extreme moving joint of the right elbow. A comprehensive synovectomy, thorough debridement, and anti-inflammatory measures were performed to control the inflammation. Anti-inflammatory medication was administered, and the joint was stabilized. The patient's condition improved postoperatively with reduced inflammation, relieved bone pain, and restored elbow joint function.

6. Open exploration surgery was performed under local anesthesia and sedation to address synovial hypertrophy, severe bone erosion, and intense inflammation affecting the extreme moving joint of the left wrist. A synovectomy, extensive debridement, and anti-inflammatory interventions were carried out to control the inflammation. The joint was stabilized, and appropriate anti-inflammatory therapy was administered. The patient experienced improved symptoms postoperatively with reduced inflammation, diminished bone pain, and enhanced wrist joint mobility.

7. Surgical intervention was conducted with regional anesthesia and a nerve block for synovial hypertrophy, extensive bone erosion, and severe inflammation involving the extreme moving joint of the right temporomandibular joint. A thorough synovectomy, meticulous debridement, and anti-inflammatory measures were performed to address the inflammation. The joint was stabilized, and systemic anti-inflammatory medications were administered. The patient showed significant improvement with reduced inflammation, relieved bone pain, and improved jaw function after the surgery.

8. Urgent surgical intervention was performed under spinal anesthesia for synovial hypertrophy, severe bone erosion, and intense inflammation affecting the extreme moving joint of the left hip. The surgical procedure involved a comprehensive synovectomy, thorough debridement, and anti-inflammatory interventions to control the inflammation. The joint was stabilized, and appropriate anti-inflammatory therapy was initiated. The patient experienced improved symptoms postoperatively with reduced inflammation, relieved bone pain, and restored hip joint function.

9. Arthroscopic surgical intervention was performed with general anesthesia for synovial hypertrophy, severe bone erosion, and intense inflammation involving the extreme moving joint of the right knee. A thorough synovectomy, meticulous debridement, and anti-inflammatory measures were implemented to address the inflammation. The joint was stabilized, and systemic anti-inflammatory medications were administered. The patient demonstrated significant improvement with reduced inflammation, relieved bone pain, and improved knee joint function postoperatively.

10. Surgical intervention was conducted with regional anesthesia and a peripheral nerve block for synovial hypertrophy, extensive bone erosion, and severe inflammation affecting the extreme moving joint of the left shoulder. A comprehensive synovectomy, meticulous debridement, and anti-inflammatory interventions were performed to control the inflammation. The joint was stabilized, and appropriate anti-inflammatory treatment was administered. The patient showed notable improvement with reduced inflammation, relieved bone pain, and enhanced shoulder mobility after the surgery.

1. The patient's synovial hypertrophy and bone erosion were mild, requiring conservative management. Follow-up includes physical therapy, pain management, and regular monitoring of symptoms.

2. The severity of synovial hypertrophy and bone erosion warrants close follow-up with a rheumatologist and orthopedic specialist. Treatment plan includes a combination of medication, physical therapy, and periodic imaging to assess disease progression.

3. Given the moderate synovial hypertrophy and significant bone erosion, an aggressive treatment approach is necessary. Close follow-up includes regular appointments for joint injections, physical therapy, and frequent imaging to monitor response to treatment.

4. The patient's condition is critical due to severe synovial hypertrophy and extensive bone erosion. Immediate surgical intervention is required, followed by a comprehensive postoperative plan involving frequent follow-ups, specialized rehabilitation, and ongoing assessment for potential complications.

5. Due to the advanced stage of synovial hypertrophy and severe bone erosion, the patient requires intensive management. Follow-up includes a multidisciplinary approach involving rheumatology, orthopedics, and pain management to optimize treatment and minimize disease progression.

6. Given the early detection of synovial hypertrophy and minimal bone erosion, a conservative treatment approach will be followed. Regular follow-ups will focus on symptom assessment, lifestyle modifications, and medication adjustments as needed.

7. The patient's synovial hypertrophy is moderate, but bone erosion is minimal. Follow-up includes a combination of physical therapy, non-steroidal anti-inflammatory drugs (NSAIDs), and periodic imaging to monitor disease progression and response to conservative measures.

8. With severe synovial hypertrophy and moderate bone erosion, close follow-up is crucial. A treatment plan involving disease-modifying anti-rheumatic drugs (DMARDs), physical therapy, and regular assessments will be implemented to manage symptoms and prevent further joint damage.

9. The patient's condition is critical due to extensive synovial hypertrophy and severe bone erosion. Immediate surgical intervention is necessary, followed by an intensive postoperative follow-up plan involving regular check-ups, imaging studies, and rehabilitation to optimize functional outcomes.

10. In cases of mild synovial hypertrophy and minimal bone erosion, conservative management is recommended. Follow-up visits will focus on symptom evaluation, patient education, and lifestyle modifications to promote joint health and prevent disease progression.

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## M67.3 Transient synovitis

1. Patient presented with hip pain and limited range of motion. Clinical examination revealed signs consistent with transient synovitis. X-ray ruled out other pathology. No surgical intervention required. Prescribed rest and analgesics. Follow-up scheduled in two weeks.

2. Operative note: Arthrocentesis performed on patient with suspected transient synovitis. Clear synovial fluid obtained, ruling out septic arthritis. No signs of other joint pathology. Joint flushed with saline. Patient advised to rest and use pain medication. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Clear synovial fluid obtained, ruling out infection. No surgical intervention required. Patient advised to rest and use non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed on patient with suspected transient synovitis. No evidence of intra-articular pathology found. Joint irrigated with saline. Patient advised to rest and use pain medication. Follow-up in one week.

5. Patient presented with hip pain and limited range of motion. Clinical and imaging findings consistent with transient synovitis. No surgical intervention required. Prescribed rest, ice, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage performed on patient with transient synovitis. Effusion aspirated, and joint irrigated with saline. No signs of septic arthritis or other joint pathology observed. Patient instructed to rest and use analgesics. Follow-up in one week.

7. Patient underwent hip aspiration for suspected transient synovitis. Synovial fluid analysis showed no signs of infection or crystal deposition. Joint flushed with saline. Patient advised to rest, elevate the leg, and use pain medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic ultrasound-guided aspiration performed on patient with suspected transient synovitis. Synovial fluid analysis revealed no evidence of infection or other abnormalities. Joint flushed with saline. Patient instructed to rest and use anti-inflammatory medication. Follow-up in one week.

9. Patient presented with hip pain and decreased mobility. Clinical evaluation consistent with transient synovitis. No surgical intervention required. Prescribed rest, physical therapy, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage and aspiration performed on patient with transient synovitis. Synovial fluid analysis negative for infection. Joint flushed and irrigated. No other intra-articular abnormalities observed. Patient advised to rest, apply ice, and take pain medication. Follow-up in one week.

1. Patient presented with acute hip pain and limited range of motion. Diagnosis of transient synovitis confirmed based on clinical examination and exclusion of other pathologies. Non-surgical management initiated with rest, analgesics, and physical therapy. Follow-up scheduled in two weeks to monitor progress.

2. Operative note: Arthrocentesis performed on patient with suspected transient synovitis. Synovial fluid obtained was clear and showed no signs of infection. Joint lavage performed using saline solution. Patient instructed to rest and use pain medication. Follow-up in one week.

3. Patient underwent hip joint aspiration for suspected transient synovitis. Synovial fluid analysis revealed no signs of infection or inflammatory markers. Joint irrigated with saline. Non-surgical management advised, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed to assess hip joint in patient with suspected transient synovitis. No evidence of intra-articular abnormalities or pathology found. Joint lavage performed. Patient advised to rest and use pain relief medication. Follow-up in one week.

5. Patient presented with hip pain and reduced mobility. Clinical examination consistent with transient synovitis. No surgical intervention required. Prescribed rest, application of ice packs, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage performed on patient with transient synovitis. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Non-surgical management initiated with rest and pain medication. Follow-up in one week.

7. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Synovial fluid analysis revealed no signs of infection or crystals. Joint lavage performed with saline. Non-surgical management recommended, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic arthroscopy performed on patient with suspected transient synovitis. No abnormalities or intra-articular pathology observed. Joint lavage performed. Patient advised to rest, apply cold packs, and use pain relief medication. Follow-up in one week.

9. Patient presented with hip pain and restricted range of motion. Clinical evaluation consistent with transient synovitis. No surgical intervention required. Prescribed rest, elevation of the leg, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage and aspiration performed on patient with transient synovitis. Synovial fluid analysis showed no signs of infection or other abnormalities. Joint flushed and irrigated. Non-surgical management initiated with rest, ice application, and pain medication. Follow-up in one week.

1. Patient presented with hip pain and limited range of motion. Clinical examination and imaging findings consistent with transient synovitis. Non-surgical management initiated with rest, analgesics, and local anesthesia for pain relief. Follow-up scheduled in two weeks to assess progress.

2. Operative note: Arthrocentesis performed on patient with suspected transient synovitis under local anesthesia. Clear synovial fluid obtained, ruling out septic arthritis. Joint lavage performed using saline solution. Patient advised to rest and use pain medication. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis ruled out infection. Joint irrigated with saline. Non-surgical management prescribed, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed on patient with suspected transient synovitis under regional anesthesia. No intra-articular abnormalities or pathology observed. Joint lavage performed. Patient instructed to rest and use pain relief medication. Follow-up in one week.

5. Patient presented with acute hip pain and decreased mobility. Clinical evaluation and imaging consistent with transient synovitis. Non-surgical management initiated with rest, systemic analgesics, and local anesthesia for targeted pain relief. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage and aspiration performed on patient with transient synovitis under local anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Non-surgical management advised, including rest, pain medication, and physical therapy. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis under regional anesthesia. Synovial fluid analysis revealed no signs of infection or inflammatory markers. Joint lavage performed with saline. Non-surgical management recommended, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic arthroscopy performed to evaluate hip joint in patient with suspected transient synovitis under general anesthesia. No intra-articular abnormalities detected. Joint lavage performed. Patient advised to rest, use pain relief medication, and initiate physical therapy. Follow-up in one week.

9. Patient presented with hip pain and limited range of motion. Clinical examination consistent with transient synovitis. Non-surgical management initiated with rest, local anesthesia for pain control, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage performed on patient with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Non-surgical management initiated with rest, pain medication, and physical therapy. Follow-up in one week.

1. Patient presented with hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Non-surgical management initiated with rest, analgesics, and referral to orthopedic specialist for further evaluation and management. Follow-up scheduled in two weeks to monitor progression of bone erosion.

2. Operative note: Arthrocentesis performed on patient with transient synovitis and associated bone erosion. Synovial fluid analysis ruled out infection. Joint lavage performed using saline solution. Orthopedic consultation recommended for management of bone erosion. Patient advised to rest and use pain medication. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and bone erosion. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Joint irrigated with saline. Orthopedic referral made for management of bone erosion. Follow-up scheduled in two weeks.

4. Operative note: Diagnostic arthroscopy performed on patient with transient synovitis and evidence of bone erosion under general anesthesia. No additional intra-articular abnormalities detected. Joint lavage performed. Orthopedic consultation arranged for management of bone erosion. Patient instructed to rest and use pain relief medication. Follow-up in one week.

5. Patient presented with hip pain, limited range of motion, and significant bone erosion on imaging studies. Orthopedic consultation obtained for further evaluation and management. Non-surgical management initiated with rest, systemic analgesics, and referral to physical therapy. Follow-up scheduled in two weeks.

6. Operative note: Joint lavage and aspiration performed on patient with transient synovitis and bone erosion under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Orthopedic specialist consulted for management of bone erosion. Non-surgical management prescribed, including rest, pain medication, and physical therapy. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and bone erosion under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Orthopedic referral made for management of bone erosion. Non-surgical management advised, including rest and anti-inflammatory medication. Follow-up scheduled in two weeks.

8. Operative note: Diagnostic arthroscopy performed on patient with transient synovitis and bone erosion under general anesthesia. No additional intra-articular abnormalities observed. Joint lavage performed. Orthopedic consultation arranged for management of bone erosion. Patient instructed to rest, use pain relief medication, and initiate physical therapy. Follow-up in one week.

9. Patient presented with hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Orthopedic specialist consulted for further evaluation and management. Non-surgical management initiated with rest, local anesthesia for pain control, and non-steroidal anti-inflammatory drugs. Follow-up scheduled in two weeks.

10. Operative note: Joint lavage performed on patient with transient synovitis and bone erosion under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Orthopedic referral made for management of bone erosion. Non-surgical management initiated with rest, pain medication, and physical therapy. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of severe bone pain associated with transient synovitis. Urgent orthopedic consultation obtained for further evaluation and management. Non-surgical management initiated with rest, high-dose analgesics, and referral to pain management specialist. Follow-up scheduled in one week to assess response to pain management interventions.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Joint lavage performed using saline solution. Pain management team consulted for optimized pain control. Patient advised to rest and use high-dose analgesics. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Joint irrigated with saline. Referral made to pain management specialist for optimized pain control. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. No additional intra-articular abnormalities detected. Joint lavage performed. Pain management team consulted for optimized pain control. Patient instructed to rest and use high-dose pain relief medication. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Urgent orthopedic consultation obtained for further evaluation and management of pain. Non-surgical management initiated with rest, systemic analgesics, and referral to pain management specialist for advanced pain control interventions. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Pain management team involved for optimized pain control. Non-surgical management prescribed, including rest, high-dose pain medication, and physical therapy. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Referral made to pain management specialist for optimized pain control. Non-surgical management advised, including rest and anti-inflammatory medication. Follow-up scheduled in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. No additional intra-articular abnormalities observed. Joint lavage performed. Pain management team consulted for optimized pain control. Patient instructed to rest, use high-dose pain relief medication, and initiate physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Urgent orthopedic consultation obtained for evaluation and management of pain. Non-surgical management initiated with rest, local anesthesia for pain control, and referral to pain management specialist for advanced pain management strategies. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Referral made to pain management specialist for optimized pain control. Non-surgical management initiated with rest, high-dose pain medication, and physical therapy. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Surgical intervention in the form of arthroscopic synovectomy was performed to address the underlying pathology. Post-operative management included rest, pain medication, and physical therapy. Follow-up scheduled in two weeks to monitor recovery.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Surgical intervention in the form of synovectomy planned to address persistent symptoms. Follow-up in one week to discuss surgical options.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Surgical intervention in the form of open synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon arranged. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular findings revealed extensive synovial proliferation and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Surgical intervention in the form of joint debridement and synovectomy recommended to address bone erosion. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Surgical intervention in the form of open synovectomy planned to address persistent symptoms. Consultation with orthopedic surgeon arranged. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Surgical intervention in the form of arthroscopic synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon scheduled. Follow-up in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and joint debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Surgical intervention in the form of open synovectomy planned to address bone erosion and alleviate symptoms. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Surgical intervention in the form of open synovectomy recommended to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Surgical intervention in the form of arthroscopic synovectomy was performed to address the underlying pathology. Post-operative management included rest, pain medication, and physical therapy. Follow-up scheduled in two weeks to monitor recovery.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Surgical intervention in the form of synovectomy planned to address persistent symptoms. Follow-up in one week to discuss surgical options.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Surgical intervention in the form of open synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon arranged. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular findings revealed extensive synovial proliferation and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Surgical intervention in the form of joint debridement and synovectomy recommended to address bone erosion. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Surgical intervention in the form of open synovectomy planned to address persistent symptoms. Consultation with orthopedic surgeon arranged. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Surgical intervention in the form of arthroscopic synovectomy recommended to address bone erosion. Consultation with orthopedic surgeon scheduled. Follow-up in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and bone erosion. Surgical intervention in the form of arthroscopic synovectomy and joint debridement performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Surgical intervention in the form of open synovectomy planned to address bone erosion and alleviate symptoms. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Surgical intervention in the form of open synovectomy recommended to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone erosion associated with transient synovitis. Surgical intervention in the form of core decompression performed to alleviate pain and promote healing. Post-operative management included rest, weight-bearing restrictions, and physical therapy. Follow-up scheduled in two weeks to monitor recovery.

2. Operative note: Arthrocentesis performed on patient with severe bone pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Surgical intervention in the form of joint realignment planned to address persistent symptoms and bone erosion. Follow-up in one week to discuss surgical options.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe bone pain. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Surgical intervention in the form of joint realignment and bone grafting recommended to address bone erosion. Consultation with orthopedic surgeon arranged. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular findings revealed extensive synovial proliferation and bone erosion. Surgical intervention in the form of arthroscopic joint debridement and bone grafting performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant bone pain related to transient synovitis. Surgical intervention in the form of joint realignment and bone grafting recommended to address bone erosion and improve joint stability. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis negative for infection. Joint flushed and irrigated using saline solution. Surgical intervention in the form of joint realignment and bone grafting planned to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe bone pain under local anesthesia. Synovial fluid analysis ruled out infection. Joint lavage performed with saline. Surgical intervention in the form of arthroscopic joint realignment and bone grafting recommended to address bone erosion. Consultation with orthopedic surgeon scheduled. Follow-up in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe bone pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and bone erosion. Surgical intervention in the form of arthroscopic joint realignment and bone grafting performed. Post-operative management included rest, pain medication, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of bone pain associated with transient synovitis. Surgical intervention in the form of joint realignment and bone grafting planned to address bone erosion and restore joint function. Referral made to orthopedic surgeon for further evaluation and surgical planning. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe bone pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. No signs of septic arthritis or other joint pathology observed. Surgical intervention in the form of joint realignment and bone grafting recommended to address persistent symptoms and bone erosion. Consultation with orthopedic surgeon arranged. Follow-up in one week.

1. Patient presented with severe hip pain, restricted range of motion, and signs of a severe infection involving the hip joint due to transient synovitis. Urgent surgical intervention in the form of open joint debridement and irrigation performed to address the infection. Intravenous antibiotics initiated post-operatively. Close monitoring and infectious disease consultation arranged. Follow-up in one week to assess response to treatment.

2. Operative note: Arthrocentesis performed on patient with severe infection involving the hip joint caused by transient synovitis. Synovial fluid analysis confirmed the presence of bacterial infection. Surgical intervention in the form of open joint debridement and extensive irrigation conducted to remove infected tissues. Intravenous antibiotics initiated. Infectious disease specialist consulted for further management. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of the infected hip joint associated with transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis revealed the presence of bacterial infection. Urgent surgical intervention in the form of open joint debridement and thorough irrigation performed. Intravenous antibiotics initiated. Infectious disease consultation obtained. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe infection involving the hip joint due to transient synovitis under general anesthesia. Intra-articular findings showed significant inflammation and signs of infection. Surgical intervention in the form of arthroscopic joint debridement and irrigation performed. Intravenous antibiotics initiated post-operatively. Infectious disease specialist involved in management. Follow-up in one week.

5. Patient presented with severe hip pain, restricted range of motion, and radiographic evidence of bone erosion associated with an extreme joint infection caused by transient synovitis. Urgent surgical intervention in the form of open joint debridement and extensive irrigation conducted to address the infection. Intravenous antibiotics initiated post-operatively. Close monitoring and infectious disease consultation arranged. Follow-up in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe infection involving the extreme moving joint due to transient synovitis under regional anesthesia. Synovial fluid analysis confirmed the presence of bacterial infection. Surgical intervention in the form of open joint debridement and thorough irrigation performed. Intravenous antibiotics initiated. Infectious disease specialist consulted for further management. Follow-up in one week.

7. Patient underwent joint aspiration for suspected transient synovitis and severe infection involving the extreme moving joint under local anesthesia. Synovial fluid analysis revealed the presence of bacterial infection. Joint lavage performed with saline. Urgent surgical intervention in the form of open joint debridement and thorough irrigation planned to address the infection. Infectious disease consultation obtained. Follow-up scheduled in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe infection involving the extreme moving joint due to transient synovitis under general anesthesia. Intra-articular examination showed severe inflammation and signs of infection. Surgical intervention in the form of arthroscopic joint debridement and irrigation performed. Intravenous antibiotics initiated post-operatively. Infectious disease specialist involved in management. Follow-up in one week.

9. Patient presented with severe hip pain, restricted range of motion, and radiographic evidence of bone erosion associated with an extreme joint infection caused by transient synovitis. Urgent surgical intervention in the form of open joint debridement and thorough irrigation conducted to address the infection. Intravenous antibiotics initiated post-operatively. Close monitoring and infectious disease consultation arranged. Follow-up in one week.

10. Operative note: Joint lavage performed on patient with severe infection involving the extreme moving joint due to transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. Bacterial infection confirmed. Surgical intervention in the form of open joint debridement and thorough irrigation recommended to address the infection. Intravenous antibiotics initiated. Infectious disease consultation obtained. Follow-up in one week.

1. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of intense inflammation associated with transient synovitis. Non-surgical management initiated with rest, non-steroidal anti-inflammatory drugs (NSAIDs), and physical therapy. Close monitoring of inflammatory markers planned. Follow-up in two weeks to assess response to conservative treatment.

2. Operative note: Arthrocentesis performed on patient with severe inflammation due to transient synovitis. Synovial fluid analysis showed elevated inflammatory markers. Intra-articular corticosteroid injection administered for immediate relief. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in one week.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis and severe inflammation. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis revealed increased inflammatory markers. Non-surgical management initiated, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up scheduled in one week.

4. Operative note: Diagnostic arthroscopy performed on patient with severe inflammation associated with transient synovitis under general anesthesia. Intra-articular examination showed marked synovial hypertrophy and intense inflammation. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in one week.

5. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of significant inflammation related to transient synovitis. Non-surgical management initiated with rest, systemic corticosteroids, and referral to rheumatology specialist for advanced inflammatory control interventions. Follow-up scheduled in one week.

6. Operative note: Joint lavage and aspiration performed on patient with severe inflammation associated with transient synovitis under regional anesthesia. Synovial fluid analysis revealed elevated inflammatory markers. Joint flushed and irrigated using saline solution. Non-surgical management prescribed, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up in one week.

7. Patient underwent hip joint aspiration for suspected transient synovitis and severe inflammation under local anesthesia. Synovial fluid analysis showed increased inflammatory markers. Joint lavage performed with saline. Non-surgical management initiated, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up scheduled in one week.

8. Operative note: Diagnostic arthroscopy performed on patient with severe inflammation associated with transient synovitis under general anesthesia. Intra-articular examination revealed extensive synovial hypertrophy and intense inflammation. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in one week.

9. Patient presented with severe hip pain, limited range of motion, and radiographic evidence of inflammation associated with transient synovitis. Non-surgical management initiated with rest, local corticosteroid injection for inflammation control, and referral to rheumatology specialist. Follow-up scheduled in one week.

10. Operative note: Joint lavage performed on patient with severe inflammation associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. Elevated inflammatory markers detected. Non-surgical management prescribed, including rest, NSAIDs, and referral to rheumatology specialist. Follow-up in one week.

1. Patient presented with moderate hip pain, limited range of motion, and radiographic evidence of transient synovitis. Non-surgical management initiated with rest, pain medication, and physical therapy. Follow-up scheduled in four weeks to assess response to conservative treatment and determine the need for further intervention.

2. Operative note: Arthrocentesis performed on patient with severe hip pain due to transient synovitis. Synovial fluid analysis ruled out infection. Intra-articular corticosteroid injection administered for pain relief. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in two weeks to evaluate response and adjust treatment plan accordingly.

3. Patient underwent ultrasound-guided aspiration of hip joint for suspected transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis showed no signs of infection. Non-surgical management initiated, including rest, NSAIDs, and physical therapy. Follow-up scheduled in six weeks to assess progress and consider additional interventions if necessary.

4. Operative note: Diagnostic arthroscopy performed on patient with severe hip pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed significant synovial hypertrophy. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in four weeks to evaluate response and determine further steps.

5. Patient presented with mild hip pain, limited range of motion, and radiographic evidence of transient synovitis. Non-surgical management initiated with rest, activity modification, and pain medication as needed. Follow-up scheduled in six weeks to assess progress and determine if further intervention is required.

6. Operative note: Joint lavage and aspiration performed on patient with moderate hip pain associated with transient synovitis under regional anesthesia. Synovial fluid analysis revealed no signs of infection. Joint flushed and irrigated using saline solution. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in eight weeks to evaluate response and adjust treatment plan as necessary.

7. Patient underwent hip joint aspiration for suspected transient synovitis. Local anesthesia administered for pain control during the procedure. Synovial fluid analysis ruled out infection. Non-surgical management initiated, including rest, NSAIDs, and physical therapy. Follow-up scheduled in four weeks to assess progress and determine the need for further intervention.

8. Operative note: Diagnostic arthroscopy performed on patient with mild hip pain associated with transient synovitis under general anesthesia. Intra-articular examination revealed mild synovial hypertrophy. Joint lavage performed. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in six weeks to evaluate response and determine if additional steps are necessary.

9. Patient presented with moderate hip pain, limited range of motion, and radiographic evidence of transient synovitis. Non-surgical management initiated with rest, pain medication, and referral for physical therapy. Follow-up scheduled in two weeks to assess response to conservative treatment and decide on the need for further intervention.

10. Operative note: Joint lavage performed on patient with mild hip pain associated with transient synovitis under regional anesthesia. Synovial fluid aspirated and joint irrigated with sterile saline. Non-surgical management prescribed, including rest, NSAIDs, and physical therapy. Follow-up in four weeks to evaluate response and adjust treatment plan accordingly.

## M67.4 Ganglion

1. Procedure: Ganglion Excision Operative Note: A ganglion excision was performed on the dorsal aspect of the patient's wrist. A longitudinal incision was made over the ganglion, and dissection was carried down to expose the ganglion sac. The sac was carefully dissected and excised completely. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were noted.

2. Procedure: Ganglion Aspiration Operative Note: Ganglion aspiration was performed on the patient's volar wrist. Using sterile technique, a 22-gauge needle was inserted into the ganglion under ultrasound guidance. The cystic fluid was aspirated, and the ganglion collapsed. No evidence of infection or malignancy was noted. The patient experienced immediate relief of symptoms, and the area was dressed with a sterile dressing.

3. Procedure: Ganglion Decompression Operative Note: Ganglion decompression surgery was performed on the patient's ankle. A transverse incision was made over the ganglion, and the underlying tissues were dissected. The ganglion stalk was identified and released, relieving pressure within the cyst. The incision was closed, and the patient was placed in a compression bandage. Postoperatively, the patient was advised to limit weight-bearing activities.

4. Procedure: Ganglion Biopsy Operative Note: A ganglion biopsy was performed on the patient's hand. Under local anesthesia, an incision was made over the ganglion. The cystic fluid was aspirated, and a portion of the ganglion wall was excised for pathological examination. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were encountered.

5. Procedure: Ganglion Resection Operative Note: Ganglion resection was performed on the patient's foot. An incision was made over the ganglion, and dissection was carried down to expose the cyst. The ganglion and its stalk were carefully dissected and excised. Hemostasis was achieved, and the wound was closed in layers. The patient experienced immediate relief of symptoms, and postoperative instructions were given for wound care and follow-up.

6. Procedure: Ganglion Bursectomy Operative Note: A ganglion bursectomy was performed on the patient's knee. An arthroscopic approach was used. The ganglion was visualized and found to be originating from the joint capsule. The ganglion and the associated bursa were excised using arthroscopic instruments. Hemostasis was achieved, and the joint was irrigated. The patient tolerated the procedure well, and postoperative rehabilitation was initiated.

7. Procedure: Ganglion Coagulation Operative Note: Ganglion coagulation was performed on the patient's finger. A small incision was made over the ganglion, and the cystic fluid was aspirated. Electrocautery was used to cauterize the inner lining of the ganglion. Hemostasis was achieved, and the wound was closed with a sterile dressing. The patient reported immediate improvement in symptoms, and postoperative instructions were given for wound care.

8. Procedure: Ganglion Recurrence Excision Operative Note: The patient presented with a recurrent ganglion on the dorsal aspect of the wrist. An incision was made over the ganglion, and the cyst was carefully dissected and excised. The previous surgical site was explored, and no residual ganglion tissue was found. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and appropriate postoperative follow-up was planned.

9. Procedure: Ganglion Marsupialization Operative Note: Ganglion marsupialization was performed on the patient's ankle. An incision was made over the ganglion, and the cyst was dissected and opened. The edges of the cyst were sutured to the surrounding skin, creating a permanent opening. The cyst was thoroughly irrigated, and the wound was closed with sutures. The patient experienced immediate relief of symptoms, and postoperative care instructions were provided.

10. Procedure: Ganglion Ligament Resection Operative Note: The patient presented with a ganglion arising from the scapholunate ligament. An incision was made over the ganglion, and dissection was carried down to expose the ligament. The ganglion was excised, and a portion of the involved ligament was resected. Hemostasis was achieved, and the wound was closed in layers. The patient was placed in a splint postoperatively and referred for hand therapy.

1. Procedure: Ganglion Cryotherapy Operative Note: Ganglion cryotherapy was performed on the patient's knee. A small incision was made over the ganglion, and a cryoprobe was inserted into the cyst under ultrasound guidance. The ganglion was frozen using liquid nitrogen, destroying the cystic tissue. The cryoprobe was then removed, and the incision was closed with sutures. The patient tolerated the procedure well, and postoperative instructions were given for pain management and rehabilitation.

2. Procedure: Ganglion Capsulotomy Operative Note: Ganglion capsulotomy was performed on the patient's shoulder. An arthroscopic approach was used to access the joint. The ganglion, originating from the joint capsule, was visualized and carefully dissected. A capsulotomy was performed to release the ganglion and relieve joint compression. Hemostasis was achieved, and the joint was irrigated. The patient's shoulder stability was assessed, and postoperative rehabilitation was initiated.

3. Procedure: Ganglion Drainage Operative Note: Ganglion drainage was performed on the patient's foot. Under local anesthesia, a small incision was made over the ganglion, and the cystic fluid was drained using a syringe. Gentle pressure was applied to evacuate the cyst completely. The wound was dressed with a sterile dressing, and the patient was advised to keep the area clean and dry. Postoperative follow-up was scheduled.

4. Procedure: Ganglion Repair with Graft Operative Note: The patient presented with a large ganglion on the volar aspect of the wrist. An incision was made over the ganglion, and the cyst was carefully dissected and excised. To prevent recurrence, a graft was harvested from the patient's palmaris longus tendon and used to reinforce the defect. Hemostasis was achieved, and the wound was closed in layers. Postoperative immobilization and hand therapy were initiated.

5. Procedure: Ganglion Sclerotherapy Operative Note: Ganglion sclerotherapy was performed on the patient's hand. Following sterile preparation, a needle was inserted into the ganglion under ultrasound guidance. A sclerosing agent was injected into the cyst to induce fibrosis and collapse. The needle was removed, and a compression dressing was applied. The patient was advised to limit hand use and keep the area elevated for optimal results.

6. Procedure: Ganglion Neurolysis Operative Note: Ganglion neurolysis was performed on the patient's sciatic nerve. The ganglion was visualized using intraoperative imaging. Adhesions around the nerve were carefully dissected and released, allowing for improved nerve mobility. The ganglion was preserved during the procedure. Hemostasis was achieved, and the wound was closed. Postoperatively, the patient was monitored for neurological improvement and provided with pain management instructions.

7. Procedure: Ganglion Radiofrequency Ablation Operative Note: Ganglion radiofrequency ablation was performed on the patient's lumbar facet joint. Under fluoroscopic guidance, a radiofrequency needle was placed near the ganglion. Radiofrequency energy was delivered to create a thermal lesion, interrupting the ganglion's pain signals. The needle was removed, and the patient reported immediate pain relief. Postoperative instructions included activity modification and follow-up evaluation.

8. Procedure: Ganglion Endoscopic Resection Operative Note: Ganglion endoscopic resection was performed on the patient's elbow. Two small incisions were made, and an endoscope and instruments were inserted. The ganglion was visualized, dissected, and excised using endoscopic techniques. Hemostasis was achieved, and the incisions were closed with sutures. The patient experienced improvement in range of motion and was advised on postoperative care and rehabilitation exercises.

9. Procedure: Ganglion Laser Ablation Operative Note: Ganglion laser ablation was performed on the patient's spine. Under fluoroscopic guidance, a laser fiber was inserted into the ganglion. Laser energy was delivered to heat and destroy the ganglion tissue. The fiber was removed, and hemostasis was achieved. The patient reported immediate pain reduction. Postoperative instructions included post-procedural care and follow-up evaluation.

10. Procedure: Ganglion Arthrotomy Operative Note: Ganglion arthrotomy was performed on the patient's hip joint. A surgical approach was used to expose the joint. The ganglion, arising from the synovium, was identified and carefully dissected. An arthrotomy was performed to excise the ganglion and evaluate the joint for any underlying pathology. Hemostasis was achieved, and the wound was closed in layers. The patient was started on a postoperative rehabilitation program.

1. Procedure: Ganglion Excision Operative Note: A ganglion excision was performed on the patient's dorsal wrist under local anesthesia with 1% lidocaine. A longitudinal incision was made over the ganglion, and dissection was carried down to expose the ganglion sac. The sac was carefully dissected and excised completely. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were noted.

2. Procedure: Ganglion Aspiration Operative Note: Ganglion aspiration was performed on the patient's volar wrist under local anesthesia with 2% lidocaine. Using sterile technique, a 22-gauge needle was inserted into the ganglion under ultrasound guidance. The cystic fluid was aspirated, and the ganglion collapsed. No evidence of infection or malignancy was noted. The patient experienced immediate relief of symptoms, and the area was dressed with a sterile dressing.

3. Procedure: Ganglion Decompression Operative Note: Ganglion decompression surgery was performed on the patient's ankle under regional anesthesia with a popliteal nerve block. A transverse incision was made over the ganglion, and the underlying tissues were dissected. The ganglion stalk was identified and released, relieving pressure within the cyst. The incision was closed, and the patient was placed in a compression bandage. Postoperatively, the patient was advised to limit weight-bearing activities.

4. Procedure: Ganglion Biopsy Operative Note: A ganglion biopsy was performed on the patient's hand under general anesthesia with endotracheal intubation. An incision was made over the ganglion, and the cystic fluid was aspirated. A portion of the ganglion wall was excised for pathological examination. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and no immediate complications were encountered.

5. Procedure: Ganglion Resection Operative Note: Ganglion resection was performed on the patient's foot under regional anesthesia with an ankle block. An incision was made over the ganglion, and dissection was carried down to expose the cyst. The ganglion and its stalk were carefully dissected and excised. Hemostasis was achieved, and the wound was closed in layers. The patient experienced immediate relief of symptoms, and postoperative instructions were given for wound care and follow-up.

6. Procedure: Ganglion Bursectomy Operative Note: A ganglion bursectomy was performed on the patient's knee under spinal anesthesia. An arthroscopic approach was used. The ganglion was visualized and found to be originating from the joint capsule. The ganglion and the associated bursa were excised using arthroscopic instruments. Hemostasis was achieved, and the joint was irrigated. The patient tolerated the procedure well, and postoperative rehabilitation was initiated.

7. Procedure: Ganglion Coagulation Operative Note: Ganglion coagulation was performed on the patient's finger under local anesthesia with 0.5% bupivacaine. A small incision was made over the ganglion, and the cystic fluid was aspirated. Electrocautery was used to cauterize the inner lining of the ganglion. Hemostasis was achieved, and the wound was closed with a sterile dressing. The patient reported immediate improvement in symptoms, and postoperative instructions were given for wound care.

8. Procedure: Ganglion Recurrence Excision Operative Note: The patient presented with a recurrent ganglion on the dorsal aspect of the wrist. An incision was made over the ganglion, and the cyst was carefully dissected and excised. The previous surgical site was explored, and no residual ganglion tissue was found. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, which was performed under conscious sedation with intravenous midazolam and fentanyl.

9. Procedure: Ganglion Marsupialization Operative Note: Ganglion marsupialization was performed on the patient's ankle under local anesthesia with 1% lidocaine. An incision was made over the ganglion, and the cyst was dissected and opened. The edges of the cyst were sutured to the surrounding skin, creating a permanent opening. The cyst was thoroughly irrigated, and the wound was closed with sutures. The patient experienced immediate relief of symptoms, and postoperative care instructions were provided.

10. Procedure: Ganglion Ligament Resection Operative Note: The patient presented with a ganglion arising from the scapholunate ligament. An incision was made over the ganglion, and dissection was carried down to expose the ligament. The ganglion was excised, and a portion of the involved ligament was resected. Hemostasis was achieved, and the wound was closed in layers. The patient was placed under general anesthesia with a laryngeal mask airway for the procedure. Postoperatively, immobilization and hand therapy were initiated.

1. Procedure: Ganglion Excision with Bone Erosion Operative Note: A ganglion excision with bone erosion was performed on the patient's wrist. An incision was made over the ganglion, and dissection revealed erosion of the underlying bone due to chronic pressure. The ganglion sac was carefully dissected and excised, and the eroded bone was debrided. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and postoperative instructions were given for immobilization and bone healing.

2. Procedure: Ganglion Aspiration with Bone Erosion Operative Note: Ganglion aspiration with bone erosion was performed on the patient's ankle. Using sterile technique, a 22-gauge needle was inserted into the ganglion under ultrasound guidance, revealing bone erosion adjacent to the cyst. The cystic fluid was aspirated, and the ganglion collapsed. The eroded bone was debrided, and thorough irrigation was performed. The patient experienced immediate relief of symptoms, and postoperative instructions were given for bone healing and rehabilitation.

3. Procedure: Ganglion Decompression with Bone Erosion Operative Note: Ganglion decompression surgery with bone erosion was performed on the patient's knee. A transverse incision was made over the ganglion, exposing the cyst and underlying bone erosion. The ganglion stalk was released, and meticulous debridement of the eroded bone was performed. The incision was closed, and the patient was placed in a compression bandage. Postoperatively, weight-bearing activities were restricted to promote bone healing.

4. Procedure: Ganglion Biopsy with Bone Erosion Operative Note: A ganglion biopsy with bone erosion was performed on the patient's hand. An incision was made over the ganglion, revealing bone erosion upon dissection. A portion of the ganglion wall and the eroded bone were excised for pathological examination. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and appropriate postoperative follow-up was planned for bone healing assessment.

5. Procedure: Ganglion Resection with Bone Erosion Operative Note: Ganglion resection with bone erosion was performed on the patient's foot. An incision was made over the ganglion, exposing the cyst and adjacent bone erosion. The ganglion and its stalk were meticulously dissected and excised. The eroded bone was debrided, and thorough irrigation was performed. Hemostasis was achieved, and the wound was closed in layers. Postoperatively, the patient was instructed for immobilization and bone healing.

6. Procedure: Ganglion Bursectomy with Bone Erosion Operative Note: A ganglion bursectomy with bone erosion was performed on the patient's knee. An arthroscopic approach was used to visualize the ganglion, which revealed bone erosion within the joint. The ganglion and the associated bursa were excised using arthroscopic instruments. The eroded bone was debrided, and the joint was irrigated. Hemostasis was achieved, and the patient tolerated the procedure well. Postoperatively, rehabilitation and bone healing protocols were initiated.

7. Procedure: Ganglion Coagulation with Bone Erosion Operative Note: Ganglion coagulation with bone erosion was performed on the patient's finger. A small incision was made over the ganglion, exposing bone erosion adjacent to the cyst. The cystic fluid was aspirated, and the inner lining of the ganglion was cauterized using electrocautery. The eroded bone was debrided, and meticulous hemostasis was achieved. The wound was closed with a sterile dressing, and the patient was provided with postoperative instructions for bone healing.

8. Procedure: Ganglion Recurrence Excision with Bone Erosion Operative Note: The patient presented with a recurrent ganglion with underlying bone erosion on the dorsal aspect of the wrist. An incision was made over the ganglion, revealing the cyst and adjacent bone erosion. The ganglion was carefully dissected and excised, and the eroded bone was debrided. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and appropriate follow-up was planned for bone healing assessment.

9. Procedure: Ganglion Marsupialization with Bone Erosion Operative Note: Ganglion marsupialization with bone erosion was performed on the patient's ankle. An incision was made over the ganglion, exposing the cyst and adjacent bone erosion. The cystic lining was carefully dissected and sutured to the surrounding skin, creating a permanent opening. The eroded bone was debrided, and thorough irrigation was performed. The wound was closed, and postoperative instructions were given for bone healing and rehabilitation.

10. Procedure: Ganglion Ligament Resection with Bone Erosion Operative Note The patient presented with a ganglion arising from the scapholunate ligament, with evidence of bone erosion. An incision was made over the ganglion, exposing the ligament and eroded bone. The ganglion was excised, and a portion of the involved ligament and eroded bone were resected. Hemostasis was achieved, and the wound was closed in layers. The patient was placed under general anesthesia, and postoperatively, immobilization and bone healing protocols were initiated.

1. Procedure: Ganglion Excision with Severe Bone Pain Operative Note: A ganglion excision was performed on the patient's wrist under regional anesthesia. The patient presented with severe bone pain associated with the ganglion. An incision was made over the ganglion, and dissection was carried out carefully to avoid exacerbating the pain. The ganglion sac was completely excised, and meticulous hemostasis was achieved. The wound was closed in layers. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up evaluation.

2. Procedure: Ganglion Aspiration with Severe Bone Pain Operative Note: Ganglion aspiration was performed on the patient's ankle under local anesthesia. The patient reported severe bone pain associated with the ganglion. Using sterile technique, the cystic fluid was aspirated from the ganglion, providing temporary relief of symptoms. The patient's pain level was closely monitored throughout the procedure. Postoperatively, pain management measures were implemented, and the patient was scheduled for further evaluation and treatment if needed.

3. Procedure: Ganglion Decompression with Severe Bone Pain Operative Note: Ganglion decompression surgery was performed on the patient's knee under spinal anesthesia. The patient experienced severe bone pain related to the ganglion. The ganglion stalk was carefully released to alleviate pressure and decompress the affected area. The procedure was performed with utmost care to minimize pain. Postoperatively, pain control measures were initiated, and the patient was advised on rehabilitation protocols to manage the underlying bone pain.

4. Procedure: Ganglion Biopsy with Severe Bone Pain Operative Note: A ganglion biopsy was performed on the patient's hand under general anesthesia. The patient presented with severe bone pain associated with the ganglion. An incision was made over the ganglion, and a portion of the ganglion wall was excised for pathological examination. Special attention was given to managing the patient's pain during the procedure. Postoperatively, pain management strategies were employed, and the patient was scheduled for further evaluation based on biopsy results.

5. Procedure: Ganglion Resection with Severe Bone Pain Operative Note: Ganglion resection was performed on the patient's foot under regional anesthesia. The patient reported severe bone pain associated with the ganglion. An incision was made over the ganglion, and the cyst and underlying eroded bone were meticulously resected. Pain control measures were carefully implemented throughout the procedure. Postoperatively, the patient was provided with pain management instructions and scheduled for follow-up evaluation.

6. Procedure: Ganglion Bursectomy with Severe Bone Pain Operative Note: A ganglion bursectomy was performed on the patient's knee under general anesthesia. The patient experienced severe bone pain related to the ganglion. The ganglion and associated bursa were excised meticulously to relieve the pressure and alleviate pain. Pain management strategies were employed intraoperatively and continued postoperatively. The patient was instructed on pain control measures and rehabilitation exercises to manage the severe bone pain.

7. Procedure: Ganglion Coagulation with Severe Bone Pain Operative Note: Ganglion coagulation was performed on the patient's finger under local anesthesia. The patient reported severe bone pain associated with the ganglion. The ganglion sac was cauterized using electrocautery to achieve coagulation. Pain management measures were implemented during the procedure to alleviate the patient's pain. Postoperatively, pain control strategies were employed, and the patient was scheduled for follow-up evaluation.

8. Procedure: Ganglion Recurrence Excision with Severe Bone Pain Operative Note: The patient presented with a recurrent ganglion on the dorsal aspect of the wrist, accompanied by severe bone pain. An incision was made over the ganglion, and complete excision was performed, paying special attention to managing the patient's pain. The wound was closed meticulously. Postoperatively, pain management techniques were employed, and the patient was scheduled for further evaluation to address the severe bone pain.

9. Procedure: Ganglion Marsupialization with Severe Bone Pain Operative Note: Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The patient experienced severe bone pain associated with the ganglion. The cystic lining was sutured to the surrounding skin to create a permanent opening, relieving pressure and reducing pain. Intraoperative pain management strategies were employed. Postoperatively, pain control measures were initiated, and the patient was scheduled for follow-up evaluation.

10. Procedure: Ganglion Ligament Resection with Severe Bone Pain Operative Note: The patient presented with a ganglion arising from the scapholunate ligament, causing severe bone pain. An incision was made over the ganglion, and meticulous dissection was performed to minimize pain. The ganglion and involved ligament were resected carefully. Special attention was given to managing the patient's pain during the procedure. Postoperatively, pain control measures were implemented, and the patient was instructed on rehabilitation protocols to address the severe bone pain.

1. Procedure: Ganglion Excision with Surgical Intervention Operative Note: A ganglion excision was performed on the patient's wrist under local anesthesia. The ganglion was carefully dissected and excised, and the surrounding tissues were thoroughly inspected. During the procedure, a surgical intervention was required to repair a small tendon tear that was identified. The tear was repaired using sutures, and the wound was closed. Postoperatively, the patient was instructed on tendon rehabilitation protocols and scheduled for follow-up evaluation.

2. Procedure: Ganglion Aspiration with Surgical Intervention Operative Note: Ganglion aspiration was performed on the patient's ankle under conscious sedation. The cystic fluid was successfully aspirated from the ganglion, providing symptomatic relief. However, during the procedure, a surgical intervention was necessary to address a small articular cartilage defect adjacent to the ganglion. The defect was debrided and treated accordingly. The patient tolerated the procedure well, and postoperative care instructions were provided.

3. Procedure: Ganglion Decompression with Surgical Intervention Operative Note: Ganglion decompression surgery was performed on the patient's knee under general anesthesia. The ganglion stalk was released to alleviate pressure and decompress the affected area. Additionally, a surgical intervention was performed to address a meniscal tear that was discovered during the procedure. The torn meniscus was trimmed and repaired. The patient was immobilized postoperatively and instructed on rehabilitation protocols for optimal recovery.

4. Procedure: Ganglion Biopsy with Surgical Intervention Operative Note:A ganglion biopsy was performed on the patient's hand under regional anesthesia. The ganglion wall was excised for pathological examination. Additionally, a surgical intervention was necessary to address a small bone spur that was identified adjacent to the ganglion. The bone spur was carefully removed. The patient tolerated the procedure well, and postoperative instructions were given for wound care and follow-up evaluation.

5. Procedure: Ganglion Resection with Surgical Intervention Operative Note: Ganglion resection was performed on the patient's foot under general anesthesia. The ganglion and underlying tissues were meticulously dissected and excised. Furthermore, a surgical intervention was required to repair a small ligament tear that was discovered during the procedure. The torn ligament was repaired using sutures, and appropriate tension was restored. The patient was placed in a compression bandage postoperatively, and rehabilitation protocols were initiated.

6. Procedure: Ganglion Bursectomy with Surgical Intervention Operative Note: A ganglion bursectomy was performed on the patient's knee under spinal anesthesia. The ganglion and associated bursa were carefully excised. Additionally, a surgical intervention was necessary to address a small meniscal tear that was identified during the procedure. The torn meniscus was trimmed and repaired. The patient tolerated the procedure well, and postoperative instructions were provided for pain management and rehabilitation.

7. Procedure: Ganglion Coagulation with Surgical Intervention Operative Note: Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery to achieve coagulation. Moreover, a surgical intervention was required to address a small nerve entrapment that was observed during the procedure. The entrapped nerve was released, providing relief to the patient. Postoperatively, the patient was instructed on wound care and given pain management guidelines.

8. Procedure: Ganglion Recurrence Excision with Surgical Intervention Operative Note: The patient presented with a recurrent ganglion on the dorsal aspect of the wrist. A repeat excision was performed, removing the ganglion completely. Additionally, a surgical intervention was necessary to address a small tendon adhesion that was discovered during the procedure. The adhesion was carefully released, restoring normal tendon function. The wound was closed, and the patient was advised on postoperative care and follow-up evaluation.

9. Procedure: Ganglion Marsupialization with Surgical Intervention Operative Note: Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin, creating a permanent opening. Moreover, a surgical intervention was required to address a small joint capsule contracture that was identified during the procedure. The contracture was released, restoring normal joint range of motion. The patient was provided with postoperative instructions for wound care and rehabilitation.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention Operative Note: The patient presented with a ganglion arising from the scapholunate ligament. The ganglion and associated ligament were meticulously resected. Furthermore, a surgical intervention was necessary to address a small bone erosion that was discovered adjacent to the ganglion. The eroded bone was debrided and treated accordingly. The patient tolerated the procedure well, and postoperative care instructions were given for wound healing and rehabilitation.

1. Procedure: Ganglion Excision with Extensive Surgical Intervention Operative Note: A ganglion excision was performed on the patient's wrist under general anesthesia. The ganglion was carefully dissected and completely excised. Additionally, extensive surgical intervention was required to address a complex tendon injury and bone erosion associated with the ganglion. Tendon repair, bone grafting, and fixation were performed to restore function and stability. The wound was closed meticulously, and the patient was placed in a splint for immobilization and scheduled for postoperative rehabilitation.

2. Procedure: Ganglion Aspiration with Surgical Intervention for Joint Instability Operative Note: Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated from the ganglion, providing symptomatic relief. Moreover, a surgical intervention was necessary to address concurrent joint instability identified during the procedure. Ligament reconstruction and stabilization procedures were performed to restore joint integrity. Postoperatively, the patient was instructed on weight-bearing restrictions and referred for physical therapy.

3. Procedure: Ganglion Decompression with Surgical Intervention for Nerve Entrapment Operative Note: Ganglion decompression surgery was performed on the patient's hand under local anesthesia. The ganglion stalk was released to alleviate pressure and decompress the affected area. Additionally, a surgical intervention was required to address nerve entrapment caused by the ganglion. The entrapped nerve was meticulously released, providing relief to the patient. The wound was closed, and the patient was instructed on hand therapy exercises for nerve regeneration.

4. Procedure: Ganglion Biopsy with Surgical Intervention for Bone Fracture Operative Note: A ganglion biopsy was performed on the patient's foot under general anesthesia. The ganglion wall was excised for pathological examination. Furthermore, a surgical intervention was necessary to address an underlying bone fracture associated with the ganglion. The fracture was anatomically reduced and stabilized using internal fixation. The patient was immobilized postoperatively and instructed on weight-bearing restrictions for optimal fracture healing.

5. Procedure: Ganglion Resection with Surgical Intervention for Vascular Impingement Operative Note: Ganglion resection was performed on the patient's elbow under regional anesthesia. The ganglion and adjacent tissues were meticulously excised. Additionally, a surgical intervention was required to address vascular impingement caused by the ganglion. Vascular repair and reconstruction procedures were performed to restore blood flow. The wound was closed, and the patient was monitored closely for vascular compromise postoperatively.

6. Procedure: Ganglion Bursectomy with Surgical Intervention for Tendon Adhesion Operative Note: A ganglion bursectomy was performed on the patient's knee under spinal anesthesia. The ganglion and associated bursa were meticulously excised. Moreover, a surgical intervention was necessary to address a tendon adhesion caused by the ganglion. The adhesion was carefully released, allowing for normal tendon movement. The patient was provided with postoperative instructions for wound care and referred for physical therapy.

7. Procedure: Ganglion Coagulation with Surgical Intervention for Joint Contracture Operative Note: Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. Additionally, a surgical intervention was required to address a joint contracture associated with the ganglion. The contracture was released through capsular release and tenolysis procedures. The patient was instructed on postoperative hand therapy exercises to regain full joint range of motion.

8. Procedure: Ganglion Recurrence Excision with Surgical Intervention for Ligament Tear Operative Note: The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. Moreover, a surgical intervention was necessary to address a ligament tear identified during the procedure. Ligament repair or reconstruction was performed to restore stability and function. The wound was closed meticulously, and the patient was placed in a splint for immobilization.

9. Procedure: Ganglion Marsupialization with Surgical Intervention for Tendon Rupture Operative Note: Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin to create a permanent opening. Furthermore, a surgical intervention was required to address a tendon rupture associated with the ganglion. Tendon repair or reconstruction was performed to restore normal function. The patient was instructed on postoperative weight-bearing restrictions and referred for physical therapy.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention for Joint Instability Operative Note: The patient presented with a ganglion arising from the wrist ligament. The ganglion and associated ligament were meticulously resected. Additionally, a surgical intervention was necessary to address joint instability caused by ligament laxity. Ligament reconstruction or stabilization procedures were performed to restore joint stability. Postoperatively, the patient was instructed on immobilization and referred for rehabilitation to regain full wrist function.

1. Procedure: Ganglion Excision with Surgical Intervention for Severe Joint Infection Operative Note: A ganglion excision was performed on the patient's elbow under general anesthesia. The ganglion and surrounding tissues were meticulously excised. Additionally, due to the presence of severe infection involving the extreme moving joint, a surgical intervention was necessary. Joint debridement, irrigation, and thorough cleansing were performed to eradicate the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for resolution of the infection.

2. Procedure: Ganglion Aspiration with Surgical Intervention for Septic Joint Operative Note: Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated, providing symptomatic relief. However, a surgical intervention was required due to the presence of a septic joint caused by the severe infection. Joint washout and debridement were performed to remove infected tissue and debris. Postoperatively, appropriate antibiotic therapy was initiated, and the patient was monitored closely for infection control.

3. Procedure: Ganglion Decompression with Surgical Intervention for Infected Joint Operative Note: Ganglion decompression surgery was performed on the patient's shoulder under general anesthesia. The ganglion stalk was released to alleviate pressure. Additionally, a surgical intervention was necessary to address the infected joint. Joint exploration, debridement, and irrigation were performed to remove infected tissues and promote healing. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for resolution of the joint infection.

4. Procedure: Ganglion Biopsy with Surgical Intervention for Extreme Joint Infection Operative Note: A ganglion biopsy was performed on the patient's ankle under regional anesthesia. The ganglion wall was excised for pathological examination. Furthermore, a surgical intervention was required to address an extreme joint infection. Joint debridement, thorough irrigation, and abscess drainage were performed to control the infection. Postoperatively, appropriate antibiotic therapy was initiated, and the patient was monitored for signs of infection resolution.

5. Procedure: Ganglion Resection with Surgical Intervention for Septic Arthritic Joint Operative Note: Ganglion resection was performed on the patient's hip under general anesthesia. The ganglion and surrounding tissues were meticulously resected. Additionally, a surgical intervention was necessary to address a septic arthritic joint caused by the severe infection. Joint debridement, synovectomy, and irrigation were performed to eradicate the infection and alleviate arthritic symptoms. Postoperatively, the patient was started on intravenous antibiotics and scheduled for close follow-up.

6. Procedure: Ganglion Bursectomy with Surgical Intervention for Infected Bursa and Joint Operative Note: A ganglion bursectomy was performed on the patient's knee under regional anesthesia. The ganglion and associated bursa were meticulously excised. Furthermore, a surgical intervention was required to address the presence of an infected bursa and joint. Bursal and joint debridement, thorough irrigation, and drainage were performed to control the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for infection resolution.

7. Procedure: Ganglion Coagulation with Surgical Intervention for Septic Extreme Joint Operative Note: Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. Additionally, a surgical intervention was required to address a septic extreme joint caused by the severe infection. Joint debridement, irrigation, and abscess drainage were performed to control the infection. Postoperatively, appropriate antibiotic therapy was initiated, and the patient was closely monitored for joint infection resolution.

8. Procedure: Ganglion Recurrence Excision with Surgical Intervention for Infected Extreme JointvOperative Note: The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. Moreover, a surgical intervention was necessary to address the presence of an infected extreme joint. Joint exploration, debridement, and thorough irrigation were performed to control the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for joint infection resolution.

9. Procedure: Ganglion Marsupialization with Surgical Intervention for Septic Moving Joint Operative Note: Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin, creating a permanent opening. Additionally, a surgical intervention was necessary to address the septic moving joint caused by the severe infection. Joint debridement, irrigation, and abscess drainage were performed to control the infection. The patient was started on intravenous antibiotics and scheduled for close follow-up.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention for Infected Extreme Joint Operative Note: The patient presented with a ganglion arising from the knee ligament. The ganglion and associated ligament were meticulously resected. Furthermore, a surgical intervention was necessary to address the presence of an infected extreme joint. Joint debridement, synovectomy, and thorough irrigation were performed to control the infection. Postoperatively, intravenous antibiotics were administered, and the patient was closely monitored for joint infection resolution.

1. Procedure: Ganglion Excision with Surgical Intervention for Inflamed Joint Operative Note: A ganglion excision was performed on the patient's wrist under general anesthesia. The ganglion and surrounding tissues were meticulously excised. Additionally, a surgical intervention was necessary due to the presence of an inflamed joint. Joint debridement and irrigation were performed to alleviate inflammation and promote healing. Postoperatively, the patient was prescribed anti-inflammatory medications and instructed on proper joint immobilization.

2. Procedure: Ganglion Aspiration with Surgical Intervention for Acutely Inflamed Joint Operative Note: Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated, providing immediate relief. However, a surgical intervention was required due to acute inflammation in the joint. Joint debridement and irrigation were performed to reduce inflammation and improve joint function. Postoperatively, the patient was advised on pain management strategies and referred for physical therapy.

3. Procedure: Ganglion Decompression with Surgical Intervention for Chronically Inflamed JointOperative Note: Ganglion decompression surgery was performed on the patient's shoulder under general anesthesia. The ganglion stalk was released to relieve pressure and compression. Additionally, a surgical intervention was necessary to address chronic inflammation in the joint. Synovectomy and joint debridement were performed to alleviate inflammation and improve joint mobility. Postoperatively, the patient was prescribed anti-inflammatory medications and instructed on rehabilitation exercises.

4. Procedure: Ganglion Biopsy with Surgical Intervention for Inflamed Bursa and Joint Operative Note: A ganglion biopsy was performed on the patient's ankle under regional anesthesia. The ganglion wall was excised for pathological examination. Furthermore, a surgical intervention was required to address inflammation in the bursa and joint. Bursal and joint debridement, irrigation, and synovectomy were performed to reduce inflammation and promote healing. Postoperatively, the patient was prescribed anti-inflammatory medications and advised on joint protection measures.

5. Procedure: Ganglion Resection with Surgical Intervention for Inflamed Arthritic Joint Operative Note: Ganglion resection was performed on the patient's hip under general anesthesia. The ganglion and surrounding tissues were meticulously resected. Additionally, a surgical intervention was necessary to address inflammation in the arthritic joint. Joint debridement, synovectomy, and irrigation were performed to reduce inflammation and alleviate arthritic symptoms. Postoperatively, the patient was prescribed anti-inflammatory medications and referred for rehabilitation.

6. Procedure: Ganglion Bursectomy with Surgical Intervention for Inflamed Bursa and Joint Capsule Operative Note: A ganglion bursectomy was performed on the patient's knee under regional anesthesia. The ganglion and associated bursa were meticulously excised. Furthermore, a surgical intervention was required to address inflammation in the bursa and joint capsule. Bursal and joint capsule debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint function. Postoperatively, the patient was prescribed anti-inflammatory medications and advised on activity modification.

7. Procedure: Ganglion Coagulation with Surgical Intervention for Inflamed Extreme Joint Operative Note: Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. Additionally, a surgical intervention was necessary to address inflammation in the extreme joint. Joint debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint mobility. Postoperatively, the patient was prescribed anti-inflammatory medications and instructed on joint protection techniques.

8. Procedure: Ganglion Recurrence Excision with Surgical Intervention for Inflamed Joint Operative Note: The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. Moreover, a surgical intervention was necessary to address inflammation in the joint. Joint debridement, irrigation, and synovectomy were performed to alleviate inflammation and promote healing. Postoperatively, the patient was prescribed anti-inflammatory medications and referred for occupational therapy.

9. Procedure: Ganglion Marsupialization with Surgical Intervention for Inflamed Moving Joint Operative Note: Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin to create a permanent opening. Additionally, a surgical intervention was necessary to address inflammation in the moving joint. Joint debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint mobility. The patient was prescribed anti-inflammatory medications and instructed on joint protection measures.

10. Procedure: Ganglion Ligament Resection with Surgical Intervention for Inflamed Extreme Joint Operative Note: The patient presented with a ganglion arising from the knee ligament. The ganglion and associated ligament were meticulously resected. Furthermore, a surgical intervention was necessary to address inflammation in the extreme joint. Joint debridement, irrigation, and synovectomy were performed to reduce inflammation and improve joint function. Postoperatively, the patient was prescribed anti-inflammatory medications and scheduled for follow-up evaluation.

1. Procedure: Ganglion Excision for Diagnosis of Benign Cyst Operative Note: Ganglion excision was performed on the patient's wrist under local anesthesia. The ganglion and surrounding tissues were meticulously excised. The diagnosis confirmed a benign cyst. Postoperatively, the patient was instructed to monitor the surgical site for signs of infection or recurrence. Follow-up evaluation was scheduled in six weeks unless any concerning symptoms arise.

2. Procedure: Ganglion Aspiration for Diagnosis of Ganglion Cyst Operative Note: Ganglion aspiration was performed on the patient's knee under regional anesthesia. The cystic fluid was successfully aspirated, confirming the diagnosis of a ganglion cyst. The patient experienced immediate relief. Postoperatively, the patient was advised to observe for any recurrence or worsening of symptoms. A follow-up appointment was scheduled in four weeks to monitor progress.

3. Procedure: Ganglion Decompression for Diagnosis of Ganglion Impingement Operative Note: Ganglion decompression surgery was performed on the patient's shoulder under general anesthesia. The ganglion stalk was released to alleviate impingement symptoms. The diagnosis confirmed ganglion impingement. Postoperatively, the patient was prescribed pain medication and advised to follow up in two weeks for a postoperative evaluation and assessment of symptoms.

4. Procedure: Ganglion Biopsy for Diagnostic Evaluation of Mass Operative Note: A ganglion biopsy was performed on the patient's ankle under regional anesthesia. The ganglion wall was excised for pathological examination to determine the nature of the mass. Postoperatively, the patient was instructed to rest and elevate the affected limb. The follow-up plan depended on the biopsy results, with a consultation scheduled in one week to discuss the findings and further treatment options.

5. Procedure: Ganglion Resection for Diagnosis of Ganglion Tumor Operative Note: Ganglion resection was performed on the patient's hip under general anesthesia. The ganglion and surrounding tissues were meticulously resected. The pathological evaluation confirmed the presence of a ganglion tumor. Postoperatively, the patient was referred to an oncology specialist for further evaluation and treatment. A follow-up appointment was scheduled to coordinate the ongoing care.

6. Procedure: Ganglion Bursectomy for Diagnosis of Bursal Inflammation Operative Note: A ganglion bursectomy was performed on the patient's knee under regional anesthesia. The ganglion and associated inflamed bursa were meticulously excised. The diagnosis revealed bursal inflammation. Postoperatively, the patient was prescribed anti-inflammatory medications and advised on activity modification. A follow-up appointment was scheduled in four weeks to assess the response to treatment.

7. Procedure: Ganglion Coagulation for Diagnosis of Ganglion Cystic Degeneration Operative Note: Ganglion coagulation was performed on the patient's finger under local anesthesia. The ganglion sac was cauterized using electrocautery. The diagnosis confirmed ganglion cystic degeneration. Postoperatively, the patient was instructed on wound care and advised to monitor for any signs of infection or recurrence. A follow-up appointment was scheduled in six weeks unless any concerns arise.

8. Procedure: Ganglion Recurrence Excision for Diagnosis of Recurrent Ganglion Cyst Operative Note: The patient presented with a recurrent ganglion on the wrist. A repeat excision was performed, removing the ganglion completely. The diagnosis confirmed a recurrent ganglion cyst. Postoperatively, the patient was advised on activity restrictions and instructed to observe for any recurrence or persistent symptoms. A follow-up appointment was scheduled in two weeks for a wound check and assessment of symptoms.

9. Procedure: Ganglion Marsupialization for Diagnosis of Symptomatic Ganglion Cyst Operative Note: Ganglion marsupialization was performed on the patient's ankle under regional anesthesia. The ganglion sac was sutured to the surrounding skin, creating a permanent opening. The diagnosis confirmed a symptomatic ganglion cyst. Postoperatively, the patient was prescribed pain medication and advised on self-care measures. A follow-up appointment was scheduled in four weeks to assess symptom improvement and wound healing.

10. Procedure: Ganglion Ligament Resection for Diagnosis of Ganglion-Associated Ligament Tear Operative Note: The patient presented with a ganglion arising from the knee ligament. The ganglion and associated ligament were meticulously resected. The diagnosis revealed a ganglion-associated ligament tear. Postoperatively, the patient was referred to physical therapy for rehabilitation and instructed to follow up in six weeks for a comprehensive evaluation of joint stability and functional recovery.

## M67.8 Other specified disorders of synovium and tendon

1. Operative Note: Patient presented with other specified disorder of synovium and tendon. A medial incision was made, allowing access to the affected area. Careful dissection revealed synovial thickening and tendon involvement. Debridement was performed, removing abnormal tissue. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including immobilization and physical therapy.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. A dorsal approach was utilized to access the affected site. Intraoperatively, synovial hypertrophy and tendon inflammation were observed. Partial synovectomy and tenotomy were performed to alleviate symptoms. Hemostasis was ensured, and the incision was closed. Postoperatively, the patient was advised on pain management and rehabilitation exercises.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. A lateral approach was chosen, providing optimal exposure. Intraoperative findings included synovial proliferation and tendon adhesions. The affected synovium was excised, and tenolysis was performed to restore tendon function. Hemostasis was confirmed, and the wound was sutured. The patient was instructed on postoperative care, including wound care and activity restrictions.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A volar approach was utilized to access the affected area. Intraoperatively, synovial thickening and tendon nodules were observed. Complete synovectomy and tenolysis were performed, followed by meticulous hemostasis. The wound was closed, and the patient received postoperative instructions for pain management and rehabilitation exercises.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon. An arthroscopic approach was employed, allowing visualization of the joint. Arthroscopy revealed synovial hypertrophy and tendon impingement. Synovectomy and tendon release were performed using specialized instruments. The joint was irrigated, and hemostasis was achieved. The incisions were closed, and the patient was educated on postoperative care, including physical therapy.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A mini-open approach was employed, providing access to the affected region. Intraoperative assessment revealed synovial inflammation and tendon thickening. Partial synovectomy and tendon debridement were performed, followed by meticulous hemostasis. The incision was closed, and the patient received postoperative instructions for wound care and gradual mobilization.

7. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. An endoscopic approach was chosen to minimize invasiveness. Endoscopy revealed synovial proliferation and tendon entrapment. Synovectomy and tenotomy were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient was counseled on postoperative care, including pain management and gradual return to normal activities.

8. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A posterior approach was employed, providing direct access to the affected site. Intraoperatively, synovial hyperplasia and tendon degeneration were observed. Synovectomy and tendon repair were performed, ensuring adequate hemostasis. The wound was closed, and the patient received postoperative instructions for immobilization and rehabilitation exercises.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon. An ultrasound-guided approach was employed for precise localization. Ultrasonography revealed synovial thickening and tendon adhesions. Synovectomy and tenolysis were performed under ultrasound guidance. Hemostasis was ensured, and the wound was closed. The patient was educated on postoperative care, including pain management and gradual return to normal activities.

10. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. A transverse incision was made, providing exposure to the affected region. Intraoperatively, synovial inflammation and tendon contracture were noted. Synovectomy and tendon release were performed, followed by meticulous hemostasis. The incision was closed, and the patient was provided with postoperative instructions for wound care and physical therapy.

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. A subcutaneous approach was employed, allowing access to the affected area. Intraoperatively, synovial proliferation and tendon thickening were observed. Synovectomy and tenotomy were performed, followed by thorough hemostasis. The wound was closed, and postoperative instructions were provided, including immobilization and gradual range-of-motion exercises.

2. Operative Note: Patient presented with other specified disorder of synovium and tendon. An open approach was chosen to visualize the affected site. Intraoperative findings revealed synovial hypertrophy and tendon entrapment. Complete synovectomy and tendon release were performed, ensuring meticulous hemostasis. The incision was closed, and the patient received postoperative instructions for pain management and physical therapy.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A medial parapatellar approach was utilized, providing excellent exposure. Intraoperative assessment demonstrated synovial thickening and tendon degeneration. Partial synovectomy and tenodesis were performed, followed by appropriate hemostasis. The incision was closed, and the patient was educated on postoperative care, including wound care and gradual mobilization.

4. Operative Note: The patient underwent arthroscopic surgery for other specified disorder of synovium and tendon. Multiple portals were created, allowing thorough joint inspection. Arthroscopy revealed synovial hyperplasia and tendon adhesions. Extensive synovectomy and tenolysis were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions for pain management and rehabilitation exercises.

5. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A lateral transposition approach was employed, providing direct access to the affected region. Intraoperatively, synovial inflammation and tendon contracture were noted. Synovectomy and tendon repositioning were performed, ensuring adequate hemostasis. The incision was closed, and the patient was provided with postoperative instructions for wound care and gradual return to normal activities.

6. Operative Note: Patient presented with other specified disorder of synovium and tendon. An endoscopic-assisted approach was chosen, combining visualization techniques. Intraoperative assessment revealed synovial thickening and tendon impingement. Endoscopic synovectomy and tendon decompression were performed, followed by meticulous hemostasis. The incisions were closed, and the patient was educated on postoperative care, including pain management and physical therapy.

7. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. A mini-open approach was employed, allowing access to the affected area. Intraoperatively, synovial proliferation and tendon inflammation were observed. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for wound care and gradual rehabilitation.

8. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon. A percutaneous approach was utilized, minimizing tissue trauma. Intraoperative findings included synovial hypertrophy and tendon thickening. Percutaneous synovectomy and tenolysis were performed, followed by meticulous hemostasis. The access points were closed, and the patient was counseled on postoperative care, including pain management and progressive mobilization.

9. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. An anterolateral approach was employed, providing excellent exposure to the affected site. Intraoperative assessment revealed synovial thickening and tendon degeneration. Complete synovectomy and tendon repair were performed, ensuring adequate hemostasis. The incision was closed, and the patient received postoperative instructions for wound care and gradual return to normal activities.

10. Operative Note: Patient presented with other specified disorder of synovium and tendon. An ultrasonography-guided approach was utilized to precisely target the pathology. Ultrasonographic findings revealed synovial hyperplasia and tendon adhesions. Synovectomy and tenolysis were performed under ultrasound guidance, with meticulous hemostasis achieved. The incision was closed, and the patient was provided with postoperative instructions for pain management and a tailored rehabilitation program.

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under general anesthesia. A dorsal approach was utilized, providing access to the affected area. Intraoperatively, synovial thickening and tendon involvement were observed. Debridement was performed while maintaining a moderate level of anesthesia. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including immobilization and physical therapy.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon. The procedure was performed under regional anesthesia, with a peripheral nerve block targeting the affected area. A lateral approach was chosen, allowing visualization of the pathology. Intraoperative findings revealed synovial hypertrophy and tendon adhesions. Partial synovectomy and tenotomy were performed while maintaining an appropriate level of anesthesia. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for pain management and rehabilitation exercises.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under local anesthesia with conscious sedation. An arthroscopic approach was employed, providing visualization of the joint. Arthroscopy revealed synovial proliferation and tendon impingement. Synovectomy and tendon release were performed while closely monitoring the patient's sedation level. The joint was irrigated, and hemostasis was achieved. The incisions were closed, and the patient was educated on postoperative care, including pain management and gradual return to normal activities.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. The procedure was performed under monitored anesthesia care (MAC) with deep sedation. A volar approach was chosen, allowing access to the affected region. Intraoperative findings included synovial thickening and tendon nodules. Complete synovectomy and tenolysis were performed while closely monitoring the patient's sedation depth. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided for pain management and rehabilitation.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon. The surgery was performed under general anesthesia with neuromuscular blockade. An endoscopic approach was employed, providing excellent visualization. Intraoperative assessment revealed synovial hyperplasia and tendon entrapment. Synovectomy and tenotomy were performed while maintaining appropriate muscle relaxation. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions for pain management and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The procedure was performed under regional anesthesia with intravenous sedation. A mini-open approach was employed, providing access to the affected area. Intraoperative assessment revealed synovial inflammation and tendon thickening. Partial synovectomy and tendon debridement were performed while maintaining a moderate level of sedation. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for wound care and gradual mobilization.

7. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under local anesthesia. An ultrasound-guided approach was employed for precise localization. Ultrasonography revealed synovial thickening and tendon adhesions. Synovectomy and tenolysis were performed under local anesthesia, with the patient remaining awake and comfortable throughout the procedure. Hemostasis was achieved, and the wound was closed. The patient was educated on postoperative care, including pain management and gradual return to normal activities.

8. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. The procedure was performed under general anesthesia with balanced anesthesia technique. A posterior approach was employed, providing direct access to the affected site. Intraoperative findings revealed synovial hyperplasia and tendon degeneration. Synovectomy and tendon repair were performed while carefully monitoring the patient's anesthetic depth. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for immobilization and rehabilitation exercises.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon. The surgery was performed under regional anesthesia with light sedation. An open approach was chosen to visualize the affected site. Intraoperative findings included synovial proliferation and tendon inflammation. Complete synovectomy and tenodesis were performed while maintaining a light level of sedation. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions for wound care and gradual return to normal activities.

10. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon under general anesthesia with controlled hypotension. A subcutaneous approach was employed, allowing access to the affected area. Intraoperatively, synovial proliferation and tendon degeneration were observed. Partial synovectomy and tenolysis were performed while maintaining controlled hypotension to minimize bleeding. Hemostasis was ensured, and the wound was closed. The patient was provided with postoperative instructions for pain management and a tailored rehabilitation program.

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon with associated bone erosion. A medial incision was made, allowing access to the affected area. Intraoperatively, synovial thickening, tendon involvement, and bone erosion were observed. Debridement was performed to remove abnormal tissue, including the eroded bone fragments. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including immobilization, physical therapy, and appropriate measures to address bone healing.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon, complicated by bone erosion. A dorsal approach was utilized, providing access to the affected region. Intraoperative findings included synovial hypertrophy, tendon adhesions, and bone erosion. Synovectomy, tenolysis, and bone debridement were performed to address the pathology. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided, emphasizing the importance of bone healing and rehabilitation exercises.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, with significant bone erosion. An arthroscopic approach was employed to visualize the joint and associated pathology. Arthroscopy revealed synovial proliferation, tendon impingement, and bone erosion. Synovectomy, tendon release, and bone debridement were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including bone healing support and rehabilitation to restore joint function.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by extensive bone erosion. A lateral approach was chosen to address the pathology. Intraoperative assessment revealed synovial thickening, tendon contracture, and bone erosion. Complete synovectomy, tenodesis, and bone grafting were performed to restore joint stability and address the bone erosion. Hemostasis was achieved, and the incision was closed. Postoperative instructions were provided for bone healing, physical therapy, and gradual return to normal activities.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon, with significant bone erosion. An open approach was employed to address the pathology comprehensively. Intraoperatively, synovial hyperplasia, tendon thickening, and bone erosion were observed. Partial synovectomy, tenotomy, and bone debridement were performed to remove the diseased tissues. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, including bone healing support, wound care, and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon, complicated by extensive bone erosion. A volar approach was chosen to access the affected area. Intraoperative findings included synovial inflammation, tendon nodules, and bone erosion. Complete synovectomy, tenolysis, and bone repair were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided, emphasizing bone healing, immobilization, and gradual restoration of joint function.

7. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, with significant bone erosion. An endoscopic approach was employed, combining visualization techniques to address the pathology. Intraoperative assessment revealed synovial proliferation, tendon entrapment, and bone erosion. Endoscopic synovectomy, tendon release, and bone debridement were performed to restore joint integrity. Hemostasis was achieved, and the incisions were closed. The patient received postoperative instructions, including bone healing support, pain management, and rehabilitation exercises.

8. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by severe bone erosion. The procedure was performed under general anesthesia, and a posterior approach was employed to access the affected site. Intraoperative findings included synovial hypertrophy, tendon inflammation, and extensive bone erosion. Complete synovectomy, tenodesis, and bone grafting were performed to address the pathology comprehensively. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions, including bone healing support, physical therapy, and gradual return to normal activities.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon, with significant bone erosion. The surgery was performed under regional anesthesia, with a peripheral nerve block targeting the affected area. A mini-open approach was chosen to visualize the pathology. Intraoperative findings revealed synovial thickening, tendon degeneration, and bone erosion. Partial synovectomy, tenolysis, and bone debridement were performed while closely monitoring the patient's comfort and addressing the bone erosion. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for bone healing support, wound care, and rehabilitation exercises.

10. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, complicated by significant bone erosion. The procedure was performed under general anesthesia, with controlled hypotension to minimize bleeding from the eroded bone. An anterolateral approach was employed, providing direct access to the affected region. Intraoperative assessment revealed synovial hyperplasia, tendon adhesions, and bone erosion. Complete synovectomy, tenodesis, and bone repair were performed while maintaining controlled hypotension. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions for bone healing support, pain management, and a tailored rehabilitation program.

1. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, complicated by severe bone pain. A medial approach was utilized, providing access to the affected area. Intraoperatively, synovial thickening, tendon involvement, and significant bone erosion were observed. Debridement was performed to remove the diseased tissue, including the eroded bone fragments. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, including pain management strategies, immobilization, and rehabilitation exercises.

2. Operative Note: Surgical intervention was required for other specified disorder of synovium and tendon, with associated severe bone pain. A dorsal approach was employed, allowing visualization of the affected region. Intraoperative findings included synovial hypertrophy, tendon adhesions, and bone erosion. Synovectomy, tenolysis, and bone debridement were performed to address the pathology and alleviate the severe bone pain. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided, emphasizing pain control measures, bone healing support, and rehabilitation.

3. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, with severe bone pain. An arthroscopic approach was employed, providing excellent visualization of the joint and associated pathology. Arthroscopy revealed synovial proliferation, tendon impingement, and significant bone erosion contributing to the severe bone pain. Synovectomy, tendon release, and bone debridement were performed to alleviate the pain and address the underlying pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies and tailored rehabilitation exercises.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by severe bone pain. A lateral approach was chosen to address the pathology and alleviate the pain. Intraoperative assessment revealed synovial thickening, tendon contracture, and severe bone erosion causing significant pain. Complete synovectomy, tenodesis, bone grafting, and nerve decompression were performed to relieve the severe bone pain and restore joint stability. Hemostasis was achieved, and the incision was closed. Postoperative instructions were provided, focusing on pain management, bone healing, and rehabilitation.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon, accompanied by severe bone pain. An open approach was employed to address the pathology and alleviate the pain comprehensively. Intraoperative findings included synovial hyperplasia, tendon thickening, and severe bone erosion contributing to the severe bone pain. Partial synovectomy, tenotomy, bone debridement, and nerve decompression were performed to alleviate the severe bone pain and restore function. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing pain management strategies, wound care, and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon, complicated by severe bone pain. A volar approach was chosen to address the pathology and alleviate the pain effectively. Intraoperative findings included synovial inflammation, tendon nodules, and severe bone erosion contributing to the severe bone pain. Complete synovectomy, tenolysis, bone repair, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided, focusing on pain management, bone healing support, and rehabilitation exercises.

7. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, with severe bone pain. An endoscopic approach was employed, combining visualization techniques to address the pathology and alleviate the pain. Intraoperative assessment revealed synovial proliferation, tendon entrapment, and severe bone erosion contributing to the severe bone pain. Endoscopic synovectomy, tendon release, bone debridement, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was achieved, and the incisions were closed. The patient received postoperative instructions, including pain management strategies, bone healing support, and tailored rehabilitation program.

8. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention, complicated by severe bone pain. The procedure was performed under general anesthesia, with controlled hypotension to minimize intraoperative pain. A posterior approach was employed to access the affected site and alleviate the severe bone pain. Intraoperative findings included synovial hypertrophy, tendon inflammation, and severe bone erosion contributing to the severe bone pain. Complete synovectomy, tenodesis, bone grafting, and nerve decompression were performed to alleviate the severe bone pain and restore joint stability. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions, emphasizing pain management strategies, bone healing support, and a tailored rehabilitation program.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon, accompanied by severe bone pain. The surgery was performed under regional anesthesia, with intravenous analgesia to ensure pain control throughout the procedure. A mini-open approach was chosen to visualize the pathology and alleviate the severe bone pain. Intraoperative findings revealed synovial thickening, tendon degeneration, and severe bone erosion contributing to the severe bone pain. Partial synovectomy, tenolysis, bone debridement, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, focusing on pain management strategies, bone healing support, and rehabilitation exercises.

10. Operative Note: The patient underwent surgery for other specified disorder of synovium and tendon, complicated by severe bone pain. The procedure was performed under general anesthesia, with adequate analgesia to alleviate the severe bone pain during the operation. An anterolateral approach was employed to access the affected region and address the severe bone pain effectively. Intraoperative assessment revealed synovial hyperplasia, tendon adhesions, and severe bone erosion contributing to the severe bone pain. Complete synovectomy, tenodesis, bone repair, and nerve decompression were performed to alleviate the severe bone pain and restore joint function. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing pain management strategies, bone healing support, and a tailored rehabilitation program.

1. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. A posterior approach was chosen to access the affected area. Intraoperative findings included synovial hypertrophy and tendon degeneration. Complete synovectomy and tendon repair were performed to address the pathology. Hemostasis was achieved, and the wound was closed. The patient received postoperative instructions for immobilization and rehabilitation exercises.

2. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. An open approach was employed, providing direct access to the affected site. Intraoperative findings revealed synovial proliferation and tendon inflammation. Synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the incision was closed. The patient received postoperative instructions for wound care and gradual return to normal activities.

3. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening and tendon impingement. Synovectomy and tendon release were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including immobilization, physical therapy, and gradual return to normal activities.

4. Operative Note: Other specified disorder of synovium and tendon necessitated surgical intervention. A lateral approach was chosen to address the pathology. Intraoperative assessment revealed synovial hyperplasia and tendon contracture. Complete synovectomy and tenolysis were performed to remove the diseased tissues. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided for pain management and a tailored rehabilitation program.

5. Operative Note: Patient presented with other specified disorder of synovium and tendon, requiring surgical intervention. An open approach was employed to comprehensively address the pathology. Intraoperative findings included synovial inflammation and tendon nodules. Partial synovectomy and tenotomy were performed to remove the diseased tissues. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, including wound care and rehabilitation exercises.

6. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A volar approach was chosen to access the affected area. Intraoperative findings included synovial hyperplasia and tendon adhesions. Complete synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions were provided for pain management and a tailored rehabilitation program.

7. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative assessment revealed synovial proliferation and tendon entrapment. Endoscopic synovectomy and tendon release were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies and rehabilitation exercises.

8. Operative Note: Other specified disorder of synovium and tendon required surgical intervention. The procedure was performed under general anesthesia. A posterior approach was employed, providing direct access to the affected region. Intraoperative findings included synovial hypertrophy and tendon inflammation. Synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for wound care and rehabilitation exercises.

9. Operative Note: Patient presented with other specified disorder of synovium and tendon, necessitating surgical intervention. An open approach was chosen to access the affected area. Intraoperative findings revealed synovial thickening and tendon degeneration. Partial synovectomy and tendon repair were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for immobilization and gradual return to normal activities.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An arthroscopic approach was employed, providing excellent visualization of the joint and associated pathology. Arthroscopy revealed synovial proliferation and tendon impingement. Synovectomy and tendon release were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies, immobilization, and rehabilitation exercises.

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. A medial approach was chosen to access the affected area. Intraoperative findings included synovial hypertrophy and tendon inflammation. Complete synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given for pain management, immobilization, and gradual return to normal activities.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. A dorsal approach was employed to access the affected region. Intraoperative findings revealed synovial thickening and tendon adhesions. Synovectomy and tenolysis were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for wound care, pain management, and a tailored rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. An endoscopic approach was utilized to visualize the joint and associated pathology. Intraoperative findings included synovial hyperplasia and tendon degeneration. Endoscopic synovectomy and tenotomy were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies, immobilization, and rehabilitation exercises.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An anterolateral approach was chosen to access the affected site. Intraoperative assessment revealed synovial inflammation and tendon nodules. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. Postoperative instructions were provided for pain management, wound care, and a tailored rehabilitation program.

5. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. A volar approach was employed to access the affected area. Intraoperative findings included synovial proliferation and tendon contracture. Complete synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the wound was closed. The patient received postoperative instructions for pain management, immobilization, and a tailored rehabilitation program.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An open approach was chosen to address the pathology. Intraoperative findings revealed synovial hyperplasia and tendon entrapment. Partial synovectomy and tendon release were performed to address the pathology. Hemostasis was ensured, and the incision was closed. Postoperative instructions were provided for pain management, wound care, and rehabilitation exercises.

7. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The procedure was performed under general anesthesia. A lateral approach was employed to access the affected region. Intraoperative findings included synovial hypertrophy and tendon inflammation. Synovectomy and tenodesis were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. The patient received postoperative instructions for immobilization, pain management, and gradual return to normal activities.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening and tendon impingement. Synovectomy and tendon repair were performed using specialized instruments. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including pain management strategies, immobilization, and tailored rehabilitation exercises.

9. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial proliferation and tendon adhesions. Endoscopic synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing pain management, immobilization, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. A posterior approach was chosen to access the affected area. Intraoperative findings revealed synovial inflammation and tendon degeneration. Complete synovectomy and tenotomy were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions for pain management, wound care, and a tailored rehabilitation program.

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. The procedure was performed under general anesthesia. An open approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy, tendon inflammation, and evidence of severe infection. Extensive synovectomy, tendon debridement, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was achieved, and the wound was closed. Postoperative instructions included antibiotics, wound care, and a tailored rehabilitation program.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, tendon adhesions, and evidence of severe infection. Arthroscopic synovectomy, tenolysis, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including antibiotics, immobilization, and a rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. A medial approach was chosen to access the affected area. Intraoperative findings included synovial hyperplasia, tendon degeneration, and evidence of severe infection. Complete synovectomy, tendon repair, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing antibiotics, wound care, and a tailored rehabilitation program.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial proliferation, tendon entrapment, and evidence of severe infection. Endoscopic synovectomy, tendon release, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including antibiotics, pain management, and rehabilitation exercises.

5. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. The procedure was performed under general anesthesia. A posterior approach was employed to access the affected region. Intraoperative findings included synovial inflammation, tendon nodules, and evidence of severe infection. Partial synovectomy, tenodesis, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was confirmed, and the wound was closed. Postoperative instructions included antibiotics, wound care, and immobilization.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An open approach was chosen to comprehensively address the pathology and control the infection. Intraoperative findings included synovial hyperplasia, tendon contracture, and evidence of severe infection. Complete synovectomy, tenolysis, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing antibiotics, wound care, and a tailored rehabilitation program.

7. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An anterolateral approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy, tendon inflammation, and evidence of severe infection. Partial synovectomy, tenodesis, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, including antibiotics, pain management, and a tailored rehabilitation program.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, tendon impingement, and evidence of severe infection. Arthroscopic synovectomy, tendon repair, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing antibiotics, wound care, and a tailored rehabilitation program.

9. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. A volar approach was employed to access the affected area. Intraoperative findings included synovial proliferation, tendon adhesions, and evidence of severe infection. Complete synovectomy, tenolysis, and irrigation with antibiotic solution were performed to address the pathology and control the infection. Hemostasis was ensured, and the wound was closed. The patient received postoperative instructions, including antibiotics, pain management, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with a severe infection on the extreme moving joint. An open approach was chosen to address the pathology and control the infection. Intraoperative findings included synovial hyperplasia, tendon degeneration, and evidence of severe infection. Partial synovectomy, tendon debridement, and irrigation with antibiotic solution were performed to address the pathology and eradicate the infection. Hemostasis was achieved, and the wound was closed. Postoperative instructions included antibiotics, wound care, pain management, and a tailored rehabilitation program.

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with severe inflammation. An open approach was employed to access the affected area. Intraoperative findings revealed marked synovial hypertrophy, tendon inflammation, and extensive inflammation of the surrounding tissues. Complete synovectomy, tendon repair, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions included anti-inflammatory medication, wound care, and a tailored rehabilitation program.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with moderate inflammation. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, mild tendon inflammation, and localized inflammation within the joint. Arthroscopic synovectomy, tenodesis, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including anti-inflammatory medication, wound care, and a tailored rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with minimal inflammation. A medial approach was chosen to access the affected area. Intraoperative findings included mild synovial hypertrophy, minimal tendon inflammation, and absence of significant inflammation in the surrounding tissues. Partial synovectomy, tenolysis, and irrigation were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing pain management, wound care, and a tailored rehabilitation program.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with severe inflammation. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings revealed extensive synovial hyperplasia, severe tendon inflammation, and significant inflammation within the joint capsule. Endoscopic synovectomy, tendon release, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including anti-inflammatory medication, pain management, and rehabilitation exercises.

5. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon with moderate inflammation. The procedure was performed under general anesthesia. A posterior approach was employed to access the affected region. Intraoperative findings included moderate synovial inflammation, tendon nodules, and localized inflammation within the joint. Partial synovectomy, tenodesis, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was confirmed, and the wound was closed. Postoperative instructions included anti-inflammatory medication, wound care, and immobilization.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with minimal inflammation. An open approach was chosen to comprehensively address the pathology. Intraoperative findings revealed mild synovial hypertrophy, minimal tendon inflammation, and absence of significant inflammation in the surrounding tissues. Complete synovectomy, tenolysis, and irrigation were performed to address the pathology. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing pain management, wound care, and a tailored rehabilitation program.

7. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with severe inflammation. An anterolateral approach was employed to access the affected area. Intraoperative findings included marked synovial hyperplasia, severe tendon inflammation, and diffuse inflammation within the joint. Partial synovectomy, tenodesis, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, including anti-inflammatory medication, pain management, and a tailored rehabilitation program.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with moderate inflammation. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening, moderate tendon inflammation, and localized inflammation within the joint. Arthroscopic synovectomy, tendon repair, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, including anti-inflammatory medication, wound care, and a tailored rehabilitation program.

9. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon with minimal inflammation. A volar approach was employed to access the affected area. Intraoperative findings included mild synovial proliferation, minimal tendon inflammation, and absence of significant inflammation in the surrounding tissues. Complete synovectomy, tenolysis, and irrigation were performed to address the pathology. Hemostasis was ensured, and the wound was closed. The patient received postoperative instructions, emphasizing pain management, wound care, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon with severe inflammation. An open approach was chosen to address the pathology. Intraoperative findings included marked synovial hypertrophy, severe tendon inflammation, and extensive inflammation of the surrounding tissues. Partial synovectomy, tendon debridement, and anti-inflammatory irrigation were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions included anti-inflammatory medication, wound care, pain management, and a tailored rehabilitation program.

Certainly! Here are 10 synthetic operative notes pertaining to other specified disorders of synovium and tendon, where the follow-up depends on the severity of the diagnosis:

1. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. The severity of the diagnosis necessitates close follow-up with the patient. An open approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy and tendon degeneration. Complete synovectomy and tenotomy were performed to address the pathology. Hemostasis was achieved, and the wound was closed. Postoperative instructions included regular follow-up visits, pain management, and a tailored rehabilitation program.

2. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Due to the severity of the diagnosis, frequent follow-up appointments are essential. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening and tendon adhesions. Arthroscopic synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, and a tailored rehabilitation program.

3. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The severity of the diagnosis warrants an intensive follow-up plan. A medial approach was chosen to access the affected area. Intraoperative findings included synovial proliferation and tendon inflammation. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was ensured, and the incision was closed. The patient received postoperative instructions, emphasizing close monitoring with regular follow-up visits, pain management, and a tailored rehabilitation program.

4. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Given the severity of the diagnosis, a comprehensive follow-up strategy is crucial. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial hyperplasia and tendon degeneration. Endoscopic synovectomy and tenotomy were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing frequent follow-up visits, pain management, and a tailored rehabilitation program.

5. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. The severity of the diagnosis necessitates a diligent follow-up plan. An open approach was chosen to comprehensively address the pathology. Intraoperative findings included synovial hyperplasia and tendon contracture. Complete synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. Postoperative instructions included regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

6. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Given the severity of the diagnosis, a structured follow-up protocol is crucial. An anterolateral approach was employed to access the affected area. Intraoperative findings included synovial inflammation and tendon entrapment. Partial synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

7. Operative Note: Surgical intervention was necessary for other specified disorder of synovium and tendon. The severity of the diagnosis requires frequent follow-up assessments. An arthroscopic approach was utilized to visualize the joint and associated pathology. Arthroscopy revealed synovial thickening and tendon inflammation. Arthroscopic synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

8. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Due to the severity of the diagnosis, a strict follow-up schedule is imperative. A volar approach was employed to access the affected area. Intraoperative findings included synovial hypertrophy and tendon degeneration. Complete synovectomy and tenotomy were performed to address the pathology. Hemostasis was ensured, and the wound was closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

9. Operative Note: Surgical intervention was performed for other specified disorder of synovium and tendon. The severity of the diagnosis mandates close monitoring through regular follow-up visits. An open approach was chosen to comprehensively address the pathology. Intraoperative findings included synovial hyperplasia and tendon adhesions. Partial synovectomy and tenolysis were performed to address the pathology. Hemostasis was achieved, and the incision was closed. Postoperative instructions included regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

10. Operative Note: The patient underwent surgical intervention for other specified disorder of synovium and tendon. Given the severity of the diagnosis, a meticulous follow-up plan is essential. An endoscopic approach was employed to visualize the joint and associated pathology. Intraoperative findings included synovial proliferation and tendon inflammation. Endoscopic synovectomy and tenodesis were performed to address the pathology. Hemostasis was achieved, and the portals were closed. The patient received postoperative instructions, emphasizing regular follow-up visits, pain management, wound care, and a tailored rehabilitation program.

## M67.9 Disorder of synovium and tendon, unspecified

1. Operative Note: Patient underwent a synovectomy and tendon repair for synovium and tendon disorder. The synovium was excised using arthroscopic techniques, followed by meticulous debridement of the affected tendon. Tendon repair was performed using sutures to restore its integrity. The procedure was successful, and the patient was advised postoperative rehabilitation for optimal recovery.

2. Operative Note: A patient presented with a disorder of the synovium and tendon, necessitating surgical intervention. An open synovectomy was performed, with careful excision of the diseased synovial tissue. Concurrently, the affected tendon was repaired using suture techniques. Intraoperative findings revealed synovial hypertrophy and tendon inflammation. The procedure concluded without complications, and the patient was referred for postoperative physical therapy.

3. Operative Note: This operative intervention addressed a synovium and tendon disorder. Through arthroscopic means, the synovial tissue was meticulously resected, alleviating the inflammatory process. Additionally, the affected tendon was repaired with sutures, aiming to restore its function. The patient tolerated the procedure well, and follow-up consultations were scheduled to assess their progress and implement a suitable rehabilitation program.

4. Operative Note: Surgical management was pursued to address a synovium and tendon disorder in the patient. An open synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, the involved tendon underwent meticulous debridement and repair with sutures. Intraoperatively, evidence of synovial hyperplasia and tendon degeneration was noted. The patient's postoperative course was uneventful, and they were referred for physiotherapy to optimize their recovery.

5. Operative Note: A synovectomy and tendon repair were conducted to address the patient's synovium and tendon disorder. Utilizing arthroscopic techniques, the diseased synovium was meticulously excised, alleviating the inflammation. Simultaneously, the damaged tendon underwent thorough debridement and repair using sutures. Intraoperative findings confirmed synovial proliferation and tendon degeneration. The patient was discharged with appropriate postoperative care instructions and scheduled for follow-up visits.

6. Operative Note: The patient underwent surgical intervention for a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided, followed by repair using sutures. Intraoperative examination revealed synovial hypertrophy and tendon degeneration. The patient's postoperative recovery was uneventful, and a comprehensive rehabilitation program was recommended to optimize functional outcomes.

7. Operative Note: This operative procedure addressed the patient's disorder of the synovium and tendon. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon was meticulously debrided and repaired using sutures. Intraoperatively, synovial proliferation and tendon inflammation were noted. The patient tolerated the surgery well, and postoperative physical therapy was initiated to facilitate their recovery.

8. Operative Note: The patient underwent surgery to address a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed to excise the hypertrophic synovial tissue. Concurrently, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient was discharged with appropriate postoperative instructions and advised to follow up for rehabilitation and further evaluation of their condition.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting the synovium and tendon. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue. Concurrently, the damaged tendon underwent debridement and repair utilizing sutures. Intraoperative examination revealed synovial hyperplasia and tendon inflammation. The patient recovered well postoperatively and was referred for physical therapy to optimize their functional recovery.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures. Intraoperatively, synovial hypertrophy and tendon degeneration were noted. The patient's postoperative course was uncomplicated, and they were advised to participate in a rehabilitation program for improved outcomes.

1. Operative Note: The patient underwent surgical intervention for a synovium and tendon disorder. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, the affected tendon was meticulously debrided and repaired using suture techniques. Intraoperative findings revealed synovial inflammation and tendon degeneration. The patient tolerated the procedure well, and postoperative rehabilitation was recommended for optimal recovery.

2. Operative Note: A synovium and tendon disorder in the patient necessitated surgical management. An open synovectomy was performed, excising the pathologic synovial tissue. The damaged tendon underwent meticulous debridement and repair using sutures. Intraoperative examination confirmed synovial proliferation and tendon inflammation. The patient's postoperative course was uneventful, and they were advised to follow up for further evaluation and rehabilitation.

3. Operative Note: This operative intervention addressed a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed to remove the hypertrophic synovial tissue, reducing inflammation. Concurrently, the affected tendon was meticulously debrided and repaired with sutures. Intraoperatively, evidence of synovial hypertrophy and tendon degeneration was observed. The patient's recovery was satisfactory, and a comprehensive rehabilitation program was recommended.

4. Operative Note: Surgical management was pursued to address a synovium and tendon disorder in the patient. An open synovectomy was performed, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's postoperative course was smooth, and they were referred for physiotherapy to optimize their recovery.

5. Operative Note: A synovectomy and tendon repair were conducted to address the patient's synovium and tendon disorder. Utilizing arthroscopic techniques, the diseased synovium was meticulously excised, alleviating the inflammation. Simultaneously, the damaged tendon underwent thorough debridement and repair using sutures. Intraoperative findings confirmed synovial proliferation and tendon degeneration. The patient's postoperative recovery was satisfactory, and they were advised on postoperative care measures.

6. Operative Note: The patient underwent surgical intervention for a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided, followed by repair using sutures. Intraoperative examination revealed synovial hypertrophy and tendon degeneration. The patient's postoperative recovery was uneventful, and a comprehensive rehabilitation program was recommended to optimize functional outcomes.

7. Operative Note: This operative procedure addressed the patient's disorder of the synovium and tendon. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon was meticulously debrided and repaired using sutures. Intraoperatively, synovial proliferation and tendon inflammation were noted. The patient tolerated the surgery well, and postoperative physical therapy was initiated to facilitate their recovery.

8. Operative Note: The patient underwent surgery to address a disorder involving the synovium and tendon. Arthroscopic synovectomy was performed to excise the hypertrophic synovial tissue. Concurrently, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's postoperative course was unremarkable, and they were discharged with instructions for postoperative rehabilitation.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting the synovium and tendon. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue. Concurrently, the damaged tendon underwent debridement and repair utilizing sutures. Intraoperative examination revealed synovial hyperplasia and tendon inflammation. The patient's postoperative recovery was smooth, and they were advised to follow up for rehabilitation and further evaluation of their condition.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving the synovium and tendon. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures. Intraoperatively, synovial hypertrophy and tendon degeneration were noted. The patient's postoperative course was satisfactory, and they were recommended to participate in a structured rehabilitation program for optimal outcomes.

1. Operative Note: The patient underwent surgical intervention for a synovium and tendon disorder under general anesthesia. Arthroscopic synovectomy was performed with appropriate anesthesia dosage, excising the hypertrophic synovial tissue. Concurrently, the affected tendon was meticulously debrided and repaired using sutures. Intraoperative findings revealed synovial inflammation and tendon degeneration. The patient's vital signs remained stable throughout the procedure, and postoperative pain control was achieved using a suitable analgesic regimen.

2. Operative Note: A synovium and tendon disorder in the patient necessitated surgical management under regional anesthesia. An open synovectomy was performed, with the anesthesia dosage tailored to the patient's needs, excising the pathologic synovial tissue. The damaged tendon underwent meticulous debridement and repair using sutures. Intraoperative examination confirmed synovial proliferation and tendon inflammation. The patient's anesthesia experience was uneventful, and they were referred for postoperative pain management.

3. Operative Note: This operative intervention addressed a disorder involving the synovium and tendon under local anesthesia. Arthroscopic synovectomy was performed using an appropriate anesthesia dosage, excising the hypertrophic synovial tissue and reducing inflammation. Concurrently, the affected tendon was meticulously debrided and repaired with sutures. Intraoperatively, evidence of synovial hypertrophy and tendon degeneration was observed. The patient remained comfortable throughout the procedure, and postoperative pain control measures were implemented.

4. Operative Note: Surgical management was pursued to address a synovium and tendon disorder in the patient under conscious sedation. An open synovectomy was performed with a carefully titrated anesthesia dosage, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's sedation level was appropriately maintained, ensuring their comfort and cooperation during the procedure.

5. Operative Note: A synovectomy and tendon repair were conducted to address the patient's synovium and tendon disorder under general anesthesia. Utilizing arthroscopic techniques with the appropriate anesthesia dosage, the diseased synovium was meticulously excised, alleviating inflammation. Simultaneously, the damaged tendon underwent thorough debridement and repair using sutures. Intraoperative findings confirmed synovial proliferation and tendon degeneration. The patient's anesthesia was well-managed, and postoperative pain control measures were implemented.

6. Operative Note: The patient underwent surgical intervention for a disorder involving the synovium and tendon under regional anesthesia. Arthroscopic synovectomy was performed, with the anesthesia dosage tailored to the patient's needs, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided and repaired using sutures. Intraoperative examination revealed synovial hypertrophy and tendon degeneration. The patient remained comfortable and cooperative throughout the procedure, and appropriate postoperative pain management was provided.

7. Operative Note: This operative procedure addressed the patient's disorder of the synovium and tendon under local anesthesia with monitored anesthesia care. An open synovectomy was performed using a carefully titrated anesthesia dosage, removing the pathologic synovial tissue. The involved tendon was meticulously debrided and repaired with sutures. Intraoperatively, synovial proliferation and tendon inflammation were noted. The patient was awake and responsive during the surgery, and postoperative pain control measures were implemented.

8. Operative Note: The patient underwent surgery to address a disorder involving the synovium and tendon under general anesthesia with controlled depth. Arthroscopic synovectomy was performed with the appropriate anesthesia dosage, excising the hypertrophic synovial tissue. Concurrently, the affected tendon underwent meticulous debridement and repair using sutures. Intraoperative findings confirmed synovial hyperplasia and tendon degeneration. The patient's anesthesia was well-maintained throughout the procedure, and postoperative pain management was initiated.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting the synovium and tendon under local anesthesia with sedation. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue, with the anesthesia dosage adjusted to maintain patient comfort. Concurrently, the damaged tendon underwent debridement and repair utilizing sutures. Intraoperative examination revealed synovial hyperplasia and tendon inflammation. The patient remained relaxed and pain-free during the procedure, and suitable postoperative pain control measures were implemented.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving the synovium and tendon under general anesthesia with an emphasis on minimizing dosage. Arthroscopic synovectomy was performed, excising the pathological synovial tissue while closely monitoring the patient's anesthesia depth. The affected tendon underwent meticulous debridement and repair using sutures. Intraoperatively, synovial hypertrophy and tendon degeneration were noted. The patient's anesthesia was carefully managed to ensure their well-being, and appropriate postoperative pain management was initiated.

1. Operative Note: The patient underwent surgical intervention for a synovium, tendon, and bone erosion disorder. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, meticulous debridement and repair of the affected tendon were conducted using sutures. Additionally, bone erosion was addressed through bone grafting and stabilization. Intraoperative findings revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with appropriate rehabilitation and follow-up imaging planned.

2. Operative Note: A synovium, tendon, and bone erosion disorder in the patient necessitated surgical management. An open synovectomy was performed, excising the pathologic synovial tissue. The damaged tendon underwent meticulous debridement and repair using sutures, with concurrent bone grafting and stabilization to address bone erosion. Intraoperative examination confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative recovery was closely monitored, and appropriate measures were taken to ensure bone healing and functional restoration.

3. Operative Note: This operative intervention addressed a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, meticulously excising the hypertrophic synovial tissue. Concurrently, the affected tendon was debrided and repaired using sutures, while bone erosion was addressed through bone grafting and stabilization. Intraoperative findings revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing and rehabilitation to optimize outcomes.

4. Operative Note: Surgical management was pursued to address a synovium, tendon, and bone erosion disorder in the patient. An open synovectomy was performed, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures, with concurrent bone grafting and stabilization to address bone erosion. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was carefully monitored, with appropriate measures taken to promote bone healing and functional recovery.

5. Operative Note: A synovectomy, tendon repair, and bone erosion management were conducted to address the patient's synovium, tendon, and bone erosion disorder. Utilizing arthroscopic techniques, the hypertrophic synovial tissue was meticulously excised, alleviating inflammation. Concurrently, the damaged tendon was debrided and repaired using sutures, while bone erosion was addressed through bone grafting and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative recovery was closely monitored, with appropriate rehabilitation and bone healing strategies implemented.

6. Operative Note: The patient underwent surgical intervention for a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hypertrophy, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with specific emphasis on bone healing and functional rehabilitation.

7. Operative Note: This operative procedure addressed the patient's disorder of synovium, tendon, and bone erosion. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon underwent meticulous debridement and repair with sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperatively, extensive synovial proliferation, tendon degeneration, and significant bone erosion were observed. The patient's postoperative course was closely monitored, with emphasis on bone healing, functional restoration, and rehabilitation.

8. Operative Note: The patient underwent surgery to address a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. Concurrently, the affected tendon was meticulously debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was carefully monitored, with emphasis on bone healing and comprehensive rehabilitation.

9. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, and bone erosion. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue. Concurrently, the damaged tendon was debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing, functional recovery, and rehabilitation.

10. Operative Note: This surgical procedure aimed to alleviate the patient's disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperatively, extensive synovial hypertrophy, tendon degeneration, and significant bone erosion were noted. The patient's postoperative course was closely monitored, with comprehensive rehabilitation and regular imaging planned to assess bone healing and functional outcomes.

1. Operative Note: The patient underwent surgical intervention for a synovium, tendon, and bone erosion disorder. A comprehensive procedure was performed, including arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative course will involve close monitoring, rehabilitation, and regular imaging to assess healing and functional recovery.

2. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, and bone erosion. The procedure involved an open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was well-executed, and the patient's postoperative management will focus on pain control, rehabilitation, and monitoring for bone healing and functional restoration.

3. Operative Note: This operative intervention aimed to address a challenging synovium, tendon, and bone erosion disorder. The surgical approach included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will involve pain management, physical therapy, and regular follow-up for assessing bone healing and functional recovery.

4. Operative Note: A surgical intervention was performed to address the patient's synovium, tendon, and bone erosion disorder. The comprehensive procedure included open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was meticulously executed, and the patient's postoperative management will focus on pain control, rehabilitation, and close monitoring for bone healing and functional restoration.

5. Operative Note: The patient underwent surgical intervention for a complex synovium, tendon, and bone erosion disorder. The procedure involved arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will include pain management, physiotherapy, and regular imaging to assess bone healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a challenging synovium, tendon, and bone erosion disorder. The procedure encompassed open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative management will involve pain control, rehabilitation, and close follow-up to evaluate bone healing and functional outcomes.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, and bone erosion disorder. The comprehensive procedure involved arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will focus on pain management, physical therapy, and regular monitoring for bone healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address the complex synovium, tendon, and bone erosion disorder in the patient. The procedure encompassed open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative management will involve pain control, rehabilitation, and close follow-up to assess bone healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a challenging synovium, tendon, and bone erosion disorder. The procedure involved arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will include pain management, physiotherapy, and regular imaging to evaluate bone healing and functional recovery.

10. Operative Note: Surgical intervention was performed to address the patient's synovium, tendon, and bone erosion disorder. The procedure included open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was executed with precision, and the patient's postoperative management will involve pain control, rehabilitation, and close monitoring for bone healing and functional restoration.

1. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, and bone erosion. The procedure included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative assessment confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative management will focus on pain control, rehabilitation, and close monitoring for bone healing and functional restoration.

2. Operative Note: The patient underwent surgical intervention for a challenging synovium, tendon, and bone erosion disorder. The comprehensive procedure included open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings revealed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative care will involve pain management, rehabilitation, and close monitoring for bone healing and functional recovery.

3. Operative Note: This operative procedure aimed to alleviate the patient's disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the pathological synovial tissue. The affected tendon underwent meticulous debridement and repair using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperatively, extensive synovial hypertrophy, tendon degeneration, and significant bone erosion were noted. The patient's postoperative course was closely monitored, with comprehensive rehabilitation and regular imaging planned to assess bone healing and functional outcomes.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, and bone erosion. An open synovectomy was performed, meticulously removing the hypertrophic synovial tissue. Concurrently, the damaged tendon was debrided and repaired using sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing, functional recovery, and rehabilitation.

5. Operative Note: The patient underwent surgical intervention for a complex synovium, tendon, and bone erosion disorder. The procedure included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was meticulously executed, and the patient's postoperative management will involve pain control, rehabilitation, and regular follow-up to assess bone healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, and bone erosion. An open synovectomy was performed, excising the diseased synovial tissue. Simultaneously, the affected tendon underwent meticulous debridement and repair using sutures, with concurrent bone grafting and stabilization to address bone erosion. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with appropriate measures taken to promote bone healing and functional recovery.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, and bone erosion disorder. The comprehensive procedure included arthroscopic synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The surgical intervention was successful, and the patient's postoperative care will focus on pain management, physical therapy, and regular monitoring for bone healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address a challenging synovium, tendon, and bone erosion disorder. The procedure encompassed open synovectomy, meticulous tendon debridement and repair, and bone grafting with stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The surgical intervention was skillfully executed, and the patient's postoperative management will involve pain control, rehabilitation, and close follow-up to evaluate bone healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a disorder involving synovium, tendon, and bone erosion. Arthroscopic synovectomy was performed, excising the hypertrophic synovial tissue. The affected tendon was meticulously debrided and repaired using sutures, while bone erosion was addressed through bone grafting and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with emphasis on bone healing and functional rehabilitation.

10. Operative Note: Surgical management was pursued to address a synovium, tendon, and bone erosion disorder in the patient. An open synovectomy was performed, removing the pathologic synovial tissue. The involved tendon underwent meticulous debridement and repair with sutures, while bone erosion was managed through bone grafting and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, and significant bone erosion. The patient's postoperative course was closely monitored, with specific emphasis on bone healing, functional recovery, and rehabilitation.

1. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent fluid. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will include antibiotic therapy, wound care, rehabilitation, and close monitoring for healing and functional recovery.

2. Operative Note: The patient underwent surgical intervention for a challenging disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and purulent fluid collection. The surgical intervention was carefully executed to address the infection, and the patient's postoperative care will involve intravenous antibiotics, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

3. Operative Note: This operative procedure aimed to address the patient's disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The surgery included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was successful in eradicating the infection, and the patient's postoperative management will focus on antibiotic therapy, wound care, physical therapy, and close monitoring for healing and functional recovery.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure involved thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and purulent fluid accumulation. The surgical intervention was carefully performed to control the infection, and the patient's postoperative care will include intravenous antibiotics, wound management, rehabilitation, and regular follow-up for assessing healing and functional outcomes.

5. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will involve antibiotic therapy, wound care, physical therapy, and close monitoring for healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and purulent fluid collection. The surgical intervention was carefully executed to address the infection, and the patient's postoperative care will involve intravenous antibiotics, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and purulent fluid accumulation. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will focus on antibiotic therapy, wound care, physical therapy, and regular monitoring for healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address a challenging disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure encompassed thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was skillfully executed to control the infection, and the patient's postoperative management will include intravenous antibiotics, wound care, rehabilitation, and close follow-up for assessing healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was meticulously executed to control the infection, and the patient's postoperative care will involve antibiotic therapy, wound management, physical therapy, and regular follow-up to assess healing and functional recovery.

10. Operative Note: Surgical intervention was performed to address the patient's disorder involving synovium, tendon, bone erosion, and severe infection on the extreme moving joint. The comprehensive procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and presence of purulent discharge. The surgical intervention was successful in controlling the infection, and the patient's postoperative management will focus on antibiotic therapy, wound care, physical therapy, and close monitoring for healing and functional restoration.

1. Operative Note: Surgical intervention was performed to address a complex disorder involving synovium, tendon, bone erosion, severe infection, and intense inflammation on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and marked inflammatory changes. The surgical intervention was carefully executed to control the infection and alleviate the inflammation. The patient's postoperative management will include antibiotic therapy, anti-inflammatory medication, wound care, rehabilitation, and close monitoring for healing and functional recovery.

2. Operative Note: The patient underwent surgical intervention for a challenging disorder involving synovium, tendon, bone erosion, severe infection, and heightened inflammation on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and intense inflammatory response. The surgical intervention was skillfully executed to address the infection and mitigate the inflammation. The patient's postoperative care will involve antibiotic therapy, anti-inflammatory medication, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

3. Operative Note: This operative procedure aimed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and severe inflammation on the extreme moving joint. The surgery included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and intense inflammatory changes. The surgical intervention was successful in controlling the infection and reducing inflammation. The patient's postoperative management will focus on antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and close monitoring for healing and functional recovery.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, bone erosion, severe infection, and pronounced inflammation on the extreme moving joint. The procedure involved thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and marked inflammatory response. The surgical intervention was carefully performed to control the infection and manage the inflammation. The patient's postoperative care will include antibiotic therapy, anti-inflammatory medication, wound management, rehabilitation, and regular follow-up for assessing healing and functional outcomes.

5. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, severe infection, and significant inflammation on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and prominent inflammatory changes. The surgical intervention was successful in controlling the infection and managing the inflammation. The patient's postoperative management will involve antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and close monitoring for healing and functional recovery.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, severe infection, and elevated inflammation on the extreme moving joint. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and heightened inflammatory response. The surgical intervention was carefully executed to control the infection and manage the inflammation. The patient's postoperative care will include antibiotic therapy, anti-inflammatory medication, wound care, rehabilitation, and regular follow-up to assess healing and functional recovery.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, bone erosion, severe infection, and inflammatory changes on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and notable inflammatory response. The surgical intervention was successful in controlling the infection and addressing the inflammation. The patient's postoperative management will involve antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and regular monitoring for healing and functional recovery.

8. Operative Note: A surgical intervention was performed to address a challenging disorder involving synovium, tendon, bone erosion, severe infection, and inflammatory changes on the extreme moving joint. The procedure encompassed thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and marked inflammatory response. The surgical intervention was skillfully executed to control the infection and manage the inflammation. The patient's postoperative management will include antibiotic therapy, anti-inflammatory medication, wound care, rehabilitation, and close follow-up for assessing healing and functional outcomes.

9. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, severe infection, and intense inflammation on the extreme moving joint. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and heightened inflammatory response. The surgical intervention was carefully executed to address the infection and alleviate the inflammation. The patient's postoperative care will involve antibiotic therapy, anti-inflammatory medication, wound management, physiotherapy, and regular follow-up for assessing healing and functional outcomes.

10. Operative Note: Surgical intervention was performed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and severe inflammation on the extreme moving joint. The comprehensive procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and intense inflammatory response. The surgical intervention was successful in controlling the infection and reducing inflammation. The patient's postoperative management will focus on antibiotic therapy, anti-inflammatory medication, wound care, physical therapy, and close monitoring for healing and functional restoration.

1. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a severe pathological condition. The surgical intervention was carefully executed to address the diagnosis. The patient's postoperative management will involve regular follow-ups with imaging, functional assessments, and consultations with specialists to determine the appropriate treatment plan.

2. Operative Note: The patient underwent surgical intervention for a challenging disorder involving synovium, tendon, bone erosion, severe infection, and a moderate diagnosis. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a moderate pathological condition. The surgical intervention was skillfully executed to address the diagnosis. The patient's postoperative care will involve regular follow-ups with the primary care physician and specialist consultations to monitor the progression of the condition and determine the need for additional interventions.

3. Operative Note: This operative procedure aimed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and a mild diagnosis. The surgery included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a mild pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician to assess the response to treatment and adjust the management plan as necessary.

4. Operative Note: Surgical intervention was pursued to address a disorder affecting synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure involved thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a severe pathological condition. The surgical intervention was carefully performed to address the diagnosis. The patient's postoperative care will involve frequent follow-ups with the primary care physician, regular imaging and laboratory tests, and consultations with specialists to monitor the progression of the condition and determine further treatment options.

5. Operative Note: The patient underwent surgical intervention for a complex disorder involving synovium, tendon, bone erosion, severe infection, and a moderate diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a moderate pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician and specialist evaluations to monitor the response to treatment and adjust the management plan accordingly.

6. Operative Note: Surgical intervention was performed to address a disorder involving synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative assessment revealed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a severe pathological condition. The surgical intervention was skillfully executed to address the diagnosis. The patient's postoperative care will involve frequent follow-ups with the primary care physician, regular imaging and laboratory tests, and consultations with specialists to closely monitor the progression of the condition and determine the need for additional interventions.

7. Operative Note: This surgical intervention targeted the patient's synovium, tendon, bone erosion, severe infection, and a mild diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a mild pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician to monitor the response to treatment and make adjustments to the management plan as required.

8. Operative Note: A surgical intervention was performed to address a challenging disorder involving synovium, tendon, bone erosion, severe infection, and a moderate diagnosis. The procedure encompassed thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative examination revealed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a moderate pathological condition. The surgical intervention was skillfully executed to address the diagnosis. The patient's postoperative care will involve periodic follow-ups with the primary care physician and specialist consultations to assess the treatment response and determine the need for further interventions.

9. Operative Note: The patient underwent surgical intervention for a disorder involving synovium, tendon, bone erosion, severe infection, and a mild diagnosis. The comprehensive procedure included thorough debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial hyperplasia, tendon degeneration, significant bone erosion, and a mild pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative management will involve periodic follow-ups with the primary care physician to monitor the treatment response and make adjustments to the management plan as necessary.

10. Operative Note: Surgical intervention was performed to address the patient's disorder involving synovium, tendon, bone erosion, severe infection, and a severe diagnosis. The procedure included extensive debridement of infected tissues, synovectomy, meticulous tendon repair, bone grafting, and stabilization. Intraoperative findings confirmed extensive synovial proliferation, tendon degeneration, significant bone erosion, and a severe pathological condition. The surgical intervention was successful in addressing the diagnosis. The patient's postoperative care will involve frequent follow-ups with the primary care physician, regular imaging and laboratory tests, and consultations with specialists to closely monitor the progression of the condition and determine further treatment options.

## M68.0 Synovitis and tenosynovitis in bacterial diseases classified elsewhere

Operative Note 1: Synovitis and Tenosynovitis Excision Procedure: The patient underwent a surgical excision of synovitis and tenosynovitis in the right knee joint. A midline incision was made, and the affected synovial and tenosynovial tissues were meticulously dissected and excised. The surgical site was irrigated with saline, and hemostasis was achieved. Closure was performed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 2: Drainage of Septic Tenosynovitis Procedure: The patient presented with septic tenosynovitis in the left hand. Under sterile conditions, a longitudinal incision was made over the affected tendon sheath. Pus was evacuated, and the tendon sheath was thoroughly irrigated with saline solution. A drain was placed to ensure adequate drainage. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 3: Arthroscopic Synovectomy for Infectious Synovitis Procedure: The patient underwent arthroscopic synovectomy for infectious synovitis in the right shoulder joint. Arthroscopy was performed, and the inflamed synovial tissue was visualized. Using arthroscopic instruments, synovectomy was carried out to remove the infected synovium. The joint was thoroughly irrigated, and hemostasis was achieved. The arthroscope was removed, and the portals were closed with sutures. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 4: Debridement of Infected Tenosynovitis Procedure: The patient underwent debridement of infected tenosynovitis in the left ankle. A curvilinear incision was made, and the infected tenosynovial tissues were carefully debrided. Necrotic tissue and purulent material were thoroughly removed. The wound was irrigated with a sterile solution and left open for secondary healing. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 5: Tenolysis with Synovectomy for Bacterial Tenosynovitis Procedure: The patient underwent tenolysis with synovectomy for bacterial tenosynovitis in the right hand. A longitudinal incision was made, and the affected tendon sheath was carefully opened. Adhesions were released, and the infected synovium was excised. The tendon was freed from the surrounding scar tissue. The wound was irrigated and closed in layers. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 6: Drainage and Lavage of Pyogenic Synovitis Procedure: The patient presented with pyogenic synovitis in the left hip joint. A sterile approach was used, and a capsular incision was made. Purulent material was drained, and the joint was lavaged with copious amounts of sterile saline solution. A drain was placed, and the wound was closed in layers. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 7: Synovectomy and Joint Debridement for Reactive Synovitis Procedure: The patient underwent synovectomy and joint debridement for reactive synovitis in the right elbow joint. A posterior incision was made, and the inflamed synovium was visualized. Synovectomy was performed to remove the hypertrophic synovial tissue. Joint debridement was carried out to remove loose bodies and inflammatory debris. The wound was closed, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 8: Tenosynovectomy for Infectious Tenosynovitis Procedure: The patient underwent tenosynovectomy for infectious tenosynovitis in the left wrist. A longitudinal incision was made over the affected tendon sheath. The infected tenosynovium was carefully excised, and the tendon was freed from the diseased tissue. The wound was irrigated and closed in layers. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 9: Joint Aspiration and Injection for Septic Arthritis with Synovitis Procedure: The patient presented with septic arthritis and synovitis in the right knee joint. A sterile technique was used to perform joint aspiration, and purulent fluid was aspirated. The joint was then injected with an appropriate antibiotic solution. The procedure was performed under ultrasound guidance to ensure accurate needle placement. The patient tolerated the procedure well, and there were no complications.

Operative Note 10: Arthroscopic Debridement of Infected Synovitis Procedure: The patient underwent arthroscopic debridement of infected synovitis in the left ankle joint. Arthroscopy was performed, and infected synovial tissue was identified and removed using arthroscopic instruments. The joint was thoroughly irrigated with saline solution. The arthroscope was removed, and the portals were closed with sutures. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 11: Synovial Biopsy for Suspected Bacterial Synovitis Procedure: The patient underwent a synovial biopsy to investigate suspected bacterial synovitis in the right hip joint. Under sterile conditions, a small incision was made, and a biopsy sample of the synovial tissue was obtained. Hemostasis was achieved, and the wound was closed with sutures. The sample was sent for histopathological examination and microbial culture. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 12: Tenorrhaphy for Tenosynovitis-Induced Tendon Rupture Procedure: The patient presented with tendon rupture due to tenosynovitis in the right index finger. A dorsal incision was made over the affected tendon, and the ruptured ends were identified. The tendon was repaired using absorbable sutures in a figure-eight fashion. The tenosynovial tissue was excised, and the wound was closed with interrupted sutures. The patient's finger was immobilized with a splint postoperatively, and there were no complications.

Operative Note 13: Joint Lavage and Synovectomy for Chronic Bacterial Synovitis Procedure: The patient underwent joint lavage and synovectomy for chronic bacterial synovitis in the left shoulder joint. An arthrotomy was performed, and the joint was lavaged with sterile saline to remove inflammatory debris. Synovectomy was then carried out to excise the hypertrophic synovial tissue. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 14: Tendon Sheath Irrigation and Debridement for Pyogenic Tenosynovitis Procedure: The patient presented with pyogenic tenosynovitis in the right thumb. A longitudinal incision was made over the affected tendon sheath, and the sheath was opened. The tendon and sheath were thoroughly irrigated with sterile saline to remove pus and debris. Debridement was performed to excise necrotic tissue. The wound was closed in layers, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 15: Synovial Cyst Excision in Tenosynovitis Procedure: The patient underwent surgical excision of a synovial cyst associated with tenosynovitis in the right wrist. A dorsal incision was made, and the cyst was identified and carefully dissected from the surrounding tissues. The inflamed tenosynovial tissue was excised, and the wound was closed with sutures. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 16: Joint Arthroscopy and Synovial Biopsy for Infectious Synovitis Procedure: The patient underwent joint arthroscopy and synovial biopsy for infectious synovitis in the left knee joint. Arthroscopy was performed, and the joint was thoroughly inspected. Multiple synovial biopsy samples were obtained using arthroscopic instruments. Hemostasis was achieved, and the portals were closed with sutures. The biopsy samples were sent for pathological and microbiological analysis. The patient tolerated the procedure well, and there were no complications.

Operative Note 17: Drainage of Subcutaneous Abscess Associated with Tenosynovitis Procedure: The patient presented with a subcutaneous abscess associated with tenosynovitis in the left forearm. Under sterile conditions, an incision was made over the abscess, and purulent material was drained. The infected tenosynovial tissue was debrided, and the wound was irrigated. A drain was placed to facilitate continued drainage. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 18: Open Synovectomy for Recurrent Bacterial Synovitis Procedure: The patient underwent an open synovectomy for recurrent bacterial synovitis in the right hip joint. A curvilinear incision was made, and the hypertrophic synovial tissue was excised meticulously. The joint was irrigated, and hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 19: Tenolysis for Adhesive Tenosynovitis in Bacterial Disease Procedure: The patient underwent tenolysis for adhesive tenosynovitis in the right hand due to bacterial infection. A longitudinal incision was made over the affected tendon sheath, and adhesions were carefully released. The tenosynovial tissue was inspected and debrided as needed. The wound was irrigated and closed with sutures. The patient's range of motion improved postoperatively, and there were no complications.

Operative Note 20: Synovial Fluid Drainage and Joint Injection for Septic Arthritis with Synovitis Procedure: The patient presented with septic arthritis and synovitis in the left ankle joint. Under aseptic conditions, synovial fluid was aspirated from the joint using a sterile needle. The joint was then injected with an appropriate antibiotic solution. The procedure was performed under fluoroscopic guidance to ensure accurate needle placement. The patient tolerated the procedure well, and there were no complications.

Operative Note 21: Arthroscopic Synovectomy with General Anesthesia for Bacterial Synovitis Procedure: The patient underwent arthroscopic synovectomy for bacterial synovitis in the right knee joint under general anesthesia. The patient was placed in a supine position, and general anesthesia was induced. Arthroscopy was performed, and the infected synovial tissue was visualized. Synovectomy was carried out using arthroscopic instruments. The joint was thoroughly irrigated, and hemostasis was achieved. The arthroscope was removed, and the portals were closed with sutures. The patient recovered smoothly from anesthesia, and there were no intraoperative complications.

Operative Note 22: Drainage of Infected Tenosynovitis with Local Anesthesia Procedure: The patient presented with infected tenosynovitis in the left thumb. A digital nerve block with local anesthesia was administered for pain control. A longitudinal incision was made over the affected tendon sheath, and pus was drained. The tenosynovial tissue was irrigated with saline solution. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no complications.

Operative Note 23: Open Synovectomy with Regional Anesthesia for Chronic Bacterial Synovitis Procedure: The patient underwent open synovectomy for chronic bacterial synovitis in the right elbow joint under regional anesthesia. The patient received a brachial plexus block for anesthesia. A posterior incision was made, and the hypertrophic synovial tissue was excised meticulously. The joint was irrigated, and hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient remained comfortable throughout the procedure, and there were no intraoperative complications.

Operative Note 24: Debridement of Infected Tenosynovitis with Conscious Sedation Procedure: The patient presented with infected tenosynovitis in the right hand. Conscious sedation was administered for procedural comfort. A longitudinal incision was made over the affected tendon sheath, and the infected tenosynovial tissue was carefully debrided. The wound was irrigated with a sterile solution and closed with interrupted sutures. The patient remained stable and responsive during the procedure, and there were no complications.

Operative Note 25: Arthroscopic Synovial Biopsy with Moderate Sedation for Suspected Bacterial Synovitis Procedure: The patient underwent arthroscopic synovial biopsy for suspected bacterial synovitis in the left shoulder joint under moderate sedation. The patient was positioned comfortably, and moderate sedation was administered for pain and anxiety control. Arthroscopy was performed, and multiple synovial biopsy samples were obtained using arthroscopic instruments. The joint was irrigated, and the portals were closed with sutures. The patient had a smooth recovery from sedation, and there were no intraoperative complications.

Operative Note 26: Tenolysis with Local Anesthesia and Sedation for Tenosynovitis-Induced Tendon Adhesions Procedure: The patient underwent tenolysis for tendon adhesions caused by tenosynovitis in the right wrist. Local anesthesia was administered at the operative site, and conscious sedation was provided for patient comfort. A dorsal incision was made, and adhesions were carefully released. The tenosynovial tissue was inspected and debrided as needed. The wound was irrigated and closed with sutures. The patient remained calm and pain-free throughout the procedure, and there were no complications.

Operative Note 27: Joint Lavage and Synovectomy with Spinal Anesthesia for Acute Bacterial Synovitis Procedure: The patient underwent joint lavage and synovectomy for acute bacterial synovitis in the left hip joint under spinal anesthesia. The patient was positioned appropriately, and spinal anesthesia was administered for surgical anesthesia. An arthrotomy was performed, and the joint was lavaged with sterile saline to remove inflammatory debris. Synovectomy was then carried out to excise the hypertrophic synovial tissue. The wound was closed in layers, and a sterile dressing was applied. The patient remained hemodynamically stable throughout the procedure, and there were no complications.

Operative Note 28: Drainage of Subcutaneous Abscess with Local Anesthesia and Sedation in Tenosynovitis Procedure: The patient presented with a subcutaneous abscess associated with tenosynovitis in the left forearm. Local anesthesia with sedation was administered for pain control and patient comfort. An incision was made over the abscess, and purulent material was drained. The infected tenosynovial tissue was debrided, and the wound was irrigated. The wound was closed with interrupted sutures, and a sterile dressing was applied. The patient remained relaxed and pain-free throughout the procedure, and there were no complications.

Operative Note 29: Open Synovectomy with General Anesthesia and Intubation for Chronic Bacterial Synovitis Procedure: The patient underwent open synovectomy for chronic bacterial synovitis in the right knee joint under general anesthesia with endotracheal intubation. The patient was positioned appropriately, and general anesthesia was induced. A midline incision was made, and the hypertrophic synovial tissue was excised meticulously. The joint was irrigated, and hemostasis was achieved. The wound was closed in layers, and a sterile dressing was applied. The patient was extubated successfully postoperatively, and there were no intraoperative complications.

Operative Note 30: Tenorrhaphy with Local Anesthesia and Sedation for Tenosynovitis-Induced Tendon Rupture Procedure: The patient presented with tendon rupture due to tenosynovitis in the right Achilles tendon. Local anesthesia with sedation was administered for pain control and patient comfort. A longitudinal incision was made over the affected tendon, and the ruptured ends were identified. The tendon was repaired using absorbable sutures in a figure-eight fashion. The tenosynovial tissue was excised, and the wound was closed with interrupted sutures. The patient remained relaxed and pain-free throughout the procedure, and there were no complications.

Operative Note 31: Joint Debridement, Synovectomy, and Bone Grafting for Bacterial Synovitis with Bone Erosion Procedure: The patient underwent joint debridement, synovectomy, and bone grafting for bacterial synovitis with bone erosion in the right ankle joint. A medial approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the joint was debrided to remove necrotic bone. Bone grafting was performed to reconstruct the eroded bone surfaces. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 32: Arthroscopic Debridement, Synovectomy, and Bone Lavage for Bacterial Synovitis with Bone Erosion Procedure: The patient underwent arthroscopic debridement, synovectomy, and bone lavage for bacterial synovitis with bone erosion in the left knee joint. Arthroscopy was performed, and the joint was visualized. The infected synovial tissue was debrided, and bone lavage was carried out to remove debris and bacteria from the eroded bone surfaces. The joint was thoroughly irrigated, and the arthroscope was removed. The portals were closed with sutures. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 33: Open Synovectomy, Bone Debridement, and Stabilization for Chronic Bacterial Synovitis with Extensive Bone Erosion Procedure: The patient underwent open synovectomy, bone debridement, and stabilization for chronic bacterial synovitis with extensive bone erosion in the right shoulder joint. A deltopectoral approach was used to access the joint. The hypertrophic synovial tissue was excised, and extensive bone debridement was performed to remove necrotic bone and sequestra. The joint was stabilized using plates and screws. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 34: Joint Arthrodesis with Bone Grafting for Bacterial Synovitis and Severe Bone Erosion Procedure: The patient underwent joint arthrodesis with bone grafting for bacterial synovitis and severe bone erosion in the left wrist joint. A dorsal approach was used, and the joint surfaces were prepared for fusion. The infected synovial tissue was excised, and the eroded bone surfaces were debrided meticulously. Bone grafts were placed to promote fusion and stability. The wound was closed with sutures, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 35: Bone Biopsy and Joint Lavage for Bacterial Synovitis with Suspicion of Bone Erosion Procedure: The patient underwent bone biopsy and joint lavage for bacterial synovitis with suspicion of bone erosion in the right hip joint. A surgical approach was used to access the joint. A bone biopsy sample was obtained for histopathological examination and microbial culture. The joint was thoroughly lavaged with sterile saline to remove inflammatory debris. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 36: Joint Fusion with Bone Grafting and Debridement for Bacterial Synovitis and Extensive Bone Erosion Procedure: The patient underwent joint fusion with bone grafting and debridement for bacterial synovitis and extensive bone erosion in the right ankle joint. A medial approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised, and the eroded bone surfaces were debrided meticulously. Bone grafts were placed to promote fusion. The wound was closed in layers, and a sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 37: Arthroscopic Bone Erosion Debridement and Synovectomy for Bacterial Synovitis Procedure: The patient underwent arthroscopic bone erosion debridement and synovectomy for bacterial synovitis in the right shoulder joint. Arthroscopy was performed, and the joint was visualized. The eroded bone surfaces were debrided using arthroscopic instruments. The infected synovial tissue was excised meticulously. The joint was thoroughly irrigated, and the arthroscope was removed. The portals were closed with sutures. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 38: Open Bone Grafting and Synovectomy for Chronic Bacterial Synovitis with Bone Erosion Procedure: The patient underwent open bone grafting and synovectomy for chronic bacterial synovitis with bone erosion in the left elbow joint. A posterior approach was used, and the joint was exposed. The eroded bone surfaces were debrided, and bone grafts were placed to promote healing and stability. The hypertrophic synovial tissue was excised meticulously. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 39: Joint Reconstruction with Bone Grafting and Synovectomy for Bacterial Synovitis and Bone Erosion Procedure: The patient underwent joint reconstruction with bone grafting and synovectomy for bacterial synovitis and bone erosion in the right knee joint. A medial approach was used, and the joint was exposed. The infected synovial tissue was excised, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was thoroughly irrigated, and the wound was closed in layers. A sterile dressing was applied. The patient's symptoms improved postoperatively, and there were no complications.

Operative Note 40: Bone Curettage, Synovectomy, and Joint Lavage for Bacterial Synovitis with Focal Bone Erosion Procedure: The patient underwent bone curettage, synovectomy, and joint lavage for bacterial synovitis with focal bone erosion in the left hip joint. A surgical approach was used, and the joint was exposed. The eroded bone surfaces were curetted to remove necrotic bone and promote healing. The infected synovial tissue was excised meticulously. The joint was thoroughly lavaged with sterile saline. The wound was closed in layers, and a sterile dressing was applied. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 41: Joint Decompression and Synovectomy with Nerve Block for Bacterial Synovitis and Severe Bone Pain Procedure: The patient underwent joint decompression and synovectomy with nerve block for bacterial synovitis and severe bone pain in the right knee joint. A surgical approach was used to access the joint. The hypertrophic synovial tissue was excised meticulously, and the joint was decompressed to alleviate pressure and relieve pain. A nerve block was administered for localized anesthesia and enhanced pain management. The wound was closed in layers, and a sterile dressing was applied. The patient experienced immediate relief from severe bone pain, and there were no complications.

Operative Note 42: Bone Biopsy, Synovectomy, and Joint Lavage for Bacterial Synovitis with Severe Bone Pain Procedure: The patient underwent bone biopsy, synovectomy, and joint lavage for bacterial synovitis with severe bone pain in the left ankle joint. A surgical approach was used to access the joint. A bone biopsy sample was obtained for histopathological examination and microbial culture. The hypertrophic synovial tissue was excised meticulously, and the joint was thoroughly lavaged to remove inflammatory debris. The wound was closed in layers, and a sterile dressing was applied. The patient's severe bone pain significantly improved postoperatively, and there were no complications.

Operative Note 43: Joint Fusion and Bone Grafting for Bacterial Synovitis with Severe Bone Pain and Instability Procedure: The patient underwent joint fusion and bone grafting for bacterial synovitis with severe bone pain and instability in the right wrist joint. A dorsal approach was used, and the joint surfaces were prepared for fusion. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote fusion and stability. The wound was closed with sutures, and a sterile dressing was applied. The patient experienced immediate relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 44: Arthroscopic Bone Erosion Debridement, Synovectomy, and Pain Control Measures for Bacterial Synovitis Procedure: The patient underwent arthroscopic bone erosion debridement, synovectomy, and pain control measures for bacterial synovitis in the left shoulder joint. Arthroscopy was performed, and the joint was visualized. The eroded bone surfaces were debrided meticulously, and the infected synovial tissue was excised. Various pain control measures, including intra-articular analgesic injections and regional nerve blocks, were employed to alleviate severe bone pain. The joint was thoroughly irrigated, and the arthroscope was removed. The portals were closed with sutures. The patient experienced significant relief from severe bone pain, and there were no complications.

Operative Note 45: Joint Stabilization, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Instability Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and instability in the left knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and the joint was stabilized using appropriate fixation devices. Bone grafts were placed to promote stability and alleviate bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced immediate relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 46: Joint Lavage, Synovectomy, and Nerve Block for Bacterial Synovitis with Severe Bone Pain and Neuropathy Procedure: The patient underwent joint lavage, synovectomy, and nerve block for bacterial synovitis with severe bone pain and neuropathy in the right hip joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the joint was thoroughly lavaged with sterile saline. A nerve block was administered to alleviate severe bone pain and manage neuropathic symptoms. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and improved neuropathic symptoms, and there were no complications.

Operative Note 47: Bone Debridement, Synovectomy, and Pain Control Measures for Bacterial Synovitis with Severe Bone Pain Procedure: The patient underwent bone debridement, synovectomy, and pain control measures for bacterial synovitis with severe bone pain in the left elbow joint. A surgical approach was used, and the joint was exposed. The eroded bone surfaces were debrided meticulously, and the infected synovial tissue was excised. Various pain control measures, including local analgesic injections and systemic pain medications, were employed to alleviate severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain, and there were no complications.

Operative Note 48: Joint Reconstruction, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction Procedure: The patient underwent joint reconstruction, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint dysfunction in the right ankle joint. A medial approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was stabilized to improve joint function and alleviate severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint functionality, and there were no complications.

Operative Note 49: Bone Curettage, Synovectomy, and Pain Management Measures for Bacterial Synovitis with Severe Bone Pain Procedure: The patient underwent bone curettage, synovectomy, and pain management measures for bacterial synovitis with severe bone pain in the right hip joint. A surgical approach was used, and the joint was exposed. The eroded bone surfaces were curetted to remove necrotic bone and alleviate severe bone pain. The infected synovial tissue was excised meticulously. Various pain management measures, including local analgesic injections and systemic pain medications, were employed to control severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain, and there were no complications.

Operative Note 50: Joint Fusion, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint instability in the left shoulder joint. A posterior approach was used, and the joint surfaces were prepared for fusion. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote fusion and stability. The joint was stabilized to alleviate severe bone pain and restore joint integrity. The wound was closed with sutures, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 51: Joint Arthroplasty with Bone Grafting and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration Procedure: The patient underwent joint arthroplasty with bone grafting and synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the right hip joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was replaced with a prosthetic implant to alleviate severe bone pain and restore joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain and improved joint mobility, and there were no complications.

Operative Note 52: Joint Resection and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Tumor Formation Procedure: The patient underwent joint resection and synovectomy for bacterial synovitis with severe bone pain and tumor formation in the left knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue and the tumor were excised meticulously. The eroded bone surfaces were debrided, and the joint was thoroughly lavaged. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and the tumor was sent for pathological examination. There were no complications during the procedure.

Operative Note 53: Joint Exploration, Bone Debridement, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Infection Procedure: The patient underwent joint exploration, bone debridement, and synovectomy for bacterial synovitis with severe bone pain and infection in the right ankle joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were debrided to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 54: Joint Reconstruction, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction Procedure: The patient underwent joint reconstruction, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint dysfunction in the left shoulder joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was stabilized to improve joint function and alleviate severe bone pain. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint functionality, and there were no complications.

Operative Note 55: Joint Fusion, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint instability in the right knee joint. A surgical approach was used, and the joint surfaces were prepared for fusion. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote fusion and stability. The joint was stabilized to alleviate severe bone pain and restore joint integrity. The wound was closed with sutures, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 56: Joint Reconstruction with Arthroplasty, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration Procedure: The patient underwent joint reconstruction with arthroplasty, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the left hip joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was replaced with a prosthetic implant to alleviate severe bone pain and restore joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain and improved joint mobility, and there were no complications.

Operative Note 57: Joint Debridement, Bone Curettage, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Septic Arthritis Procedure: The patient underwent joint debridement, bone curettage, and synovectomy for bacterial synovitis with severe bone pain and septic arthritis in the right shoulder joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were curetted to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 58: Joint Stabilization, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint instability in the left elbow joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was stabilized using appropriate fixation devices. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, and there were no complications.

Operative Note 59: Joint Resection, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction Procedure: The patient underwent joint resection, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint dysfunction in the right wrist joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was resected to address joint dysfunction. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and improved joint functionality, and there were no complications.

Operative Note 60: Joint Exploration, Bone Debridement, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Infection Procedure: The patient underwent joint exploration, bone debridement, and synovectomy for bacterial synovitis with severe bone pain and infection in the left knee joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were debrided to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 61: Joint Reconstruction with Total Joint Replacement, Bone Grafting, and Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration Procedure: The patient underwent joint reconstruction with total joint replacement, bone grafting, and synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the right knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to reconstruct the eroded bone surfaces. The joint was replaced with a total joint prosthesis to alleviate severe bone pain and restore joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from severe bone pain and improved joint mobility, and there were no complications.

Operative Note 62: Joint Debridement, Bone Curettage, and Synovectomy with Joint Lavage for Bacterial Synovitis with Severe Bone Pain and Septic Arthritis Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with joint lavage for bacterial synovitis with severe bone pain and septic arthritis in the left hip joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were curetted to remove necrotic bone and infection. The joint was thoroughly lavaged with antimicrobial solutions. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 63: Joint Stabilization, Bone Grafting, and Synovectomy with Osteotomy for Bacterial Synovitis with Severe Bone Pain and Joint Instability Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with osteotomy for bacterial synovitis with severe bone pain and joint instability in the right ankle joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was stabilized using appropriate fixation devices, and an osteotomy was performed to correct joint alignment. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and joint stability improved, with no complications.

Operative Note 64: Joint Resection, Bone Grafting, and Synovectomy with Tendon Transfer for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction Procedure: The patient underwent joint resection, bone grafting, and synovectomy with tendon transfer for bacterial synovitis with severe bone pain and joint dysfunction in the left shoulder joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. Joint resection was performed to address joint dysfunction, and a tendon transfer was conducted for improved joint function. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint functionality, and there were no complications.

Operative Note 65: Joint Exploration, Bone Debridement, and Synovectomy with Antibiotic Spacer Placement for Bacterial Synovitis with Severe Bone Pain and Infection Procedure: The patient underwent joint exploration, bone debridement, and synovectomy with antibiotic spacer placement for bacterial synovitis with severe bone pain and infection in the right elbow joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were debrided to remove necrotic bone and infection. An antibiotic spacer was placed to deliver local antimicrobial therapy. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 66: Joint Fusion, Bone Grafting, and Synovectomy with Internal Fixation for Bacterial Synovitis with Severe Bone Pain and Joint Instability Procedure: The patient underwent joint fusion, bone grafting, and synovectomy with internal fixation for bacterial synovitis with severe bone pain and joint instability in the left wrist joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. The joint was fused using appropriate fixation devices. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain and regained joint stability, with no complications.

Operative Note 67: Joint Reconstruction with Arthroscopic Synovectomy for Bacterial Synovitis with Severe Bone Pain and Joint Degeneration Procedure: The patient underwent joint reconstruction with arthroscopic synovectomy for bacterial synovitis with severe bone pain and joint degeneration in the right shoulder joint. Arthroscopic access was achieved, and the hypertrophic synovial tissue was meticulously excised. The eroded bone surfaces were addressed, and joint lavage was performed. The joint was stabilized using appropriate arthroscopic techniques. The wound was closed, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint mobility, and there were no complications.

Operative Note 68: Joint Debridement, Bone Curettage, and Synovectomy with External Fixation for Bacterial Synovitis with Severe Bone Pain and Septic Arthritis Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with external fixation for bacterial synovitis with severe bone pain and septic arthritis in the left ankle joint. A surgical approach was used, and the joint was exposed. The infected synovial tissue was excised meticulously, and the eroded bone surfaces were curetted to remove necrotic bone and infection. The joint was thoroughly irrigated with antimicrobial solutions. External fixation was applied to stabilize the joint and aid in the healing process. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, and there were no signs of infection during the procedure.

Operative Note 69: Joint Stabilization, Bone Grafting, and Synovectomy with Arthroscopic Cartilage Restoration for Bacterial Synovitis with Severe Bone Pain and Joint Instability Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with arthroscopic cartilage restoration for bacterial synovitis with severe bone pain and joint instability in the right knee joint. Arthroscopic access was achieved, and the hypertrophic synovial tissue was excised meticulously. Bone grafts were placed to promote stability and alleviate severe bone pain. Arthroscopic cartilage restoration techniques were employed to address joint surface damage. The wound was closed, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint stability, and there were no complications.

Operative Note 70: Joint Resection, Bone Grafting, and Synovectomy with Ligament Repair for Bacterial Synovitis with Severe Bone Pain and Joint Dysfunction Procedure: The patient underwent joint resection, bone grafting, and synovectomy with ligament repair for bacterial synovitis with severe bone pain and joint dysfunction in the left knee joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was excised meticulously, and bone grafts were placed to promote stability and alleviate severe bone pain. Joint resection was performed to address joint dysfunction, and ligament repair was carried out to restore stability. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief from severe bone pain, improved joint functionality, and there were no complications.

Operative Note 71: Joint Exploration, Bone Debridement, and Synovectomy with Antibiotic Spacer Placement for Severe Infection and Synovitis in the Hip Joint Procedure: The patient underwent joint exploration, bone debridement, and synovectomy with antibiotic spacer placement for severe infection and synovitis in the hip joint. A surgical approach was used, and the joint was exposed. Extensive infected synovial tissue was meticulously excised, and thorough bone debridement was performed to remove necrotic bone and infection. An antibiotic spacer was carefully placed to provide local antimicrobial therapy. The wound was closed in layers, and a sterile dressing was applied. The patient's severe infection and joint symptoms were successfully addressed, and there were no complications observed during the procedure.

Operative Note 72: Joint Debridement, Bone Curettage, and Synovectomy with Intravenous Antibiotic Infusion for Severe Infection and Synovitis in the Shoulder Joint Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with intravenous antibiotic infusion for severe infection and synovitis in the shoulder joint. A surgical approach was employed, and the joint was exposed. Thorough debridement of infected synovial tissue and bone curettage were performed to eliminate the source of infection. Intravenous antibiotics were administered during the procedure to provide systemic antimicrobial therapy. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection was successfully managed, and there were no complications observed during the procedure.

Operative Note 73: Joint Stabilization, Bone Grafting, and Synovectomy with Extensive Irrigation for Severe Infection and Synovitis in the Ankle Joint Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with extensive irrigation for severe infection and synovitis in the ankle joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and aid in the healing process. The joint was thoroughly irrigated with antimicrobial solutions to eliminate infection. The wound was closed in layers, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 74: Joint Resection, Bone Grafting, and Synovectomy with Drain Placement for Severe Infection and Synovitis in the Knee Joint Procedure: The patient underwent joint resection, bone grafting, and synovectomy with drain placement for severe infection and synovitis in the knee joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and facilitate bone healing. A drain was inserted to assist in the drainage of excess fluids and reduce the risk of infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were successfully managed, and there were no complications observed during the procedure.

Operative Note 75: Joint Fusion, Bone Grafting, and Synovectomy with Intensive Antibiotic Therapy for Severe Infection and Synovitis in the Elbow Joint Procedure: The patient underwent joint fusion, bone grafting, and synovectomy with intensive antibiotic therapy for severe infection and synovitis in the elbow joint. A surgical approach was used, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and enhance bone healing. Intensive antibiotic therapy was administered throughout the procedure to combat the severe infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 76: Joint Debridement, Bone Curettage, and Synovectomy with Antibiotic Impregnated Cement Spacer for Severe Infection and Synovitis in the Wrist Joint Procedure: The patient underwent joint debridement, bone curettage, and synovectomy with antibiotic impregnated cement spacer placement for severe infection and synovitis in the wrist joint. A surgical approach was utilized, and the joint was exposed. Thorough debridement of infected synovial tissue and bone curettage were performed to eradicate the infection. An antibiotic impregnated cement spacer was carefully placed to provide localized antimicrobial therapy. The wound was meticulously closed, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 77: Joint Exploration, Bone Debridement, and Synovectomy with Intravenous Antibiotic Infusion for Severe Infection and Synovitis in the Temporomandibular Joint Procedure: The patient underwent joint exploration, bone debridement, and synovectomy with intravenous antibiotic infusion for severe infection and synovitis in the temporomandibular joint. A surgical approach was employed, and the joint was exposed. Extensive debridement of infected synovial tissue and bone was performed to eliminate the source of infection. Intravenous antibiotics were administered throughout the procedure to provide systemic antimicrobial therapy. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 78: Joint Stabilization, Bone Grafting, and Synovectomy with Extensive Irrigation for Severe Infection and Synovitis in the Sacroiliac Joint Procedure: The patient underwent joint stabilization, bone grafting, and synovectomy with extensive irrigation for severe infection and synovitis in the sacroiliac joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and facilitate bone healing. The joint was thoroughly irrigated with antimicrobial solutions to eliminate the infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were successfully managed, and there were no complications observed during the procedure.

Operative Note 79: Joint Resection, Bone Grafting, and Synovectomy with Drain Placement for Severe Infection and Synovitis in the Temporomandibular Joint Procedure: The patient underwent joint resection, bone grafting, and synovectomy with drain placement for severe infection and synovitis in the temporomandibular joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and facilitate bone healing. A drain was inserted to assist in the drainage of excess fluids and reduce the risk of infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 80: Joint Fusion, Bone Grafting, and Synovectomy with Intensive Antibiotic Therapy for Severe Infection and Synovitis in the Sternoclavicular Joint Procedure: The patient underwent joint fusion, bone grafting, and synovectomy with intensive antibiotic therapy for severe infection and synovitis in the sternoclavicular joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and enhance bone healing. Intensive antibiotic therapy was administered throughout the procedure to combat the severe infection. The wound was closed meticulously, and a sterile dressing was applied. The patient's severe infection and joint symptoms were effectively managed, and there were no complications observed during the procedure.

Operative Note 81: Joint Debridement, Synovectomy, and Intra-articular Steroid Injection for Inflammatory Synovitis with Moderate Joint Effusion in the Knee Joint Procedure: The patient underwent joint debridement, synovectomy, and intra-articular steroid injection for inflammatory synovitis with moderate joint effusion in the knee joint. A surgical approach was employed, and the joint was exposed. The inflamed synovial tissue was meticulously excised, and the joint was thoroughly irrigated. An intra-articular steroid injection was administered to reduce inflammation and manage joint effusion. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms were effectively addressed, and there were no complications observed during the procedure.

Operative Note 82: Joint Stabilization, Biologic Agent Injection, and Synovectomy for Inflammatory Synovitis with Persistent Joint Swelling in the Ankle Joint Procedure: The patient underwent joint stabilization, biologic agent injection, and synovectomy for inflammatory synovitis with persistent joint swelling in the ankle joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the joint was stabilized using appropriate techniques. A biologic agent injection was administered to target and reduce inflammation. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms and persistent joint swelling were effectively managed, and there were no complications observed during the procedure.

Operative Note 83: Joint Resection, Tendon Release, and Synovectomy for Inflammatory Synovitis with Tenosynovitis and Joint Contracture in the Elbow Joint Procedure: The patient underwent joint resection, tendon release, and synovectomy for inflammatory synovitis with tenosynovitis and joint contracture in the elbow joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the affected tendons were released to address tenosynovitis. Joint resection was performed to alleviate joint contracture. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, tenosynovitis, and joint contracture were effectively managed, and there were no complications observed during the procedure.

Operative Note 84: Joint Fusion, Bone Grafting, and Synovectomy for Inflammatory Synovitis with Bone Erosion and Joint Instability in the Shoulder Joint Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for inflammatory synovitis with bone erosion and joint instability in the shoulder joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to promote stability and address bone erosion. Joint fusion was performed to stabilize the joint. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, bone erosion, and joint instability were effectively managed, and there were no complications observed during the procedure.

Operative Note 85: Joint Debridement, Synovectomy, and Intra-articular Corticosteroid Injection for Inflammatory Synovitis with Recurrent Flares in the Hip Joint Procedure: The patient underwent joint debridement, synovectomy, and intra-articular corticosteroid injection for inflammatory synovitis with recurrent flares in the hip joint. A surgical approach was utilized, and the joint was exposed. The inflamed synovial tissue was meticulously excised, and the joint was thoroughly irrigated. An intra-articular corticosteroid injection was administered to reduce inflammation and manage recurrent flares. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms and recurrent flares were effectively addressed, and there were no complications observed during the procedure.

Operative Note 86: Joint Stabilization, Biologic Agent Injection, and Synovectomy for Inflammatory Synovitis with Joint Effusion and Cartilage Degeneration in the Wrist Joint Procedure: The patient underwent joint stabilization, biologic agent injection, and synovectomy for inflammatory synovitis with joint effusion and cartilage degeneration in the wrist joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the joint was stabilized using appropriate techniques. A biologic agent injection was administered to target and reduce inflammation. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, joint effusion, and cartilage degeneration were effectively managed, and there were no complications observed during the procedure.

Operative Note 87: Joint Resection, Tendon Repair, and Synovectomy for Inflammatory Synovitis with Tenosynovitis and Joint Instability in the Finger Joint Procedure: The patient underwent joint resection, tendon repair, and synovectomy for inflammatory synovitis with tenosynovitis and joint instability in the finger joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the affected tendons were repaired to address tenosynovitis. Joint resection was performed to alleviate joint instability. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, tenosynovitis, and joint instability were effectively managed, and there were no complications observed during the procedure.

Operative Note 88: Joint Fusion, Bone Grafting, and Synovectomy for Inflammatory Synovitis with Bone Erosion and Joint Deformity in the Hip Joint Procedure: The patient underwent joint fusion, bone grafting, and synovectomy for inflammatory synovitis with bone erosion and joint deformity in the hip joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and bone grafts were placed to address bone erosion and promote stability. Joint fusion was performed to correct joint deformity. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, bone erosion, and joint deformity were effectively managed, and there were no complications observed during the procedure.

Operative Note 89: Joint Debridement, Synovectomy, and Intra-articular Corticosteroid Injection for Inflammatory Synovitis with Recurrent Flares in the Temporomandibular Joint Procedure: The patient underwent joint debridement, synovectomy, and intra-articular corticosteroid injection for inflammatory synovitis with recurrent flares in the temporomandibular joint. A surgical approach was utilized, and the joint was exposed. The inflamed synovial tissue was meticulously excised, and the joint was thoroughly irrigated. An intra-articular corticosteroid injection was administered to reduce inflammation and manage recurrent flares. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms and recurrent flares were effectively addressed, and there were no complications observed during the procedure.

Operative Note 90: Joint Stabilization, Biologic Agent Injection, and Synovectomy for Inflammatory Synovitis with Joint Effusion and Cartilage Degeneration in the Temporomandibular Joint Procedure: The patient underwent joint stabilization, biologic agent injection, and synovectomy for inflammatory synovitis with joint effusion and cartilage degeneration in the temporomandibular joint. A surgical approach was employed, and the joint was exposed. The hypertrophic synovial tissue was meticulously excised, and the joint was stabilized using appropriate techniques. A biologic agent injection was administered to target and reduce inflammation. The wound was closed meticulously, and a sterile dressing was applied. The patient's inflammatory symptoms, joint effusion, and cartilage degeneration were effectively managed, and there were no complications observed during the procedure.

Operative Note 91: Joint Debridement, Synovectomy, and Postoperative Physical Therapy for Mild Synovitis and Tenosynovitis in the Wrist Joint Procedure: The patient underwent joint debridement, synovectomy, and postoperative physical therapy for mild synovitis and tenosynovitis in the wrist joint. A surgical approach was employed, and the joint was exposed. The inflamed synovial tissue and tenosynovial sheaths were meticulously excised. The wound was closed meticulously, and a sterile dressing was applied. The patient will be scheduled for postoperative physical therapy sessions to optimize joint function and prevent recurrence.

Operative Note 92: Joint Stabilization, Biologic Agent Injection, and Close Follow-up for Moderate Synovitis and Tenosynovitis in the Ankle Joint Procedure: The patient underwent joint stabilization, biologic agent injection, and close follow-up for moderate synovitis and tenosynovitis in the ankle joint. A surgical approach was utilized, and the joint was exposed. The hypertrophic synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will be closely monitored with regular follow-up appointments to assess the response to treatment and determine the need for additional interventions.

Operative Note 93: Joint Resection, Tendon Repair, and Long-term Rheumatology Consultation for Severe Synovitis, Tenosynovitis, and Joint Erosion in the Elbow Joint Procedure: The patient underwent joint resection, tendon repair, and long-term rheumatology consultation for severe synovitis, tenosynovitis, and joint erosion in the elbow joint. A surgical approach was employed, and the hypertrophic synovial tissue, tenosynovial sheaths, and eroded joint surfaces were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will be referred to a rheumatologist for long-term management and follow-up to optimize disease control and preserve joint function.

Operative Note 94: Joint Fusion, Bone Grafting, and Postoperative Imaging for Advanced Synovitis, Bone Erosion, and Joint Instability in the Shoulder Joint Procedure: The patient underwent joint fusion, bone grafting, and postoperative imaging for advanced synovitis, bone erosion, and joint instability in the shoulder joint. A surgical approach was employed, and the hypertrophic synovial tissue, eroded bone surfaces, and unstable joint components were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. Postoperative imaging, such as X-rays or MRI, will be scheduled to assess the fusion progress and joint stability.

Operative Note 95: Joint Debridement, Synovectomy, and Systemic Immunomodulatory Therapy for Recurrent Synovitis and Tenosynovitis in the Hip Joint Procedure: The patient underwent joint debridement, synovectomy, and systemic immunomodulatory therapy for recurrent synovitis and tenosynovitis in the hip joint. A surgical approach was employed, and the inflamed synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate systemic immunomodulatory therapy following the procedure to control the recurrent inflammation, and close follow-up appointments will be scheduled to assess the response to treatment.

Operative Note 96: Joint Stabilization, Biologic Agent Injection, and Rehabilitation Program for Chronic Synovitis and Tenosynovitis in the Knee Joint Procedure: The patient underwent joint stabilization, biologic agent injection, and a tailored rehabilitation program for chronic synovitis and tenosynovitis in the knee joint. A surgical approach was utilized, and the hypertrophic synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate a structured rehabilitation program consisting of exercises, physical therapy, and functional training to improve joint function and alleviate symptoms in conjunction with biologic agent therapy.

Operative Note 97: Joint Resection, Tendon Reconstruction, and Long-term Rheumatology Management for Severe Synovitis, Tenosynovitis, and Joint Deformity in the Finger Joint Procedure: The patient underwent joint resection, tendon reconstruction, and long-term rheumatology management for severe synovitis, tenosynovitis, and joint deformity in the finger joint. A surgical approach was employed, and the hypertrophic synovial tissue, tenosynovial sheaths, and deformed joint structures were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will be referred to a rheumatologist for ongoing management and follow-up to optimize disease control and prevent further joint deformity.

Operative Note 98: Joint Fusion, Bone Grafting, and Postoperative Physical Therapy for Extensive Synovitis, Bone Erosion, and Joint Dysfunction in the Temporomandibular Joint Procedure: The patient underwent joint fusion, bone grafting, and postoperative physical therapy for extensive synovitis, bone erosion, and joint dysfunction in the temporomandibular joint. A surgical approach was employed, and the hypertrophic synovial tissue, eroded bone surfaces, and dysfunctional joint components were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will undergo postoperative physical therapy to optimize jaw function, restore range of motion, and alleviate pain following the joint fusion procedure.

Operative Note 99: Joint Debridement, Synovectomy, and Systemic Immunomodulatory Therapy for Persistent Synovitis and Tenosynovitis in the Sternoclavicular Joint Procedure: The patient underwent joint debridement, synovectomy, and systemic immunomodulatory therapy for persistent synovitis and tenosynovitis in the sternoclavicular joint. A surgical approach was employed, and the inflamed synovial tissue and tenosynovial sheaths were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate systemic immunomodulatory therapy following the procedure to control the persistent inflammation, and close follow-up appointments will be scheduled to assess the response to treatment.

Operative Note 100: Joint Stabilization, Biologic Agent Injection, and Rehabilitation Program for Aggressive Synovitis, Bone Erosion, and Joint Dysfunction in the Hip Joint Procedure: The patient underwent joint stabilization, biologic agent injection, and a tailored rehabilitation program for aggressive synovitis, bone erosion, and joint dysfunction in the hip joint. A surgical approach was employed, and the hypertrophic synovial tissue, eroded bone surfaces, and dysfunctional joint components were meticulously addressed. The wound was closed meticulously, and a sterile dressing was applied. The patient will initiate a structured rehabilitation program consisting of exercises, physical therapy, and functional training in conjunction with biologic agent therapy to optimize joint function and restore mobility.

## M68.8 Other disorders of synovium and tendon in diseases classified elsewhere

1. Operative Note: Patient underwent arthroscopic debridement for synovial hypertrophy and tenosynovitis of the right wrist, secondary to rheumatoid arthritis. Synovium was excised, and tendon sheaths were thoroughly irrigated. The procedure was successful in alleviating pain and improving joint mobility.

2. Operative Note: Excision of nodular synovitis and tenosynovitis was performed on the left ankle due to underlying psoriatic arthritis. The inflamed synovium was excised, and the tendon sheaths were carefully cleaned. The patient tolerated the procedure well, and postoperative recovery is anticipated to be favorable.

3. Operative Note: In the setting of systemic lupus erythematosus, the patient underwent synovectomy and tendon repair for synovial hypertrophy and tendon rupture in the right knee. Synovium was excised, and the tendon was repaired using sutures. The procedure was uneventful, and the patient is expected to regain functional mobility.

4. Operative Note: The patient with gouty arthritis underwent surgical intervention for tophaceous synovitis and tenosynovitis in the left hand. Multiple tophi were excised from the synovium, and tendon sheaths were thoroughly cleaned. The patient tolerated the procedure well, and early postoperative outcomes appear promising.

5. Operative Note: Excision of synovial chondromatosis and tendon release was performed on the right shoulder of a patient with pigmented villonodular synovitis. The synovium was meticulously removed, and tendon release was accomplished successfully. The patient is expected to have improved range of motion and reduced pain postoperatively.

6. Operative Note: A patient with systemic sclerosis underwent synovectomy and tendon repair for synovial fibrosis and tendon adhesions in the fingers of the right hand. The fibrotic synovium was excised, and tendon adhesions were released. The procedure was well-tolerated, and the patient is anticipated to achieve improved hand function.

7. Operative Note: The patient with hemophilia A presented with recurrent synovial hemarthrosis and tenosynovitis in the left elbow. Arthroscopic synovectomy and tenolysis were performed, successfully removing the blood-filled synovium and releasing the tendon adhesions. The patient's pain is expected to be alleviated, and joint mobility should improve.

8. Operative Note: Synovial lipomatosis and tenosynovitis were addressed surgically in the right hip of a patient with primary synovial chondromatosis. Lipomatous synovium was excised, and the tendon sheaths were carefully cleaned. The patient tolerated the procedure well, and early rehabilitation efforts have begun.

9. Operative Note: A patient with Ehlers-Danlos syndrome underwent surgical intervention for synovial hyperplasia and tenosynovitis in the left shoulder. The hyperplastic synovium was excised, and tendon sheaths were released. The procedure was uneventful, and the patient is expected to experience reduced pain and improved joint stability.

10. Operative Note: Synovectomy and tendon repair were performed on the right foot of a patient with systemic amyloidosis. Synovial amyloid deposition and tendon rupture were addressed. The synovium was excised, and the tendon was repaired using appropriate techniques. The patient's postoperative course will be closely monitored for optimal outcomes.

1. Operative Note: Arthroscopic synovectomy and tenolysis were performed on the left knee of a patient with juvenile idiopathic arthritis. Synovial hypertrophy and tendon adhesions were addressed, allowing for improved joint mobility. The procedure was uncomplicated, and the patient is expected to have a smoother recovery.

2. Operative Note: The patient with systemic vasculitis underwent synovial biopsy and tenosynovectomy in the right ankle. The inflamed synovium was sampled for histopathological evaluation, and tendon sheaths were released. The procedure was well-tolerated, and postoperative care will focus on managing the underlying disease process.

3. Operative Note: A patient with sarcoidosis underwent synovectomy and tendon repair for synovial granuloma and tendon rupture in the left hand. The granulomatous synovium was excised, and tendon repair was achieved using appropriate sutures. The patient is expected to regain hand function and experience reduced pain.

4. Operative Note: Excision of synovial osteochondromatosis and tenosynovitis was performed on the right elbow of a patient with osteochondromatosis secondary to previous trauma. The osteochondromas were carefully removed from the synovium, and tendon sheaths were thoroughly cleaned. The patient's postoperative course is anticipated to be uneventful.

5. Operative Note: Synovectomy and tendon release were carried out on the left wrist of a patient with calcium pyrophosphate deposition disease. The calcific synovium was excised, and tendon release was accomplished successfully. The patient is expected to have improved wrist mobility and reduced pain.

6. Operative Note: A patient with systemic sclerosis underwent synovial debridement and tenolysis for synovial fibrosis and tendon adhesions in the right foot. The fibrotic synovium was meticulously removed, and tendon adhesions were released. The procedure was well-tolerated, and the patient is expected to experience improved foot function.

7. Operative Note: The patient with hemophilia B presented with recurrent synovial hemarthrosis and tenosynovitis in the right knee. Arthroscopic synovectomy and tenolysis were performed, successfully removing the blood-filled synovium and releasing the tendon adhesions. The patient's pain is expected to be alleviated, and joint mobility should improve.

8. Operative Note: Synovial lipoma and tenosynovitis were surgically addressed in the left shoulder of a patient with primary synovial chondromatosis. The lipomatous synovium was excised, and the tendon sheaths were carefully cleaned. The patient tolerated the procedure well, and early rehabilitation efforts have commenced.

9. Operative Note: A patient with Marfan syndrome underwent surgical intervention for synovial hyperplasia and tenosynovitis in the right wrist. The hyperplastic synovium was excised, and tendon sheaths were released. The procedure was uneventful, and the patient is expected to experience reduced pain and improved joint stability.

10. Operative Note: Synovectomy and tendon repair were performed on the left ankle of a patient with systemic lupus erythematosus. Synovial inflammation and tendon rupture were addressed. The synovium was excised, and the tendon was repaired using appropriate techniques. The patient's postoperative course will be closely monitored for optimal outcomes.

1. Operative Note: The patient underwent arthroscopic synovectomy and tenolysis of the right knee under general anesthesia with endotracheal intubation. Adequate anesthesia was achieved with a total of 100 mg of propofol and 50 mcg of fentanyl. The procedure was uneventful, and the patient tolerated it well. Postoperative pain was managed using a combination of oral analgesics and local anesthetic infiltration.

2. Operative Note: Excision of synovial osteochondromatosis and tenosynovitis in the left elbow was performed under regional anesthesia with ultrasound-guided nerve block. The patient received 20 ml of 0.5% bupivacaine with epinephrine for brachial plexus blockade. The procedure was completed without complications, and the patient reported minimal discomfort during the surgery.

3. Operative Note: A patient with systemic vasculitis underwent synovial biopsy and tenosynovectomy in the right ankle under monitored anesthesia care (MAC). The patient received 2 mg of midazolam and 50 mcg of fentanyl intravenously for sedation. Local anesthesia was achieved using 20 ml of 1% lidocaine with epinephrine. The procedure was well-tolerated, and the patient remained comfortable throughout.

4. Operative Note: Synovectomy and tendon repair of the right foot were performed on a patient with sarcoidosis under spinal anesthesia. The patient received 10 mg of hyperbaric bupivacaine intrathecally. The surgery proceeded smoothly, and the patient experienced complete sensory and motor blockade during the procedure. Postoperative pain control was managed using a combination of oral analgesics and intravenous patient-controlled analgesia (PCA).

5. Operative Note: The patient with hemophilia B underwent arthroscopic synovectomy and tenolysis in the right knee under general anesthesia. Anesthesia was induced with 150 mg of propofol and maintained using sevoflurane. A total of 100 mcg of fentanyl and 20 mg of rocuronium were administered for analgesia and muscle relaxation, respectively. The patient remained hemodynamically stable throughout the procedure.

6. Operative Note: Synovial lipoma excision and tenosynovectomy in the left shoulder were performed on a patient with primary synovial chondromatosis under local anesthesia with sedation. The shoulder was infiltrated with 20 ml of 1% lidocaine and 50 mcg of fentanyl was administered intravenously for conscious sedation. The procedure was well-tolerated, and the patient remained calm and comfortable throughout.

7. Operative Note: A patient with Marfan syndrome underwent synovial debridement and tenolysis in the right foot under general anesthesia with a laryngeal mask airway (LMA). Anesthesia was induced with 100 mg of propofol and maintained using desflurane. A total of 50 mcg of fentanyl and 10 mg of atracurium were administered for analgesia and muscle relaxation, respectively. The patient's vital signs remained stable throughout the procedure.

8. Operative Note: Excision of synovial hyperplasia and tenosynovitis in the right wrist was performed on a patient with Ehlers-Danlos syndrome under regional anesthesia with ultrasound-guided median nerve block. The patient received 10 ml of 1% lidocaine with epinephrine for local anesthesia. The procedure was well-tolerated, and the patient reported minimal discomfort during surgery. Postoperative pain was managed using a combination of oral analgesics and local anesthetic infiltration.

9. Operative Note: Arthroscopic synovectomy and tenolysis were performed on the left knee of a patient with juvenile idiopathic arthritis under general anesthesia with balanced anesthesia technique. The patient received a total of 100 mg of propofol, 100 mcg of fentanyl, and 30 mg of rocuronium for induction and maintenance. An endotracheal tube was placed for airway management, and the patient remained stable throughout the procedure.

10. Operative Note: Synovectomy and tendon repair of the left ankle were performed on a patient with systemic lupus erythematosus under combined spinal-epidural anesthesia. The patient received 10 mg of hyperbaric bupivacaine intrathecally for spinal anesthesia and a continuous epidural infusion of 0.125% bupivacaine with fentanyl for postoperative pain control. The surgery was completed without complications, and the patient remained comfortable during the intraoperative period.

1. Operative Note: The patient with rheumatoid arthritis underwent synovectomy, tenolysis, and bone erosion repair in the right wrist. The procedure involved excision of hypertrophic synovium, release of tendon adhesions, and bone grafting to repair eroded areas. The bone graft was harvested from the iliac crest. The surgery was successful, and postoperative immobilization and rehabilitation will be crucial for optimal outcomes.

2. Operative Note: Excision of synovial hypertrophy, tenosynovitis, and bone erosion repair was performed on the left knee of a patient with psoriatic arthritis. The inflamed synovium was removed, tendon adhesions were released, and bone erosion sites were addressed using autologous bone grafts. The procedure was well-tolerated, and the patient's postoperative course will focus on pain management and rehabilitation.

3. Operative Note: A patient with systemic lupus erythematosus underwent synovectomy, tenolysis, and bone erosion repair in the right hip. The synovium was excised, tendon adhesions were released, and eroded bone areas were reconstructed using allograft materials. The surgery was completed successfully, and the patient's postoperative care will involve close monitoring of hip function and gradual rehabilitation.

4. Operative Note: Synovectomy, tendon repair, and bone erosion reconstruction were performed on the left shoulder of a patient with gouty arthritis. The procedure involved excision of tophaceous synovium, repair of tendon rupture, and grafting of eroded bone sites with synthetic bone substitutes. The patient tolerated the surgery well, and postoperative management will include pain control and early range of motion exercises.

5. Operative Note: The patient with systemic vasculitis underwent synovial biopsy, tenosynovectomy, and bone erosion repair in the right ankle. The synovial biopsy confirmed inflammatory changes, and subsequent surgery involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure was completed without complications, and the patient's postoperative course will focus on immobilization and rehabilitation.

6. Operative Note: A patient with sarcoidosis underwent synovial debridement, tenolysis, and bone erosion repair in the right hand. The procedure involved meticulous removal of granulomatous synovium, release of tendon adhesions, and grafting of eroded bone areas with autologous bone grafts. The surgery was successful, and the patient's postoperative care will involve hand therapy and gradual return to functional activities.

7. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right elbow of a patient with synovial osteochondromatosis. The procedure involved excision of osteochondromas, release of tendon adhesions, and reconstruction of eroded bone areas using bone grafts. The surgery was uneventful, and the patient's postoperative management will include pain control and early mobilization.

8. Operative Note: A patient with hemophilia A underwent synovial debridement, tenolysis, and bone erosion repair in the left knee. The procedure involved removal of blood-filled synovium, release of tendon adhesions, and grafting of eroded bone sites using bone substitutes. The surgery was successful in reducing pain and improving joint function, and the patient's postoperative care will focus on hemostasis and rehabilitation.

9. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right ankle of a patient with synovial lipomatosis. The lipomatous synovium was excised, tendon adhesions were released, and eroded bone areas were addressed using bone graft substitutes. The procedure was completed without complications, and the patient's postoperative course will involve immobilization and gradual weight-bearing.

10. Operative Note: A patient with primary synovial chondromatosis underwent synovial debridement, tenosynovectomy, and bone erosion repair in the left shoulder. The procedure involved meticulous removal of chondromas, release of tendon adhesions, and reconstruction of eroded bone sites using autografts. The surgery was successful, and the patient's postoperative management will focus on pain control and early rehabilitation.

1. Operative Note: The patient with metastatic cancer underwent synovectomy, tenolysis, and bone erosion repair in the right knee. Severe bone pain was reported preoperatively due to tumor infiltration. The procedure involved excision of diseased synovium, release of tendon adhesions, and bone grafting to alleviate pain and stabilize eroded bone sites. The surgery was successful in providing pain relief, and the patient's postoperative care will involve palliative measures and close monitoring.

2. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left wrist of a patient with severe bone pain associated with rheumatoid arthritis. The inflamed synovium was excised, tendon adhesions were released, and bone grafting was performed to address erosion. The procedure aimed to alleviate pain and improve joint function. Postoperatively, pain management and rehabilitation will be critical for the patient's recovery.

3. Operative Note: A patient with osteomyelitis underwent synovial debridement, tenolysis, and bone erosion repair in the right foot. Severe bone pain was reported due to the underlying infection. The procedure involved meticulous removal of infected synovium, release of tendon adhesions, and bone grafting to promote healing and alleviate pain. The surgery was successful, and the patient's postoperative care will include antibiotic therapy and pain management.

4. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right shoulder of a patient with severe bone pain associated with ankylosing spondylitis. The procedure involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The surgery aimed to reduce pain and improve shoulder mobility. Postoperatively, pain control and physiotherapy will be essential for optimal outcomes.

5. Operative Note: The patient with sickle cell disease underwent synovial biopsy, tenolysis, and bone erosion repair in the left ankle. Severe bone pain was reported due to vaso-occlusive crises. The procedure involved sampling of synovium, release of tendon adhesions, and bone grafting to address erosion and provide pain relief. The surgery was successful, and the patient's postoperative care will involve pain management and close monitoring of sickle cell-related complications.

6. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left hip of a patient with severe bone pain associated with avascular necrosis. The procedure involved excision of necrotic synovium, release of tendon adhesions, and bone grafting to restore joint integrity and alleviate pain. The surgery was successful, and the patient's postoperative care will include pain control and gradual rehabilitation.

7. Operative Note: A patient with multiple myeloma underwent synovial debridement, tenolysis, and bone erosion repair in the right hand. Severe bone pain was reported due to myeloma-associated bone lesions. The procedure involved removal of diseased synovium, release of tendon adhesions, and bone grafting to stabilize eroded bone areas. The surgery aimed to reduce pain and improve hand function. Postoperatively, pain management and oncological treatment will be essential.

8. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right elbow of a patient with severe bone pain associated with psoriatic arthritis. The procedure involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The surgery aimed to alleviate pain and restore elbow mobility. Postoperatively, pain control and rehabilitation exercises will be crucial for optimal recovery.

9. Operative Note: A patient with fibrous dysplasia underwent synovial debridement, tenolysis, and bone erosion repair in the left knee. Severe bone pain was reported due to the underlying bone disorder. The procedure involved meticulous removal of abnormal synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The surgery aimed to alleviate pain and improve knee function. Postoperatively, pain management and close monitoring of the bone condition will be necessary.

10. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left shoulder of a patient with severe bone pain associated with rotator cuff tear arthropathy. The procedure involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion and alleviate pain. The surgery aimed to restore shoulder function and reduce pain. Postoperatively, pain control and physical therapy will be crucial for the patient's recovery.

1. Operative Note: The patient with septic arthritis underwent arthroscopic synovectomy, tenolysis, and bone erosion repair in the right knee. The procedure involved thorough debridement of infected synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to eradicate the infection, relieve pain, and restore joint function. Postoperatively, the patient will receive appropriate antibiotics and undergo rehabilitation for optimal recovery.

2. Operative Note: Excision of synovial plica, tenosynovectomy, and bone erosion repair were performed on the left elbow of a patient with severe bone pain associated with synovial plica syndrome. The procedure involved meticulous removal of the inflamed plica, release of tendon adhesions, and bone grafting to stabilize eroded bone areas. The surgical intervention aimed to alleviate pain and restore elbow function. Postoperatively, pain management and physical therapy will be crucial for recovery.

3. Operative Note: A patient with calcium pyrophosphate crystal deposition disease underwent synovial debridement, tenolysis, and bone erosion repair in the right wrist. The procedure involved excision of calcified synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to alleviate pain, improve joint function, and reduce the progression of the disease. Postoperatively, the patient will receive appropriate medications and undergo rehabilitation for optimal outcomes.

4. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right ankle of a patient with severe bone pain associated with rheumatoid arthritis. The procedure involved excision of hypertrophic synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to relieve pain, restore joint stability, and prevent further joint damage. Postoperatively, the patient will receive appropriate medications and undergo rehabilitation for optimal recovery.

5. Operative Note: The patient with pigmented villonodular synovitis (PVNS) underwent open synovectomy, tenolysis, and bone erosion repair in the left hip. The procedure involved meticulous excision of the abnormal synovium, release of tendon adhesions, and bone grafting to stabilize eroded bone sites. The surgical intervention aimed to alleviate pain, improve hip function, and prevent disease recurrence. Postoperatively, the patient will be closely monitored for any signs of PVNS recurrence.

6. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right shoulder of a patient with severe bone pain associated with adhesive capsulitis (frozen shoulder). The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to relieve pain, improve shoulder mobility, and restore function. Postoperatively, pain management and physical therapy will be crucial for optimal recovery.

7. Operative Note: A patient with diffuse idiopathic skeletal hyperostosis (DISH) underwent synovial debridement, tenolysis, and bone erosion repair in the thoracic spine. The procedure involved meticulous removal of ossified synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to alleviate severe bone pain, improve spinal stability, and prevent further complications. Postoperatively, the patient will be closely monitored for any signs of disease progression.

8. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left knee of a patient with severe bone pain associated with Hoffa's disease (infrapatellar fat pad impingement). The surgical intervention involved excision of hypertrophic synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, restore knee function, and prevent further damage. Postoperatively, pain management and physical therapy will be essential for optimal recovery.

9. Operative Note: A patient with Ehlers-Danlos syndrome underwent synovial debridement, tenolysis, and bone erosion repair in the right hand. The procedure involved meticulous removal of hypermobile synovium, release of tendon adhesions, and bone grafting to address erosion. The surgical intervention aimed to alleviate severe bone pain, improve hand stability, and restore function. Postoperatively, the patient will receive appropriate rehabilitation and support to manage the underlying connective tissue disorder.

10. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right ankle of a patient with severe bone pain associated with reflex sympathetic dystrophy (complex regional pain syndrome). The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, improve ankle function, and interrupt the abnormal sympathetic response. Postoperatively, pain management and multidisciplinary rehabilitation will be crucial for optimal recovery.

1. Operative Note: The patient with osteoarthritis underwent arthroscopic synovectomy, tenolysis, and bone erosion repair in the right knee. Severe bone pain and joint dysfunction were reported preoperatively. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve knee function, and delay the progression of osteoarthritis. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

2. Operative Note: Excision of synovial hemangioma, tenosynovectomy, and bone erosion repair were performed on the left wrist of a patient with severe bone pain associated with synovial hemangioma syndrome. The surgical intervention involved meticulous removal of the vascularized synovium, release of tendon adhesions, and bone grafting to stabilize eroded bone areas. The procedure aimed to alleviate pain, improve wrist function, and prevent further complications. Postoperatively, the patient will receive appropriate rehabilitation and follow-up.

3. Operative Note: A patient with Behçet's disease underwent synovial debridement, tenolysis, and bone erosion repair in the right ankle. Severe bone pain and joint instability were reported preoperatively. The surgical intervention involved removal of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, restore ankle stability, and improve functional outcomes. Postoperatively, the patient will receive appropriate immunosuppressive therapy and rehabilitation.

4. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right shoulder of a patient with severe bone pain associated with calcific tendinitis. The surgical intervention involved excision of calcified synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, improve shoulder mobility, and prevent recurrence. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

5. Operative Note: The patient with systemic sclerosis underwent synovial debridement, tenolysis, and bone erosion repair in the left hand. Severe bone pain and joint contractures were reported preoperatively. The surgical intervention involved meticulous removal of fibrotic synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve hand function, and prevent further joint deformity. Postoperatively, the patient will receive appropriate hand therapy and follow-up care.

6. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right knee of a patient with severe bone pain associated with pigmented villonodular synovitis (PVNS). The surgical intervention involved excision of abnormal synovium, release of tendon adhesions, and bone grafting to stabilize eroded areas. The procedure aimed to alleviate pain, improve knee function, and prevent disease recurrence. Postoperatively, the patient will receive appropriate rehabilitation and be closely monitored for any signs of PVNS recurrence.

7. Operative Note: A patient with systemic lupus erythematosus (SLE) underwent synovial debridement, tenolysis, and bone erosion repair in the right hip. Severe bone pain and joint dysfunction were reported preoperatively. The surgical intervention involved meticulous removal of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve hip stability, and prevent further damage. Postoperatively, the patient will receive appropriate immunosuppressive therapy and undergo rehabilitation.

8. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the left shoulder of a patient with severe bone pain associated with rotator cuff tear. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, restore shoulder function, and promote rotator cuff healing. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

9. Operative Note: A patient with gouty arthritis underwent arthroscopic synovectomy, tenolysis, and bone erosion repair in the right foot. Severe bone pain and joint deformity were reported preoperatively. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve foot function, and prevent recurrent gout attacks. Postoperatively, the patient will receive appropriate medication and undergo rehabilitation.

10. Operative Note: Synovectomy, tenosynovectomy, and bone erosion repair were performed on the right elbow of a patient with severe bone pain associated with bursitis and osteochondritis dissecans. The surgical intervention involved excision of inflamed synovium, release of tendon adhesions, and bone grafting to address erosion. The procedure aimed to alleviate pain, improve elbow function, and promote healing of the osteochondral defect. Postoperatively, the patient will undergo rehabilitation and receive appropriate pain management.

1. Operative Note: The patient with septic arthritis and severe infection in the hip joint underwent urgent surgical intervention. An extensive synovectomy, tenolysis, and bone erosion repair were performed. The procedure involved thorough debridement of infected synovium, release of tendon adhesions, and bone grafting to address erosion. The aim was to eradicate the infection, alleviate pain, and restore joint function. Postoperatively, the patient will receive intravenous antibiotics, close monitoring, and intensive rehabilitation.

2. Operative Note: A patient presented with a severe infection in the shoulder joint due to septic bursitis. Surgical intervention involved a thorough synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to eradicate the infection, alleviate severe pain, and restore shoulder mobility. Postoperatively, the patient will receive appropriate antibiotics, wound care, and rehabilitation.

3. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the knee joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore knee function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and intensive rehabilitation.

4. Operative Note: The patient presented with septic arthritis and a severe infection in the ankle joint. Urgent surgical intervention was performed, including a thorough synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to eradicate the infection, alleviate severe pain, and restore ankle mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive physical therapy.

5. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the elbow joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore elbow function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and rehabilitative exercises.

6. Operative Note: A patient with septic arthritis and a severe infection in the wrist joint underwent urgent surgical intervention. The procedure included a comprehensive synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to eradicate the infection, alleviate severe pain, and restore wrist mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive rehabilitation.

7. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the hip joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore hip function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and rehabilitative exercises.

8. Operative Note: A patient with septic arthritis and a severe infection in the shoulder joint underwent urgent surgical intervention. The procedure involved a comprehensive synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to eradicate the infection, alleviate severe pain, and restore shoulder mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive rehabilitation.

9. Operative Note: Urgent surgical intervention was performed on a patient with septic arthritis and a severe infection in the knee joint. The procedure included an extensive synovectomy, tenolysis, and bone erosion repair. Infected synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to eliminate the infection, alleviate severe pain, and restore knee function. Postoperatively, the patient will receive intravenous antibiotics, joint immobilization, and rehabilitative exercises.

10. Operative Note: A patient presented with septic arthritis and a severe infection in the ankle joint. Urgent surgical intervention was performed, including a thorough synovial debridement, tenosynovectomy, and bone erosion repair. Infected synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to eradicate the infection, alleviate severe pain, and restore ankle mobility. Postoperatively, the patient will receive intravenous antibiotics, wound care, and intensive physical therapy.

1. Operative Note: The patient presented with chronic inflammation and severe infection in the hip joint. Surgical intervention involved synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The procedure aimed to alleviate severe pain, eradicate infection, and restore hip function. Postoperatively, the patient will receive appropriate anti-inflammatory medication and undergo rehabilitative therapy.

2. Operative Note: A patient with recurrent inflammation and a severe infection in the shoulder joint underwent surgical intervention. Synovial debridement, tenolysis, and bone erosion repair were performed. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The procedure aimed to alleviate pain, eliminate infection, and restore shoulder mobility. Postoperatively, the patient will receive anti-inflammatory medication and participate in a comprehensive rehabilitation program.

3. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the knee joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to alleviate severe pain, eradicate infection, and restore knee function. Postoperatively, the patient will receive anti-inflammatory medication, undergo joint immobilization, and engage in rehabilitative exercises.

4. Operative Note: A patient with chronic inflammatory disease and severe infection in the ankle joint underwent surgical intervention. The procedure involved synovial debridement, tenolysis, and bone erosion repair. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The goal was to alleviate severe pain, eradicate infection, and restore ankle mobility. Postoperatively, the patient will receive anti-inflammatory medication and undergo intensive rehabilitative therapy.

5. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the elbow joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The objective was to alleviate severe pain, eliminate infection, and restore elbow function. Postoperatively, the patient will receive anti-inflammatory medication, joint immobilization, and rehabilitative exercises.

6. Operative Note: A patient with chronic inflammation and severe infection in the wrist joint underwent surgical intervention. Synovial debridement, tenolysis, and bone erosion repair were performed. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to alleviate severe pain, eradicate infection, and restore wrist mobility. Postoperatively, the patient will receive anti-inflammatory medication and engage in intensive rehabilitative therapy.

7. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the hip joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The aim was to alleviate severe pain, eliminate infection, and restore hip function. Postoperatively, the patient will receive anti-inflammatory medication, joint immobilization, and rehabilitative exercises.

8. Operative Note: A patient with chronic inflammation and severe infection in the shoulder joint underwent surgical intervention. The procedure involved synovial debridement, tenolysis, and bone erosion repair. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The surgical intervention aimed to alleviate severe pain, eradicate infection, and restore shoulder mobility. Postoperatively, the patient will receive anti-inflammatory medication and participate in a comprehensive rehabilitation program.

9. Operative Note: Urgent surgical intervention was performed on a patient with acute inflammation and a severe infection in the knee joint. The procedure included synovectomy, tenosynovectomy, and bone erosion repair. Inflamed synovium was meticulously excised, tendon adhesions released, and bone grafting performed to address erosion. The objective was to alleviate severe pain, eliminate infection, and restore knee function. Postoperatively, the patient will receive anti-inflammatory medication, joint immobilization, and engage in rehabilitative exercises.

10. Operative Note: A patient with chronic inflammatory disease and severe infection in the ankle joint underwent surgical intervention. The procedure involved synovial debridement, tenolysis, and bone erosion repair. Inflamed synovium was excised, tendon adhesions released, and bone grafting performed to stabilize eroded areas. The goal was to alleviate severe pain, eradicate infection, and restore ankle mobility. Postoperatively, the patient will receive anti-inflammatory medication and undergo intensive rehabilitative therapy.

1. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved synovectomy, tenosynovectomy, and bone erosion repair. The severity of the diagnosis necessitated close postoperative monitoring and follow-up appointments to assess the response to treatment. The patient will receive appropriate pain management and rehabilitation based on the severity of symptoms and disease progression.

2. Operative Note: Urgent surgical intervention was performed on a patient with a moderate diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. The surgical procedure included synovial debridement, tenolysis, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be scheduled based on the severity of symptoms and the response to treatment. The patient will receive appropriate medication, physiotherapy, and further interventions as required.

3. Operative Note: A patient with a mild diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere underwent surgical intervention. Synovectomy, tenosynovectomy, and bone erosion repair were performed. The patient's follow-up appointments will be scheduled to monitor the response to treatment and adjust the management plan accordingly. The patient will receive appropriate pain management, rehabilitation, and ongoing evaluation based on the severity of symptoms and disease progression.

4. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved an extensive synovial debridement, tenolysis, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be frequent and closely monitored due to the severity of the diagnosis. The patient will receive intensive rehabilitation, pain management, and further interventions as necessary.

5. Operative Note: Urgent surgical intervention was performed on a patient with a moderate diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. The surgical procedure included synovectomy, tenosynovectomy, and bone erosion repair. The patient's follow-up appointments will be scheduled based on the severity of symptoms and the response to treatment. The patient will receive appropriate pain management, rehabilitation, and further interventions if required.

6. Operative Note: A patient with a mild diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere underwent surgical intervention. Synovial debridement, tenolysis, and bone erosion repair were performed. The patient's follow-up appointments will be arranged based on the severity of symptoms and the progression of the disease. The patient will receive appropriate pain management, rehabilitative therapy, and periodic evaluations.

7. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved extensive synovectomy, tenosynovectomy, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be frequent and closely monitored due to the severity of the diagnosis. The patient will receive intensive rehabilitation, pain management, and further interventions as necessary.

8. Operative Note: Urgent surgical intervention was performed on a patient with a moderate diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. The surgical procedure included synovial debridement, tenolysis, and bone erosion repair. The patient's follow-up appointments will be scheduled based on the severity of symptoms and the response to treatment. The patient will receive appropriate pain management, rehabilitation, and further interventions if required.

9. Operative Note: A patient with a mild diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere underwent surgical intervention. Synovectomy, tenosynovectomy, and bone erosion repair were performed. The patient's follow-up appointments will be arranged based on the severity of symptoms and the progression of the disease. The patient will receive appropriate pain management, rehabilitative therapy, and periodic evaluations.

10. Operative Note: The patient presented with a severe diagnosis of Other disorders of synovium and tendon in diseases classified elsewhere. Surgical intervention involved an extensive synovial debridement, tenolysis, and bone erosion repair. Postoperatively, the patient's follow-up appointments will be frequent and closely monitored due to the severity of the diagnosis. The patient will receive intensive rehabilitation, pain management, and further interventions as necessary.

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## M70.0 Chronic crepitant synovitis of hand and wrist

1. Operative Note: Patient underwent arthroscopic synovectomy for chronic crepitant synovitis of the hand and wrist. A 2 cm incision was made, and the arthroscope was inserted to visualize the joint. The synovial tissue was excised using a shaver and biopsy forceps. Hemostasis was achieved, and the incision was closed with sutures.

2. Operative Note: Patient underwent open synovectomy for chronic crepitant synovitis of the hand and wrist. A dorsal approach was utilized, and the extensor retinaculum was incised. The synovial tissue was identified and excised meticulously. Hemostasis was achieved, and the wound was closed in layers using sutures.

3. Operative Note: Patient underwent ultrasound-guided corticosteroid injection for chronic crepitant synovitis of the hand and wrist. Under aseptic conditions, the synovial sheath was identified using ultrasound guidance. A mixture of local anesthetic and corticosteroid was injected into the affected area, aiming for symptomatic relief. The patient tolerated the procedure well, and post-injection instructions were provided.

4. Operative Note: Patient underwent joint lavage and debridement for chronic crepitant synovitis of the hand and wrist. A volar approach was used, and the joint capsule was opened. Copious irrigation was performed using sterile saline, followed by meticulous debridement of the synovial tissue. The joint was thoroughly inspected, and the wound was closed with sutures.

5. Operative Note: Patient underwent synovial biopsy for chronic crepitant synovitis of the hand and wrist. A 1 cm incision was made, and the synovial membrane was exposed. A small tissue sample was obtained for histopathological examination. Hemostasis was ensured, and the incision was closed using sutures. The specimen was sent to the pathology department for analysis.

6. Operative Note: Patient underwent arthroscopic synovial biopsy for chronic crepitant synovitis of the hand and wrist. Small portals were created, and the arthroscope was introduced into the joint. A biopsy punch was used to obtain multiple synovial tissue samples for pathological evaluation. Hemostasis was achieved, and the portals were closed with sutures.

7. Operative Note: Patient underwent synovial fluid aspiration for chronic crepitant synovitis of the hand and wrist. A sterile technique was employed, and the joint space was identified. Using a needle and syringe, synovial fluid was aspirated for analysis. The procedure was well-tolerated by the patient, and post-procedure instructions were given.

8. Operative Note: Patient underwent synovial fenestration for chronic crepitant synovitis of the hand and wrist. A dorsal approach was taken, and multiple small incisions were made over the affected joints. The synovial membrane was fenestrated using a needle or electrocautery to promote fluid drainage. The wounds were dressed, and the patient was educated about wound care.

9. Operative Note: Patient underwent tenosynovectomy for chronic crepitant synovitis of the hand and wrist. A radial or ulnar approach was used, and the affected tendon sheath was exposed. Careful dissection was performed to remove the inflamed synovial tissue. Hemostasis was achieved, and the wound was closed using sutures.

10. Operative Note: Patient underwent joint immobilization for chronic crepitant synovitis of the hand and wrist. The joint was stabilized using a custom-made splint or cast. Proper positioning and immobilization were ensured to minimize joint movement. The patient was instructed on proper splint/cast care and follow-up appointments for evaluation of symptoms and joint function.

1. Operative Note: Patient underwent arthroscopic synovial debridement for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The synovial tissue was carefully debrided using arthroscopic instruments, ensuring removal of any loose bodies or adhesions. Hemostasis was achieved, and the incisions were closed with sutures.

2. Operative Note: Patient underwent joint irrigation with corticosteroid injection for chronic crepitant synovitis of the hand and wrist. A dorsal approach was utilized, and the joint capsule was opened. The joint was thoroughly irrigated with sterile saline, followed by the injection of a corticosteroid solution into the joint space. The joint capsule was closed, and the wound was sutured in layers.

3. Operative Note: Patient underwent synovial biopsy with synovectomy for chronic crepitant synovitis of the hand and wrist. A volar approach was used, and the synovial tissue was exposed. A biopsy sample was obtained for pathological analysis, and then a synovectomy was performed to remove the inflamed synovium. Hemostasis was achieved, and the wound was closed meticulously.

4. Operative Note: Patient underwent joint arthrodesis for chronic crepitant synovitis of the hand and wrist. An incision was made, and the affected joint surfaces were prepared. Fixation was achieved using screws, plates, or other hardware to promote fusion. The joint was immobilized, and the wound was closed layer by layer. Postoperative instructions were given regarding immobilization and rehabilitation.

5. Operative Note: Patient underwent ultrasound-guided hydrodissection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, an ultrasound probe was used to identify the affected area. Saline solution was injected to create a space between the synovial tissue and surrounding structures, promoting pain relief and improved mobility. The procedure was performed successfully without complications.

6. Operative Note: Patient underwent tenosynovectomy with tendon repair for chronic crepitant synovitis of the hand and wrist. A radial or ulnar approach was chosen, and the inflamed tendon sheath was exposed. The synovial tissue was excised, and any associated tendon injuries were repaired. Hemostasis was ensured, and the wound was closed with sutures.

7. Operative Note: Patient underwent joint denervation for chronic crepitant synovitis of the hand and wrist. A dorsal or volar approach was utilized, and the affected joint was exposed. The sensory nerves supplying the joint were identified and selectively denervated to alleviate pain. Hemostasis was achieved, and the wound was closed meticulously.

8. Operative Note: Patient underwent intra-articular hyaluronic acid injection for chronic crepitant synovitis of the hand and wrist. Under aseptic conditions, the joint space was accessed, and hyaluronic acid was injected to improve joint lubrication and reduce inflammation. The patient tolerated the procedure well, and post-injection instructions were provided.

9. Operative Note: Patient underwent arthroscopic synovial biopsy and synovial plication for chronic crepitant synovitis of the hand and wrist. Multiple portals were created, and the arthroscope was introduced into the joint. Biopsy samples were obtained for pathological analysis, and synovial plication was performed to tighten and stabilize the synovial membrane. The portals were closed, and the patient was discharged with appropriate postoperative care instructions.

10. Operative Note: Patient underwent joint resurfacing for chronic crepitant synovitis of the hand and wrist. An incision was made, and the joint surfaces were prepared. The damaged cartilage was removed, and a synthetic or biological implant was used to resurface the joint. The implant was secured in place, and the wound was closed meticulously. Postoperative rehabilitation plan was discussed with the patient.

1. Operative Note: Patient underwent arthroscopic synovectomy for chronic crepitant synovitis of the hand and wrist under local anesthesia. A 2 cm incision was made, and the arthroscope was inserted to visualize the joint. The synovial tissue was excised using a shaver and biopsy forceps. Hemostasis was achieved, and the incision was closed with sutures. The patient remained comfortable throughout the procedure with local anesthesia.

2. Operative Note: Patient underwent open synovectomy for chronic crepitant synovitis of the hand and wrist under regional anesthesia. A dorsal approach was utilized, and the extensor retinaculum was incised. The synovial tissue was identified and excised meticulously. Hemostasis was achieved, and the wound was closed in layers using sutures. The patient had adequate pain control with regional anesthesia.

3. Operative Note: Patient underwent ultrasound-guided corticosteroid injection for chronic crepitant synovitis of the hand and wrist under conscious sedation. Under aseptic conditions, the synovial sheath was identified using ultrasound guidance. A mixture of local anesthetic and corticosteroid was injected into the affected area, aiming for symptomatic relief. The patient was comfortable and cooperative during the procedure with conscious sedation.

4. Operative Note: Patient underwent joint lavage and debridement for chronic crepitant synovitis of the hand and wrist under general anesthesia. A volar approach was used, and the joint capsule was opened. Copious irrigation was performed using sterile saline, followed by meticulous debridement of the synovial tissue. The joint was thoroughly inspected, and the wound was closed with sutures. The patient was asleep throughout the procedure under general anesthesia.

5. Operative Note: Patient underwent synovial biopsy for chronic crepitant synovitis of the hand and wrist under monitored anesthesia care (MAC). A 1 cm incision was made, and the synovial membrane was exposed. A small tissue sample was obtained for histopathological examination. Hemostasis was ensured, and the incision was closed using sutures. The patient was comfortable and responsive under MAC.

6. Operative Note: Patient underwent arthroscopic synovial biopsy for chronic crepitant synovitis of the hand and wrist under moderate sedation. Small portals were created, and the arthroscope was introduced into the joint. A biopsy punch was used to obtain multiple synovial tissue samples for pathological evaluation. Hemostasis was achieved, and the portals were closed with sutures. The patient remained calm and relaxed with moderate sedation.

7. Operative Note: Patient underwent synovial fluid aspiration for chronic crepitant synovitis of the hand and wrist under local anesthesia. A sterile technique was employed, and the joint space was identified. Using a needle and syringe, synovial fluid was aspirated for analysis. The procedure was well-tolerated by the patient, and post-procedure instructions were given. Local anesthesia provided adequate pain control.

8. Operative Note: Patient underwent synovial fenestration for chronic crepitant synovitis of the hand and wrist under regional anesthesia. A dorsal approach was taken, and multiple small incisions were made over the affected joints. The synovial membrane was fenestrated using a needle or electrocautery to promote fluid drainage. The wounds were dressed, and the patient was educated about wound care. Regional anesthesia provided effective pain relief.

9. Operative Note: Patient underwent tenosynovectomy for chronic crepitant synovitis of the hand and wrist under general anesthesia. A radial or ulnar approach was used, and the affected tendon sheath was exposed. Careful dissection was performed to remove the inflamed synovial tissue. Hemostasis was achieved, and the wound was closed using sutures. The patient was comfortably asleep throughout the procedure under general anesthesia.

10. Operative Note: Patient underwent joint immobilization for chronic crepitant synovitis of the hand and wrist under local anesthesia with sedation. The joint was stabilized using a custom-made splint or cast. Proper positioning and immobilization were ensured to minimize joint movement. The patient was relaxed and pain-free during the procedure with a combination of local anesthesia and sedation.

1. Operative Note: Patient underwent arthroscopic synovectomy with bone erosion repair for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The synovial tissue was excised, and areas of bone erosion were identified. Bone grafts were meticulously placed to promote bone regeneration. Hemostasis was achieved, and the incisions were closed with sutures.

2. Operative Note: Patient underwent open synovectomy with bone grafting for chronic crepitant synovitis of the hand and wrist. A dorsal approach was utilized, and the extensor retinaculum was incised. The synovial tissue was identified and excised, revealing underlying bone erosion. Bone grafts were carefully placed to fill the defects. Hemostasis was achieved, and the wound was closed in layers using sutures.

3. Operative Note: Patient underwent joint reconstruction with bone augmentation for chronic crepitant synovitis of the hand and wrist. An incision was made, and the joint surfaces were exposed. The eroded bone areas were meticulously debrided, and bone grafts or synthetic bone substitutes were used to reconstruct the damaged bone. The joint was stabilized, and the wound was closed meticulously.

4. Operative Note: Patient underwent joint arthrodesis with bone fusion for chronic crepitant synovitis of the hand and wrist. An incision was made, and the affected joint surfaces were prepared. Bone resection was performed to remove the eroded areas, followed by fixation using screws, plates, or other hardware to promote bone fusion. The joint was immobilized, and the wound was closed layer by layer.

5. Operative Note: Patient underwent joint resurfacing with bone grafting for chronic crepitant synovitis of the hand and wrist. An incision was made, and the damaged joint surfaces were carefully prepared. Bone grafts were harvested from the patient or obtained from a bone bank, and these grafts were used to resurface the eroded bone areas. The grafts were secured in place, and the wound was closed meticulously.

6. Operative Note: Patient underwent arthroscopic bone debridement and bone grafting for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was introduced into the joint. The eroded bone areas were carefully debrided using arthroscopic instruments. Bone grafts were then placed to fill the defects. Hemostasis was achieved, and the incisions were closed with sutures.

7. Operative Note: Patient underwent joint reconstruction with autologous bone grafting for chronic crepitant synovitis of the hand and wrist. A dorsal or volar approach was used, and the joint was exposed. The eroded bone areas were meticulously debrided, and autologous bone grafts harvested from the patient were used for reconstruction. The joint was stabilized, and the wound was closed meticulously.

8. Operative Note: Patient underwent joint fusion with bone grafting and internal fixation for chronic crepitant synovitis of the hand and wrist. An incision was made, and the eroded joint surfaces were prepared. Bone grafts were placed between the joint surfaces to promote fusion. Internal fixation with screws or plates was performed to provide stability. The joint was immobilized, and the wound was closed layer by layer.

9. Operative Note: Patient underwent joint reconstruction with allograft bone grafting for chronic crepitant synovitis of the hand and wrist. A volar approach was chosen, and the joint was exposed. The eroded bone areas were carefully debrided, and allograft bone grafts were used for reconstruction. The joint was stabilized, and the wound was closed meticulously.

10. Operative Note: Patient underwent joint arthroplasty with bone augmentation for chronic crepitant synovitis of the hand and wrist. An incision was made, and the eroded joint surfaces were resected. Bone augmentation with bone grafts or bone substitutes was performed to restore bone integrity. The joint prosthesis was then implanted, and the wound was closed meticulously.

1. Operative Note: Patient underwent arthroscopic synovectomy for chronic crepitant synovitis of the hand and wrist due to severe bone pain. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The synovial tissue was meticulously excised to alleviate inflammation and reduce bone pain. Hemostasis was achieved, and the incisions were closed with sutures.

2. Operative Note: Patient underwent joint denervation for chronic crepitant synovitis of the hand and wrist to address severe bone pain. A dorsal or volar approach was utilized, and the affected joint was exposed. The sensory nerves supplying the joint were identified and selectively denervated to interrupt pain signals. Hemostasis was achieved, and the wound was closed meticulously.

3. Operative Note: Patient underwent joint resurfacing with bone grafting for chronic crepitant synovitis of the hand and wrist associated with severe bone pain. An incision was made, and the damaged joint surfaces were prepared. Bone grafts were meticulously placed to restore bone integrity and alleviate bone pain. The grafts were secured in place, and the wound was closed meticulously.

4. Operative Note: Patient underwent joint fusion for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the affected joint surfaces were prepared. The eroded bone areas were meticulously debrided, followed by fixation using screws, plates, or other hardware to promote bone fusion and eliminate painful joint movement. The joint was immobilized, and the wound was closed layer by layer.

5. Operative Note: Patient underwent joint reconstruction with autologous bone grafting for chronic crepitant synovitis of the hand and wrist presenting with severe bone pain. A dorsal or volar approach was used, and the joint was exposed. The eroded bone areas were meticulously debrided, and autologous bone grafts harvested from the patient were used for reconstruction to alleviate severe bone pain. The joint was stabilized, and the wound was closed meticulously.

6. Operative Note: Patient underwent joint arthrodesis for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the affected joint surfaces were prepared. The eroded bone areas were meticulously removed, and the joint was fixed in a fused position using screws, plates, or other hardware to eliminate painful joint movement. The joint was immobilized, and the wound was closed layer by layer.

7. Operative Note: Patient underwent joint debridement with bone augmentation for chronic crepitant synovitis of the hand and wrist and severe bone pain. A volar approach was chosen, and the joint was exposed. The eroded bone areas were meticulously debrided, and bone grafts or bone substitutes were placed to support bone regeneration and alleviate severe bone pain. The wound was closed meticulously.

8. Operative Note: Patient underwent joint replacement for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the eroded joint surfaces were resected. A joint prosthesis was meticulously implanted to provide stability and relieve severe bone pain. The wound was closed meticulously, and postoperative pain management was discussed with the patient.

9. Operative Note: Patient underwent joint reconstruction with allograft bone grafting for chronic crepitant synovitis of the hand and wrist accompanied by severe bone pain. A volar approach was chosen, and the joint was exposed. The eroded bone areas were meticulously debrided, and allograft bone grafts were used for reconstruction to alleviate severe bone pain. The joint was stabilized, and the wound was closed meticulously.

10. Operative Note: Patient underwent joint immobilization for chronic crepitant synovitis of the hand and wrist with severe bone pain. An incision was made, and the joint was stabilized using a custom-made splint or cast. Proper positioning and immobilization were ensured to minimize joint movement and alleviate severe bone pain. The patient was instructed on postoperative pain management and provided with appropriate pain medications.

1. Operative Note: Patient underwent arthroscopic synovectomy with joint irrigation and debridement for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The inflamed synovial tissue was meticulously excised, followed by thorough irrigation and debridement of the joint. Hemostasis was achieved, and the incisions were closed using sutures.

2. Operative Note: Patient underwent ultrasound-guided corticosteroid injection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, ultrasound guidance was used to accurately locate the affected area. A mixture of local anesthetic and corticosteroid was injected into the inflamed synovial tissue to reduce inflammation and alleviate symptoms. The injection site was dressed, and post-procedure instructions were given.

3. Operative Note: Patient underwent magnetic resonance imaging (MRI)-guided synovial biopsy for chronic crepitant synovitis of the hand and wrist. The patient was positioned in the MRI scanner, and the affected joint was accurately targeted. A biopsy needle was guided into the synovial tissue for sampling. Hemostasis was achieved, and appropriate wound care instructions were provided.

4. Operative Note: Patient underwent intra-articular hyaluronic acid injection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, the affected joint was accessed, and hyaluronic acid was injected into the joint space to provide lubrication and reduce pain. The injection site was dressed, and post-injection care instructions were discussed with the patient.

5. Operative Note: Patient underwent ultrasound-guided aspiration and corticosteroid injection for chronic crepitant synovitis of the hand and wrist. Ultrasound guidance was used to locate the affected joint and guide the aspiration of synovial fluid. After aspiration, a mixture of corticosteroid and local anesthetic was injected into the joint space to reduce inflammation and alleviate pain. The injection site was dressed, and post-procedure instructions were given.

6. Operative Note: Patient underwent arthroscopic synovial plication for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The redundant synovial tissue was meticulously folded and plicated to reduce synovial volume and improve joint stability. Hemostasis was achieved, and the incisions were closed using sutures.

7. Operative Note: Patient underwent ultrasound-guided platelet-rich plasma (PRP) injection for chronic crepitant synovitis of the hand and wrist. Under sterile conditions, ultrasound guidance was used to accurately locate the affected area. PRP, prepared from the patient's own blood, was injected into the inflamed synovial tissue to promote healing and reduce inflammation. The injection site was dressed, and post-injection care instructions were provided.

8. Operative Note: Patient underwent joint arthroscopy with thermal capsulorrhaphy for chronic crepitant synovitis of the hand and wrist. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. Thermal energy was used to shrink and tighten the joint capsule, providing stability and reducing pain. Hemostasis was achieved, and the incisions were closed using sutures.

9. Operative Note: Patient underwent joint manipulation under anesthesia for chronic crepitant synovitis of the hand and wrist. The patient was placed under general anesthesia, and the affected joint was manipulated to break up adhesions and improve range of motion. The joint was carefully mobilized, and post-procedure instructions were given to the patient.

10. Operative Note: Patient underwent open synovectomy with joint reconstruction for chronic crepitant synovitis of the hand and wrist. An incision was made, and the affected joint was exposed. The inflamed synovial tissue was meticulously excised, followed by joint reconstruction using autograft or allograft. Hemostasis was achieved, and the wound was closed meticulously.

1. Operative Note: Patient underwent emergency joint irrigation and debridement for chronic crepitant synovitis of the hand and wrist with severe infection. An urgent incision was made, and the joint was accessed. Copious irrigation with sterile saline and antiseptic solution was performed to flush out the infected material. Infected tissues, including the synovium, were meticulously debrided. Antibiotic-impregnated beads or irrigation was utilized. Hemostasis was achieved, and the wound was left open for further management.

2. Operative Note: Patient underwent urgent joint arthroscopy with abscess drainage for chronic crepitant synovitis of the hand and wrist with a severe infected abscess. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. The abscess was identified and meticulously drained. Thorough irrigation with antimicrobial solution was performed. The joint was assessed for any signs of damaged tissue or erosions. Hemostasis was achieved, and the incisions were closed using sutures.

3. Operative Note: Patient underwent joint fusion with extensive debridement for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the eroded joint surfaces were thoroughly debrided. The infected tissue and any necrotic bone were meticulously removed. The joint was fused using hardware and bone grafts to eliminate infection and provide stability. Hemostasis was achieved, and the wound was closed meticulously.

4. Operative Note: Patient underwent amputation of the affected extremity for chronic crepitant synovitis of the hand and wrist with severe joint infection that was unresponsive to conservative measures. An incision was made proximal to the affected joint, and disarticulation was performed. Careful hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management and rehabilitation plans were discussed with the patient.

5. Operative Note: Patient underwent radical synovectomy and joint reconstruction for chronic crepitant synovitis of the hand and wrist with severe joint infection. An extensive incision was made, and the joint was exposed. The infected synovium and surrounding tissues were meticulously excised. Joint reconstruction was performed using autograft or allograft, followed by thorough irrigation with antimicrobial solution. Hemostasis was achieved, and the wound was closed meticulously.

6. Operative Note: Patient underwent urgent joint washout with soft tissue debridement for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the infected joint was meticulously irrigated with sterile saline and antiseptic solution to remove infected material. Soft tissue debridement was performed to remove necrotic or devitalized tissue. Antibiotic-impregnated dressings were applied, and postoperative care instructions were provided.

7. Operative Note: Patient underwent joint salvage procedure for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the joint was exposed. Extensive debridement of the infected tissues was performed, followed by meticulous irrigation with antimicrobial solution. A combination of local or systemic antibiotics was administered. The joint was stabilized, and the wound was closed meticulously.

8. Operative Note: Patient underwent urgent joint resection arthroplasty for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the affected joint was meticulously resected to remove the infected and damaged tissue. The joint surfaces were smoothed, and the wound was thoroughly irrigated. Hemostasis was achieved, and the wound was closed using sutures.

9. Operative Note: Patient underwent joint lavage with infected tissue debridement for chronic crepitant synovitis of the hand and wrist with severe joint infection. An incision was made, and the joint was accessed. Copious lavage with sterile saline and antimicrobial solution was performed to flush out the infected material. Infected tissues, including the synovium and surrounding structures, were meticulously debrided. Antibiotic-impregnated dressings were applied, and the wound was dressed.

10. Operative Note: Patient underwent urgent joint amputation for chronic crepitant synovitis of the hand and wrist with severe joint infection that posed a significant risk to the patient's overall health. An incision was made proximal to the affected joint, and disarticulation was performed. Careful hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management, rehabilitation, and appropriate antibiotic therapy were discussed with the patient.

1. Operative Note: Patient underwent joint synovectomy and anti-inflammatory cytokine therapy for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the inflamed synovial tissue was meticulously excised. Intraoperative anti-inflammatory cytokine therapy was administered directly into the joint to reduce inflammation and promote healing. Hemostasis was achieved, and the wound was closed using sutures.

2. Operative Note: Patient underwent joint arthroscopy with synovial biopsy for chronic crepitant synovitis of the hand and wrist with severe inflammation. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. Synovial tissue samples were obtained for histopathological examination to evaluate the extent of inflammation. The joint was thoroughly irrigated, and the incisions were closed using sutures.

3. Operative Note: Patient underwent ultrasound-guided injection of anti-inflammatory medication for chronic crepitant synovitis of the hand and wrist with recurrent inflammation. Under sterile conditions, ultrasound guidance was used to accurately locate the affected area. An anti-inflammatory medication, such as corticosteroid or nonsteroidal anti-inflammatory drug, was injected into the inflamed synovial tissue to alleviate inflammation and associated symptoms. The injection site was dressed, and post-injection care instructions were provided.

4. Operative Note: Patient underwent joint fusion with synovial debridement for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the eroded joint surfaces were meticulously debrided. The inflamed synovial tissue was excised to reduce inflammation. The joint was stabilized using hardware and bone grafts to eliminate painful joint movement. Hemostasis was achieved, and the wound was closed meticulously.

5. Operative Note: Patient underwent joint irrigation and anti-inflammatory drug washout for chronic crepitant synovitis of the hand and wrist with acute exacerbation of inflammation. An incision was made, and the joint was thoroughly irrigated with sterile saline to remove inflammatory factors. An anti-inflammatory drug solution was used for washout to further reduce inflammation. Hemostasis was achieved, and the wound was closed using sutures.

6. Operative Note: Patient underwent joint denervation and anti-inflammatory therapy for chronic crepitant synovitis of the hand and wrist with persistent inflammation. A volar approach was utilized, and the affected joint was exposed. The sensory nerves supplying the joint were identified and selectively denervated to alleviate pain and reduce inflammation. Anti-inflammatory therapy, such as corticosteroid injection or intra-articular hyaluronic acid, was administered to further mitigate inflammation. The wound was closed meticulously.

7. Operative Note: Patient underwent open synovectomy with adjunctive anti-inflammatory phototherapy for chronic crepitant synovitis of the hand and wrist with refractory inflammation. An incision was made, and the inflamed synovial tissue was meticulously excised. Adjunctive anti-inflammatory phototherapy, such as low-level laser therapy, was applied to the surgical site to stimulate tissue healing and reduce inflammation. Hemostasis was achieved, and the wound was closed using sutures.

8. Operative Note: Patient underwent joint lavage with anti-inflammatory irrigation for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the joint was thoroughly irrigated with a solution containing an anti-inflammatory agent to reduce inflammation. Copious lavage was performed to flush out inflammatory factors and debris. Hemostasis was achieved, and the wound was closed using sutures.

9. Operative Note: Patient underwent joint arthroscopy with intra-articular anti-inflammatory drug delivery for chronic crepitant synovitis of the hand and wrist with recurrent inflammation. Multiple small incisions were made, and the arthroscope was inserted to visualize the joint. An anti-inflammatory drug, such as a corticosteroid or hyaluronic acid, was delivered directly into the joint to alleviate inflammation and improve joint function. The incisions were closed using sutures.

10. Operative Note: Patient underwent joint synovectomy with intraoperative biologic therapy for chronic crepitant synovitis of the hand and wrist with persistent inflammation. An incision was made, and the inflamed synovial tissue was meticulously excised. Intraoperative biologic therapy, such as platelet-rich plasma or mesenchymal stem cell injection, was administered to modulate the inflammatory response and promote tissue regeneration. Hemostasis was achieved, and the wound was closed using sutures.

1. Operative Note: Patient underwent joint synovectomy for chronic crepitant synovitis of the hand and wrist. The inflamed synovial tissue was meticulously excised. The patient will follow up in two weeks for wound assessment and suture removal. Depending on the response, further follow-up visits and physical therapy sessions will be scheduled accordingly.

2. Operative Note: Patient underwent arthroscopic debridement and irrigation for chronic crepitant synovitis of the hand and wrist. Loose fragments and debris were removed, and the joint was thoroughly irrigated. The patient will have a postoperative appointment in one week to assess the recovery progress. Further follow-up visits will be scheduled based on the patient's symptoms and response to treatment.

3. Operative Note: Patient underwent joint fusion for chronic crepitant synovitis of the hand and wrist. The joint was stabilized using hardware and bone grafts. The patient will be closely monitored during the initial healing phase. Follow-up visits will be scheduled at regular intervals to assess fusion progress and address any concerns or complications that may arise.

4. Operative Note: Patient underwent synovial biopsy for chronic crepitant synovitis of the hand and wrist. The synovial tissue samples were sent for histopathological examination to determine the underlying cause. The patient will follow up in one week to discuss the biopsy results and formulate a treatment plan based on the findings.

5. Operative Note: Patient underwent joint washout with extensive debridement for chronic crepitant synovitis of the hand and wrist. The infected and inflamed tissue was meticulously removed, and the joint was thoroughly irrigated. The patient will have frequent follow-up visits in the initial postoperative period to monitor for signs of infection resolution and assess the need for additional treatment or antibiotics.

6. Operative Note: Patient underwent joint manipulation and splinting for chronic crepitant synovitis of the hand and wrist. The joint was carefully manipulated to improve range of motion, followed by application of a splint to maintain proper alignment. The patient will be seen in one week to assess the response to manipulation and adjust the splint if necessary. Further follow-up visits will be scheduled based on the patient's progress.

7. Operative Note: Patient underwent ultrasound-guided injection for chronic crepitant synovitis of the hand and wrist. A corticosteroid and anesthetic mixture was injected into the inflamed synovial tissue. The patient will have a follow-up appointment in three weeks to evaluate the response to the injection and determine the need for additional treatments or adjustments to the medication regimen.

8. Operative Note: Patient underwent joint arthroscopy with cartilage repair for chronic crepitant synovitis of the hand and wrist. The damaged cartilage surfaces were treated using cartilage repair techniques. The patient will follow up in six weeks for a postoperative evaluation, including imaging studies, to assess the success of the cartilage repair and determine the next steps in rehabilitation and treatment.

9. Operative Note: Patient underwent joint reconstruction for chronic crepitant synovitis of the hand and wrist. The joint was reconstructed using autograft or allograft to address the underlying joint damage. The patient will have regular follow-up visits to monitor the healing process, assess functional improvement, and adjust the rehabilitation plan as needed.

10. Operative Note: Patient underwent joint amputation for chronic crepitant synovitis of the hand and wrist with extensive joint damage and irreparable complications. The patient will be closely monitored during the initial postoperative phase for wound healing and pain management. Follow-up visits will be scheduled to address prosthesis fitting, rehabilitation, and psychological support to ensure optimal recovery and adjustment to the amputation.

## M70.1 Bursitis of hand

1. Patient presented with acute hand bursitis. Following local anesthesia, a small incision was made over the inflamed bursa. The bursa was drained and irrigated, and a sterile dressing was applied. Patient instructed to elevate and immobilize the hand. Prescribed nonsteroidal anti-inflammatory drugs (NSAIDs) for pain relief. Follow-up appointment scheduled in two weeks for assessment of healing and further management if necessary.

2. Operative intervention performed for chronic hand bursitis. Under sterile conditions, a longitudinal incision was made to expose the affected bursa. Excision of the bursa was conducted, followed by thorough irrigation and hemostasis. Wound closure was achieved using absorbable sutures. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain control. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis. A small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered to reduce inflammation. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis. An incision was made to expose the inflamed bursa. Debridement of necrotic tissue was conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Postoperative instructions included hand immobilization and regular dressing changes. Prescribed analgesics for pain management. A follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis. A wide incision was made to drain the abscess. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. A drain was placed, and wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Instructed on signs of worsening infection and the need for immediate medical attention. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis. Two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and then injected with corticosteroids. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement for chronic hand bursitis. Small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous hemostasis was achieved. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis. An incision was made to explore the injured area. Hematoma evacuation and thorough irrigation were performed. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and persistent pain. Ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain relief. Advised to report any signs of infection or worsening symptoms. Follow-up appointment scheduled in two weeks for evaluation and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis. A small incision was made, and a specialized instrument was used to decompress the inflamed bursa. The procedure was completed under local anesthesia. Incision closed with adhesive strips and a sterile dressing applied. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Operative intervention performed for chronic hand bursitis. A dorsal incision was made over the affected area. The bursa was excised, and meticulous hemostasis was achieved. The wound was closed using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Instructed to avoid strenuous activities. Follow-up appointment scheduled in four weeks for wound evaluation and potential rehabilitation.

2. Patient presented with recurrent hand bursitis. Ultrasound-guided needle aspiration was performed to drain the inflamed bursa. The bursa was injected with a corticosteroid solution to alleviate inflammation. Sterile dressing applied, and hand immobilization instructed. Prescribed NSAIDs for pain relief. Follow-up appointment scheduled in two weeks for reassessment and further management if needed.

3. The patient underwent open bursectomy for severe hand bursitis. A transverse incision was made, and the inflamed bursa was excised. Thorough irrigation and hemostasis were ensured. The wound was closed using absorbable sutures. Postoperative instructions included hand elevation and regular dressing changes. Prescribed analgesics and advised on gradual hand mobilization. Follow-up appointment scheduled in three weeks for wound assessment and potential rehabilitation.

4. Surgical intervention performed for infected hand bursitis. An incision was made to drain the purulent material and debride the infected tissue. Copious irrigation with antiseptic solution was done. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised on daily dressing changes. Instructed on signs of worsening infection and the need for immediate medical attention. Follow-up appointment scheduled in two days.

5. Patient presented with bilateral hand bursitis. Two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and injected with a corticosteroid solution. Incisions closed using sutures, and sterile dressings applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and potential further interventions.

6. The patient underwent ultrasound-guided percutaneous needle aspiration for hand bursitis. The inflamed bursa was visualized using ultrasound guidance, and a needle was inserted to aspirate the fluid. Corticosteroid injection was administered for anti-inflammatory effect. Applied a compression bandage and instructed on hand elevation. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

7. Operative intervention performed for traumatic hand bursitis. An incision was made, and hematoma evacuation was conducted. Thorough irrigation was done, and the wound was closed using sutures. Prescribed analgesics and antibiotics. Instructed on hand immobilization and elevation. Follow-up appointment scheduled in one week for wound assessment and potential suture removal.

8. Patient presented with chronic hand bursitis unresponsive to conservative measures. A dorsal incision was made to expose the affected bursa. Bursectomy was performed, and meticulous hemostasis was achieved. The wound was closed using absorbable sutures. Postoperative instructions included hand immobilization, ice application, and prescribed NSAIDs. Follow-up appointment scheduled in four weeks for wound evaluation and potential rehabilitation.

9. The patient underwent arthroscopic debridement and bursectomy for refractory hand bursitis. Small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was meticulously excised, and thorough irrigation was performed. The incisions were closed with sutures, and sterile dressings were applied. Postoperative instructions included hand elevation and regular dressing changes. Follow-up appointment scheduled in four weeks for wound assessment and potential rehabilitation.

10. Surgical intervention performed for hand bursitis with associated calcification. An incision was made to expose the calcified bursa, which was excised along with the surrounding calcific deposits. Thorough irrigation and hemostasis were ensured. The wound was closed using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential rehabilitation.

1. Patient presented with acute hand bursitis. Following local anesthesia with 10 ml of 1% lidocaine, a small incision was made over the inflamed bursa. The bursa was drained and irrigated, and a sterile dressing was applied. Prescribed nonsteroidal anti-inflammatory drugs (NSAIDs) for pain relief. Follow-up appointment scheduled in two weeks for assessment of healing and further management if necessary.

2. Operative intervention performed for chronic hand bursitis. Under sterile conditions, after administering regional anesthesia with an ulnar nerve block, a longitudinal incision was made to expose the affected bursa. Excision of the bursa was conducted, followed by thorough irrigation and hemostasis. Wound closure was achieved using absorbable sutures. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain control. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered to reduce inflammation. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa. Debridement of necrotic tissue was conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Postoperative instructions included hand immobilization and regular dressing changes. Prescribed analgesics for pain management. A follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. A drain was placed, and the wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Instructed on signs of worsening infection and the need for immediate medical attention. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and then injected with corticosteroids. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous hemostasis was achieved. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area. Hematoma evacuation and thorough irrigation were performed. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and persistent pain. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. The procedure was completed under local anesthesia. Incision closed with adhesive strips and a sterile dressing applied. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Patient presented with hand bursitis and significant bone erosion. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa and the eroded bone. Debridement of necrotic tissue and bone was performed, followed by thorough irrigation and hemostasis. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. Operative intervention performed for chronic hand bursitis with bone erosion. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa and the eroded bone. Excision of the bursa and thorough debridement of the eroded bone were conducted, followed by meticulous irrigation and hemostasis. Wound closure was achieved using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis and progressive bone erosion. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered for inflammation reduction. Additional debridement of eroded bone was performed. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis with extensive bone erosion. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the eroded bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis and concurrent bone erosion. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the eroded bone. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. Additional debridement of eroded bone was performed. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis with extensive bone erosion. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae and the eroded bone. Both bursae were drained, irrigated, and injected with corticosteroids. Additional debridement of eroded bone was conducted. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement and bone erosion repair for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous debridement and repair of eroded bone were performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis with bone erosion. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area, drain the hematoma, and expose the eroded bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis with significant bone erosion. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. Incision closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and NSAIDs for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Patient presented with severe bone pain associated with hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa and the affected bone. Debridement of necrotic tissue and thorough excision of the eroded bone were performed, followed by meticulous irrigation and hemostasis. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. Operative intervention performed for chronic hand bursitis with severe bone pain. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa and the painful bone. Excision of the bursa and thorough debridement of the eroded bone were conducted, followed by meticulous irrigation and hemostasis. Wound closure was achieved using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery.

3. The patient presented with recurrent hand bursitis and severe bone pain. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered for inflammation reduction. Additional debridement of eroded bone was performed to alleviate bone pain. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient advised to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. Surgical intervention performed for severe hand bursitis with extensive bone pain. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the painful bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted, followed by meticulous irrigation and exploration. Wound closure was achieved using interrupted sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Patient presented with infected hand bursitis and severe bone pain. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the eroded bone. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. Additional debridement of eroded bone was performed to alleviate bone pain. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis with severe bone pain. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae and the painful bones. Both bursae were drained, irrigated, and injected with corticosteroids. Additional debridement of eroded bone was conducted to alleviate bone pain. Incisions were closed using absorbable sutures, and sterile dressings were applied. Instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement and bone erosion repair for chronic hand bursitis with severe bone pain. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous debridement and repair of eroded bone were performed to alleviate severe bone pain. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis with severe bone pain. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area, drain the hematoma, and expose the eroded bone. Debridement of necrotic tissue and thorough excision of the eroded bone were conducted to alleviate severe bone pain. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion causing severe bone pain. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted to alleviate severe bone pain. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive treatment for hand bursitis with significant bone erosion and severe bone pain. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. Incision closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Surgical intervention performed for chronic hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. The bursa was carefully excised, and meticulous debridement of necrotic tissue was conducted. Thorough irrigation was performed, followed by wound closure using interrupted sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. The patient underwent surgical excision for persistent hand bursitis. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Excision of the bursa and thorough debridement were performed, followed by meticulous irrigation and hemostasis. Wound closure was achieved using absorbable sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery and determine the need for additional interventions.

3. Surgical intervention performed for recurrent hand bursitis. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the bursa was drained using a syringe. Corticosteroid injection was administered for inflammation reduction. Additional debridement of necrotic tissue was conducted. The incision was closed with adhesive strips, and a sterile dressing was applied. Patient instructed to limit hand use and prescribed NSAIDs. Follow-up appointment scheduled in one week for assessment and further treatment if needed.

4. The patient underwent surgical debridement and excision of eroded bone for severe hand bursitis. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the eroded bone. Thorough debridement of necrotic tissue and excision of the eroded bone were performed. Meticulous irrigation and exploration were conducted. Wound closure was achieved using interrupted sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Surgical intervention performed for infected hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the affected bursa. Pus was aspirated, and the wound was thoroughly irrigated with antiseptic solution. Debridement of necrotic tissue was performed. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days.

6. Operative intervention performed for bilateral hand bursitis. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae. Both bursae were drained, irrigated, and injected with corticosteroids. Debridement of necrotic tissue was conducted. Incisions were closed using absorbable sutures, and sterile dressings were applied. Patient instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic debridement and repair for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and meticulous debridement of necrotic tissue was performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area and drain the hematoma. The inflamed bursa and necrotic tissue were carefully excised. Thorough irrigation and exploration were conducted. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive surgical treatment for hand bursitis with significant bone erosion. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. Incision closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Surgical intervention performed for refractory hand bursitis. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. Extensive debridement of necrotic tissue was conducted, followed by thorough irrigation and hemostasis. A biological tissue graft was applied to promote healing. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. The patient underwent surgical debridement and bursectomy for chronic hand bursitis. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Complete excision of the bursa and meticulous debridement were performed, followed by thorough irrigation and exploration. The wound was closed using interrupted sutures. Prescribed postoperative analgesics and advised on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery and determine the need for additional interventions.

3. Surgical intervention performed for recurrent hand bursitis with secondary infection. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the infected bursa was drained using a syringe. Extensive debridement of necrotic tissue and thorough irrigation with antiseptic solution were conducted. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days for wound reassessment.

4. The patient underwent surgical excision of eroded bone and debridement for severe hand bursitis. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa and the eroded bone. Thorough debridement of necrotic tissue and excision of the eroded bone were performed. Meticulous irrigation and exploration were conducted. The wound was closed using layered sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Surgical intervention performed for infected hand bursitis with abscess formation. After administering local anesthesia with 10 ml of 1% lidocaine, a wide incision was made to drain the abscess and expose the affected bursa. Pus was aspirated, and extensive debridement of necrotic tissue was conducted. The wound was thoroughly irrigated with antiseptic solution. A drain was placed to facilitate drainage. Prescribed broad-spectrum antibiotics and instructed on daily dressing changes. Follow-up appointment scheduled in two days for wound reassessment.

6. Operative intervention performed for bilateral hand bursitis with persistent symptoms. After administering regional anesthesia with an axillary nerve block, two separate incisions were made to expose the inflamed bursae. Complete excision of the bursae and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wounds were closed using absorbable sutures, and sterile dressings were applied. Patient instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

7. The patient underwent arthroscopic bursectomy and debridement for chronic hand bursitis. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and extensive debridement of necrotic tissue was performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

8. Surgical intervention performed for traumatic hand bursitis with eroded bone. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the injured area and drain the hematoma. The inflamed bursa and eroded bone were carefully excised. Thorough irrigation and exploration were conducted. The wound was closed using layered sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

9. Patient presented with hand bursitis and extensive bone erosion causing persistent symptoms. After administering regional anesthesia with a median nerve block, ultrasound-guided aspiration of the bursa was performed. Fluid was aspirated, and a corticosteroid solution was injected. Additional debridement of eroded bone was conducted. A compression bandage was applied, and the patient was instructed to rest and elevate the hand. Prescribed NSAIDs for pain management. Follow-up appointment scheduled in two weeks for reassessment and further treatment if necessary.

10. The patient underwent minimally invasive surgical treatment for hand bursitis with significant bone erosion and persistent symptoms. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa and repair the eroded bone. The procedure was completed under local anesthesia. The incision was closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

1. Urgent surgical intervention performed for severe infection of the extreme moving joint in the hand. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, a midline incision was made to expose the infected joint. Extensive debridement of necrotic tissue and thorough irrigation with antiseptic solution were conducted. The joint was stabilized, and a drain was placed for continuous drainage. Prescribed broad-spectrum antibiotics and instructed on hand immobilization. Scheduled for frequent wound reassessment and further interventions as needed.

2. The patient underwent emergency surgical drainage and debridement for a severe infection on the extreme moving joint in the hand. After administering regional anesthesia with a median nerve block, a curvilinear incision was made to access the infected joint. Pus was drained, and extensive debridement of necrotic tissue was performed. Thorough irrigation with antiseptic solution was conducted. A drain was inserted, and the wound was closed using interrupted sutures. Prescribed intravenous antibiotics and scheduled for daily wound dressing changes.

3. Surgical intervention performed for acute severe infection of the extreme moving joint in the hand. After administering local anesthesia with 10 ml of 1% lidocaine, a longitudinal incision was made to expose the infected joint. Purulent material was drained, and thorough debridement of necrotic tissue was conducted. The joint was irrigated with antiseptic solution and stabilized. A drain was placed for continuous drainage. Prescribed broad-spectrum antibiotics and advised on hand immobilization. Follow-up appointment scheduled in two days for wound reassessment and potential further interventions.

4. The patient underwent emergent surgical debridement and bursectomy for severe infection on the extreme moving joint in the hand. After administering regional anesthesia with an axillary nerve block, a curved incision was made to expose the infected joint. Complete excision of the infected bursa and meticulous debridement were performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a drain was inserted for continuous drainage. Prescribed intravenous antibiotics and scheduled for frequent wound assessment and interventions as needed.

5. Surgical intervention performed for advanced severe infection on the extreme moving joint in the hand. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, a midline incision was made to access the infected joint. Extensive debridement of necrotic tissue and purulent material was conducted. The joint was thoroughly irrigated with antiseptic solution and stabilized. A vacuum-assisted closure device was applied for continuous wound management. Prescribed broad-spectrum antibiotics and scheduled for regular wound evaluation and potential further interventions.

6. The patient underwent emergency surgical drainage and debridement for a severe infection of the extreme moving joint in the hand. After administering regional anesthesia with a median nerve block, a curvilinear incision was made to expose the infected joint. Pus was drained, and extensive debridement of necrotic tissue was performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a negative pressure wound therapy system was applied. Prescribed intravenous antibiotics and scheduled for frequent wound dressing changes and reassessment.

7. Surgical intervention performed for acute severe infection of the extreme moving joint in the hand. After administering local anesthesia with 10 ml of 1% lidocaine, a longitudinal incision was made to access the infected joint. Purulent material was drained, and meticulous debridement of necrotic tissue was conducted. The joint was irrigated with antiseptic solution and stabilized. A vacuum-assisted closure device was applied for effective wound management. Prescribed broad-spectrum antibiotics and scheduled for regular wound evaluation and potential further interventions.

8. The patient underwent emergent surgical debridement and bursectomy for severe infection on the extreme moving joint in the hand. After administering regional anesthesia with an axillary nerve block, a curved incision was made to expose the infected joint. Complete excision of the infected bursa and extensive debridement were performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a negative pressure wound therapy system was initiated. Prescribed intravenous antibiotics and scheduled for frequent wound assessment and interventions as needed.

9. Surgical intervention performed for advanced severe infection on the extreme moving joint in the hand. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, a midline incision was made to access the infected joint. Extensive debridement of necrotic tissue and purulent material was conducted. The joint was thoroughly irrigated with antiseptic solution and stabilized. A vacuum-assisted closure device was applied for continuous wound management. Prescribed broad-spectrum antibiotics and scheduled for regular wound evaluation and potential further interventions.

10. The patient underwent emergency surgical drainage and debridement for a severe infection of the extreme moving joint in the hand. After administering regional anesthesia with a median nerve block, a curvilinear incision was made to expose the infected joint. Pus was drained, and extensive debridement of necrotic tissue was performed. Thorough irrigation with antiseptic solution was conducted. The joint was stabilized, and a negative pressure wound therapy system was applied. Prescribed intravenous antibiotics and scheduled for frequent wound dressing changes and reassessment.

1. Surgical intervention performed for chronic hand bursitis with severe inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. Extensive debridement of necrotic tissue was conducted, followed by thorough irrigation and hemostasis. The inflamed bursa was excised, and a biological tissue graft was applied for enhanced healing. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in four weeks for wound evaluation and potential further interventions.

2. The patient underwent surgical debridement and bursectomy for acute hand bursitis with moderate inflammation. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Meticulous debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with interrupted sutures. Prescribed postoperative analgesics and instructed on hand immobilization. Scheduled for a follow-up visit in four weeks to monitor recovery and determine the need for additional interventions.

3. Surgical intervention performed for recurrent hand bursitis with mild inflammation. After administering local anesthesia with 5 ml of 2% lidocaine, a small incision was made, and the inflamed bursa was drained using a syringe. Debridement of necrotic tissue and thorough irrigation with antiseptic solution were conducted. The wound was left open for secondary healing. Prescribed broad-spectrum antibiotics and advised daily dressing changes. Follow-up appointment scheduled in two days for wound reassessment.

4. The patient underwent surgical excision of the inflamed bursa and debridement for severe hand bursitis with marked inflammation. After administering general anesthesia with 200 mg of propofol and 50 mcg of fentanyl, an incision was made to expose the inflamed bursa. Thorough debridement of necrotic tissue and meticulous irrigation were performed. The wound was closed using layered sutures. Prescribed analgesics for pain management and antibiotics. Follow-up appointment scheduled in three weeks for evaluation and potential additional interventions.

5. Surgical intervention performed for acute hand bursitis with moderate inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the inflamed bursa. Thorough debridement of necrotic tissue and irrigation with antiseptic solution were conducted. The inflamed bursa was excised, and the wound was closed using absorbable sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in one week for wound assessment and suture removal if indicated.

6. The patient underwent minimally invasive surgical treatment for hand bursitis with mild inflammation. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. The procedure was completed under local anesthesia. The incision was closed with adhesive strips, and a sterile dressing was applied. Postoperative instructions included hand elevation, ice application, and prescribed analgesics for pain management. Follow-up appointment scheduled in three weeks for assessment and potential additional interventions.

7. Surgical intervention performed for chronic hand bursitis with moderate inflammation. After administering regional anesthesia with an axillary nerve block, a curvilinear incision was made to expose the inflamed bursa. Complete excision of the bursa and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wounds were closed using absorbable sutures, and sterile dressings were applied. Patient instructed on hand immobilization and prescribed NSAIDs. Follow-up appointments scheduled in one and three weeks for assessment and possible further interventions.

8. The patient underwent arthroscopic bursectomy and debridement for chronic hand bursitis with mild inflammation. After administering general anesthesia with 150 mg of propofol and 100 mcg of fentanyl, small incisions were made to introduce the arthroscope and surgical instruments. The inflamed bursa was carefully excised, and thorough debridement was performed. Thorough irrigation was conducted. The incisions were closed with sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in four weeks to monitor progress and discuss rehabilitation.

9. Surgical intervention performed for acute hand bursitis with marked inflammation and swelling. After administering local anesthesia with 10 ml of 1% lidocaine, a longitudinal incision was made to expose the inflamed bursa. Pus and fluid were drained, and extensive debridement of necrotic tissue was conducted. The inflamed bursa was excised, and thorough irrigation with antiseptic solution was performed. The wound was closed using interrupted sutures. Prescribed analgesics and antibiotics. Instructed on hand elevation and immobilization. Follow-up appointment scheduled in two weeks for wound reassessment and potential further interventions.

10. The patient underwent surgical debridement and bursectomy for chronic hand bursitis with mild inflammation. After administering regional anesthesia with a median nerve block, a curved incision was made to expose the affected bursa. Complete excision of the bursa and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wound was closed using absorbable sutures, and sterile dressings were applied. Prescribed postoperative analgesics and instructed on hand immobilization. Follow-up appointment scheduled in four weeks for evaluation and potential additional interventions.

1. The patient underwent surgical intervention for severe hand bursitis with extensive inflammation. After administering regional anesthesia with an axillary nerve block, a curvilinear incision was made to access the affected bursa. Thorough debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for frequent wound assessment and hand therapy sessions based on the severity of symptoms and healing progress.

2. Surgical intervention performed for moderate hand bursitis with persistent inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to explore the inflamed bursa. Debridement of necrotic tissue and irrigation were conducted. Partial excision of the inflamed bursa was performed. The wound was closed with sutures. Prescribed postoperative analgesics and instructed on hand elevation. Follow-up appointment scheduled in two weeks to assess the response to treatment and determine the need for further interventions.

3. The patient underwent minimally invasive surgical treatment for mild hand bursitis with minimal inflammation. After administering local anesthesia with 5 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. Thorough irrigation was conducted. The incision was closed with adhesive strips, and a sterile dressing was applied. Prescribed NSAIDs for pain management. Instructed on hand elevation and movement exercises. Follow-up appointment scheduled in four weeks for reassessment and potential additional interventions.

4. Surgical intervention performed for recurrent hand bursitis with moderate inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, an incision was made to expose the inflamed bursa. Thorough debridement of necrotic tissue and irrigation were conducted. The inflamed bursa was excised, and the wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for a follow-up visit in three weeks to monitor the healing progress and evaluate the need for further interventions.

5. The patient underwent surgical debridement and bursectomy for chronic hand bursitis with mild inflammation. After administering regional anesthesia with a median nerve block, a longitudinal incision was made to expose the affected bursa. Complete excision of the bursa and meticulous debridement were performed. Thorough irrigation and exploration were conducted. The wounds were closed using absorbable sutures, and sterile dressings were applied. Patient advised to follow postoperative hand therapy protocol. Follow-up appointment scheduled in two weeks to assess the response to treatment and determine the need for further interventions.

6. Surgical intervention performed for acute hand bursitis with severe inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, a dorsal incision was made to expose the inflamed bursa. Extensive debridement of necrotic tissue was conducted, followed by thorough irrigation and hemostasis. The inflamed bursa was excised, and a biological tissue graft was applied for enhanced healing. The wound was closed using absorbable sutures. Prescribed postoperative analgesics and antibiotics. Patient instructed on hand elevation and immobilization. Follow-up appointment scheduled in three weeks for wound evaluation and potential further interventions based on the severity of symptoms.

7. The patient underwent surgical debridement and bursectomy for chronic hand bursitis with moderate inflammation. After administering regional anesthesia with an axillary nerve block,

a curvilinear incision was made to access the affected bursa. Thorough debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for regular wound assessment and hand therapy sessions based on the severity of symptoms and healing progress.

8. Surgical intervention performed for mild hand bursitis with minimal inflammation. After administering local anesthesia with 5 ml of 1% lidocaine, an incision was made to explore the inflamed bursa. Debridement of necrotic tissue and thorough irrigation were conducted. The inflamed bursa was partially excised, and the wound was closed with sutures. Prescribed NSAIDs for pain management. Instructed on hand elevation and movement exercises. Follow-up appointment scheduled in six weeks to assess the response to treatment and evaluate the need for further interventions based on the severity of symptoms.

9. The patient underwent minimally invasive surgical treatment for moderate hand bursitis with persistent inflammation. After administering local anesthesia with 10 ml of 1% lidocaine, a small incision was made, and a specialized instrument was used to decompress the inflamed bursa. Thorough irrigation was conducted. The incision was closed with adhesive strips, and a sterile dressing was applied. Prescribed NSAIDs and instructed on hand elevation and movement exercises. Follow-up appointment scheduled in four weeks for reassessment and potential additional interventions based on the severity of symptoms and healing progress.

10. Surgical intervention performed for severe hand bursitis with extensive inflammation. After administering regional anesthesia with an axillary nerve block, a curvilinear incision was made to access the affected bursa. Thorough debridement of necrotic tissue and irrigation were performed. The inflamed bursa was excised, and the wound was closed with sutures. Prescribed postoperative analgesics and antibiotics. Scheduled for frequent wound assessment and hand therapy sessions based on the severity of symptoms and healing progress. A follow-up appointment was scheduled in two weeks to assess the response to treatment and determine the need for further interventions.

## M70.2 Olecranon bursitis

1. Patient presented with swelling and tenderness over the olecranon bursa. Aspiration performed, yielding serosanguinous fluid. Bursa irrigated with saline solution and 10 mL of corticosteroid injected. Adequate pressure dressing applied.

2. Surgical excision of olecranon bursa performed due to chronic bursitis. Skin incision made over the affected area. Bursa dissected and removed completely. Wound closed with sutures and sterile dressing applied.

3. Patient underwent ultrasound-guided needle aspiration of olecranon bursa for acute bursitis. Approximately 30 mL of turbid fluid aspirated. Bursa irrigated with sterile saline and corticosteroid injected. Compression dressing applied.

4. Open bursectomy performed for chronic olecranon bursitis. Elliptical incision made over the bursa, and bursal sac excised. Wound irrigated and closed with sutures. Sterile dressing applied for healing.

5. Ultrasound-guided injection of corticosteroid administered for olecranon bursitis. Needle inserted into the bursa under real-time imaging guidance. 5 mL of corticosteroid solution injected into the bursa. Patient advised rest and application of cold packs.

6. Patient presented with recurrent olecranon bursitis. Incision and drainage performed. Bursa opened, purulent fluid drained, and cavity irrigated with saline solution. Wound packed with sterile dressing for continued drainage.

7. Minimally invasive bursectomy performed using endoscopic techniques for olecranon bursitis. Small incisions made, and endoscope inserted to visualize the bursa. Bursa dissected and removed. Incisions closed with sutures, and sterile dressing applied.

8. Patient with septic olecranon bursitis underwent surgical debridement. Bursa opened, necrotic tissue excised, and thorough irrigation performed. Antibiotic-impregnated packing inserted into the wound. Daily dressing changes and intravenous antibiotics initiated.

9. Needle aspiration and corticosteroid injection performed for acute olecranon bursitis. Aspiration yielded cloudy fluid, and bursa irrigated with saline. 2 mL of corticosteroid injected, and pressure dressing applied.

10. Arthroscopic bursectomy performed for refractory olecranon bursitis. Small incisions made, arthroscope inserted to visualize the bursa, and bursectomy carried out using specialized instruments. Incisions closed with sutures, and sterile dressing applied.

1. Patient presented with chronic olecranon bursitis. Ultrasound-guided aspiration performed, yielding thick, yellowish fluid. Bursa thoroughly irrigated, and corticosteroid injected. Compression bandage applied for support.

2. Surgical excision of infected olecranon bursa performed. Incision made, bursa carefully dissected, and purulent contents drained. Wound irrigated and closed with sutures. Antibiotics prescribed for postoperative management.

3. Patient with traumatic olecranon bursitis underwent needle aspiration. Serous fluid aspirated, and bursa irrigated with saline. Non-steroidal anti-inflammatory medication recommended for pain relief.

4. Bursectomy performed for recurrent olecranon bursitis. Skin incision made, bursa excised, and surrounding tissues debrided. Wound closed meticulously, and sterile dressing applied.

5. Ultrasound-guided corticosteroid injection administered for olecranon bursitis. Needle carefully inserted into the bursa, and 3 mL of corticosteroid solution injected. Patient advised to avoid excessive pressure on the elbow.

6. Patient presented with acute olecranon bursitis. Aspiration performed, yielding serosanguinous fluid. Bursa flushed with saline, and antibiotic injection administered. Elbow immobilized with a splint.

7. Minimally invasive endoscopic bursectomy performed for persistent olecranon bursitis. Small incisions made, endoscope inserted, and bursa removed using specialized instruments. Incisions closed and dressed.

8. Patient with septic olecranon bursitis underwent surgical drainage and debridement. Bursa opened, purulent contents drained, and necrotic tissue excised. Wound packed with sterile dressing for ongoing wound care.

9. Needle aspiration and corticosteroid injection performed for recurrent olecranon bursitis. Fluid aspirated, and bursa irrigated with saline. 5 mL of corticosteroid injected, followed by a compression bandage.

10. Arthroscopic bursectomy with lavage performed for refractory olecranon bursitis. Small portals created, arthroscope inserted, and bursa debrided and thoroughly irrigated. Portals closed with sutures, and sterile dressing applied.

1. Patient underwent local anesthesia-assisted needle aspiration for olecranon bursitis. Bursa aspirated under sterile conditions, and serous fluid obtained. Bursa irrigated, and local anesthetic administered for pain management during the procedure.

2. Surgical excision of olecranon bursa performed under general anesthesia due to chronic bursitis. Incision made, bursa dissected, and completely removed. Wound closed with sutures. Patient monitored closely during anesthesia and postoperatively.

3. Ultrasound-guided needle aspiration of olecranon bursa performed under conscious sedation. Approximately 20 mL of turbid fluid aspirated. Bursa irrigated with saline, and mild sedation administered for patient comfort.

4. Open bursectomy performed under regional anesthesia for chronic olecranon bursitis. Incision made, bursa excised, and surrounding tissues debrided. Regional anesthesia provided effective pain control during the procedure.

5. Ultrasound-guided injection of corticosteroid administered under local anesthesia for olecranon bursitis. Needle inserted into the bursa with minimal discomfort, and corticosteroid solution injected. Local anesthesia ensured patient comfort.

6. Patient presented with recurrent olecranon bursitis. Incision and drainage performed under general anesthesia. Bursa opened, purulent fluid drained, and cavity irrigated with saline solution. Wound packed under appropriate anesthesia for continued drainage.

7. Minimally invasive bursectomy performed using endoscopic techniques under regional anesthesia for olecranon bursitis. Small incisions made, and endoscope inserted to visualize the bursa. Bursa dissected and removed, with regional anesthesia providing pain control.

8. Patient with septic olecranon bursitis underwent surgical debridement under general anesthesia. Bursa opened, necrotic tissue excised, and thorough irrigation performed. General anesthesia ensured patient comfort and immobility during the procedure.

9. Needle aspiration and corticosteroid injection performed under local anesthesia for acute olecranon bursitis. Aspiration yielded cloudy fluid, and bursa irrigated with saline. Corticosteroid injected under local anesthesia, minimizing discomfort.

10. Arthroscopic bursectomy performed under regional anesthesia for refractory olecranon bursitis. Small incisions made, arthroscope inserted to visualize the bursa, and bursectomy carried out using specialized instruments. Regional anesthesia provided effective pain control throughout the procedure.

1. Patient presented with extensive bone erosion associated with chronic olecranon bursitis. Surgical intervention performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed with autograft. Wound closed meticulously, and postoperative imaging ordered for follow-up assessment.

2. Ultrasound-guided aspiration of olecranon bursa performed under local anesthesia. Significant bone erosion observed on imaging. Bursa aspirated, lavaged, and corticosteroid injected. Patient advised to undergo further evaluation for bone integrity.

3. Surgical excision and debridement of infected olecranon bursa and bone erosion performed under general anesthesia. Bursa removed, necrotic bone excised, and irrigation with antibiotic solution performed. Wound closed with sutures, and intravenous antibiotics initiated.

4. Patient with traumatic olecranon bursitis and associated bone erosion underwent arthroscopic evaluation and debridement under regional anesthesia. Bursa inspected, necrotic bone fragments removed, and thorough irrigation performed. Regional anesthesia provided optimal pain control during the procedure.

5. Ultrasound-guided corticosteroid injection performed under local anesthesia for olecranon bursitis and evident bone erosion. Corticosteroid injected into the bursa, and patient referred for further imaging and orthopedic consultation for bone evaluation.

6. Patient presented with chronic olecranon bursitis and significant bone erosion. Open bursectomy and bone grafting performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed using allograft. Wound closed meticulously, and postoperative immobilization prescribed.

7. Needle aspiration and corticosteroid injection performed under local anesthesia for olecranon bursitis with associated bone erosion. Aspiration yielded fluid mixed with bone fragments, and corticosteroid injected. Patient referred for orthopedic evaluation to assess bone erosion.

8. Minimally invasive endoscopic bursectomy and bone debridement performed under regional anesthesia for olecranon bursitis and evident bone erosion. Endoscope inserted, bursa removed, and necrotic bone fragments excised. Regional anesthesia ensured patient comfort during the procedure.

9. Patient with septic olecranon bursitis and extensive bone erosion underwent surgical debridement and bone grafting under general anesthesia. Bursa opened, necrotic tissue and bone removed, and irrigation performed. Bone defect reconstructed with autograft. Postoperative antibiotics initiated.

10. Arthroscopic evaluation and bone debridement performed under regional anesthesia for refractory olecranon bursitis with bone erosion. Arthroscope inserted, bursa and bone assessed, and debridement performed. Regional anesthesia provided optimal pain control throughout the procedure.

1. Patient presented with severe bone pain associated with chronic olecranon bursitis and bone erosion. Surgical intervention performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed with autograft. Postoperative pain management plan initiated for adequate pain control.

2. Ultrasound-guided aspiration of olecranon bursa performed under local anesthesia for severe bone pain. Aspiration yielded turbid fluid, and corticosteroid injected. Patient prescribed analgesics for bone pain relief and advised for further evaluation.

3. Surgical excision and debridement of infected olecranon bursa and bone erosion performed under general anesthesia. Bursa removed, necrotic bone excised, and thorough irrigation performed. Postoperative pain control optimized with a multimodal analgesic regimen.

4. Patient with traumatic olecranon bursitis and severe bone pain underwent arthroscopic evaluation and debridement under regional anesthesia. Bursa inspected, necrotic bone fragments removed, and thorough irrigation performed. Regional anesthesia provided effective pain control during the procedure.

5. Ultrasound-guided corticosteroid injection performed under local anesthesia for severe bone pain associated with olecranon bursitis and bone erosion. Corticosteroid injected into the bursa, and patient referred for further orthopedic evaluation and management of bone pain.

6. Patient presented with chronic olecranon bursitis and severe bone pain. Open bursectomy and bone grafting performed under general anesthesia. Bursa excised, necrotic bone debrided, and bone defect reconstructed using allograft. Enhanced pain management initiated postoperatively.

7. Needle aspiration and corticosteroid injection performed under local anesthesia for olecranon bursitis with severe bone pain. Aspiration yielded fluid mixed with bone fragments, and corticosteroid injected. Patient referred for orthopedic evaluation and comprehensive pain management.

8. Minimally invasive endoscopic bursectomy and bone debridement performed under regional anesthesia for olecranon bursitis and severe bone pain. Endoscope inserted, bursa removed, and necrotic bone fragments excised. Regional anesthesia ensured optimal pain control during the procedure.

9. Patient with septic olecranon bursitis and severe bone pain underwent surgical debridement and bone grafting under general anesthesia. Bursa opened, necrotic tissue and bone removed, and irrigation performed. Bone defect reconstructed with autograft. Aggressive postoperative pain management implemented.

10. Arthroscopic evaluation and bone debridement performed under regional anesthesia for refractory olecranon bursitis with severe bone pain. Arthroscope inserted, bursa and bone assessed, and debridement performed. Regional anesthesia provided effective pain control throughout the procedure, and tailored pain management plan implemented postoperatively.

1. Patient with severe bone pain and chronic olecranon bursitis underwent surgical intervention with open bursectomy and bone debridement. General anesthesia administered, bursa excised, necrotic bone removed, and thorough irrigation performed. Postoperative pain management initiated for optimal pain control.

2. Surgical intervention in the form of arthroscopic bursectomy and bone debridement performed for severe bone pain and refractory olecranon bursitis. Regional anesthesia administered, bursa inspected and removed, and necrotic bone fragments excised. Postoperative pain control optimized with a multimodal approach.

3. Patient presented with septic olecranon bursitis and severe bone pain necessitating surgical intervention. Under general anesthesia, bursa opened, infected material drained, and bone debridement performed. Postoperative pain management initiated for effective pain relief.

4. Surgical intervention in the form of open bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with chronic olecranon bursitis. General anesthesia administered, bursa excised, necrotic bone removed, and bone defect reconstructed with graft material. Postoperative pain control optimized.

5. Patient with traumatic olecranon bursitis and severe bone pain underwent surgical intervention with arthroscopic bursectomy and bone debridement. Regional anesthesia provided, bursa inspected, necrotic bone fragments removed, and thorough irrigation performed. Postoperative pain management implemented for adequate pain relief.

6. Surgical intervention in the form of open bursectomy and bone grafting performed for severe bone pain and extensive bone erosion associated with olecranon bursitis. General anesthesia administered, bursa excised, necrotic bone debrided, and bone defect reconstructed with graft material. Enhanced postoperative pain control initiated.

7. Patient presented with chronic olecranon bursitis, severe bone pain, and failed conservative management, necessitating surgical intervention. Under general anesthesia, bursa excised, necrotic bone removed, and thorough irrigation performed. Postoperative pain management tailored for optimal pain relief.

8. Surgical intervention with endoscopic bursectomy and bone debridement performed for severe bone pain and refractory olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and necrotic bone fragments excised. Postoperative pain control optimized with a comprehensive approach.

9. Patient with septic olecranon bursitis and severe bone pain underwent urgent surgical intervention with open bursectomy and bone debridement. General anesthesia administered, bursa opened, infected material drained, and necrotic bone removed. Postoperative pain management initiated for effective pain control.

10. Surgical intervention in the form of arthroscopic bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with chronic olecranon bursitis. Regional anesthesia administered, bursa inspected, necrotic bone fragments removed, and bone defect reconstructed with graft material. Postoperative pain control optimized for improved comfort.

1. Patient with severe bone pain and chronic olecranon bursitis underwent surgical intervention with arthroscopic bursectomy, bone debridement, and platelet-rich plasma injection. Regional anesthesia administered, bursa excised, necrotic bone fragments removed, and platelet-rich plasma injected for tissue regeneration. Postoperative pain management initiated for optimal pain control.

2. Surgical intervention in the form of open bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with refractory olecranon bursitis. General anesthesia administered, bursa excised, necrotic bone removed, and bone defect reconstructed with autograft. Comprehensive postoperative pain management implemented.

3. Patient presented with septic olecranon bursitis and severe bone pain requiring urgent surgical intervention. Under general anesthesia, bursa opened, infected material drained, bone debridement performed, and antibiotic-impregnated bone cement applied. Postoperative pain control optimized for effective pain relief.

4. Surgical intervention with endoscopic bursectomy, bone debridement, and bone substitute application performed for severe bone pain and chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, necrotic bone fragments excised, and bone substitute applied for tissue regeneration. Postoperative pain management tailored for optimal comfort.

5. Patient with traumatic olecranon bursitis and severe bone pain underwent surgical intervention with open bursectomy, bone debridement, and internal fixation. General anesthesia administered, bursa excised, necrotic bone removed, and bone fragments stabilized with screws. Postoperative pain control optimized with a multimodal analgesic regimen.

6. Surgical intervention in the form of arthroscopic bursectomy, bone debridement, and microfracture procedure performed for severe bone pain associated with chronic olecranon bursitis. Regional anesthesia administered, bursa inspected, necrotic bone fragments removed, and microfracture technique utilized for tissue healing. Comprehensive postoperative pain management implemented.

7. Patient presented with chronic olecranon bursitis, severe bone pain, and extensive bone erosion necessitating surgical intervention. Under general anesthesia, open bursectomy, bone debridement, and allograft bone reconstruction performed. Postoperative pain control optimized with a tailored pain management plan.

8. Surgical intervention with endoscopic bursectomy, bone debridement, and radiofrequency ablation performed for severe bone pain and refractory olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, necrotic bone fragments excised, and radiofrequency energy used for pain relief. Postoperative pain management initiated for effective pain control.

9. Patient with septic olecranon bursitis and severe bone pain underwent surgical intervention with open bursectomy, bone debridement, and vacuum-assisted closure. General anesthesia administered, bursa opened, infected material drained, necrotic bone removed, and wound managed with vacuum-assisted closure for enhanced healing. Postoperative pain control optimized.

10. Surgical intervention in the form of arthroscopic bursectomy, bone debridement, and bone grafting performed for severe bone pain associated with chronic olecranon bursitis. Regional anesthesia administered, bursa inspected, necrotic bone fragments removed, and bone defect reconstructed with allograft. Postoperative pain control optimized for improved comfort.

1. Patient with severe infection on the extreme moving joint of olecranon bursitis underwent emergent surgical intervention. Under general anesthesia, incision made, infected material drained, extensive debridement performed, and wound thoroughly irrigated. Intravenous antibiotics initiated, and postoperative wound care plan established.

2. Surgical intervention with open bursectomy and aggressive debridement performed for severe infection on the extreme moving joint associated with olecranon bursitis. General anesthesia administered, bursa excised, necrotic tissue removed, and wound irrigated with antiseptic solution. Postoperative antibiotic therapy initiated.

3. Patient presented with septic olecranon bursitis and severe infection on the extreme moving joint, necessitating immediate surgical intervention. Under general anesthesia, bursa opened, purulent material drained, and thorough debridement performed. Wound closed with drains in place, and intravenous antibiotics initiated.

4. Surgical intervention in the form of arthroscopic bursectomy and extensive debridement performed for severe infection on the extreme moving joint associated with refractory olecranon bursitis. Regional anesthesia provided, bursa inspected, infected tissue removed, and joint lavaged with antibiotic solution. Postoperative antibiotic therapy implemented.

5. Patient with traumatic olecranon bursitis and severe infection on the extreme moving joint underwent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa excised, necrotic tissue removed, and joint irrigated with antimicrobial solution. Postoperative antibiotic treatment initiated.

6. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe infection on the extreme moving joint associated with chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and infected tissue meticulously debrided. Postoperative antibiotic regimen initiated.

7. Patient presented with septic olecranon bursitis and severe infection on the extreme moving joint, necessitating urgent surgical intervention. Under general anesthesia, open bursectomy, extensive debridement, and joint irrigation performed. Postoperative intravenous antibiotics initiated, and wound closely monitored.

8. Surgical intervention in the form of arthroscopic bursectomy, debridement, and irrigation performed for severe infection on the extreme moving joint associated with refractory olecranon bursitis. Regional anesthesia administered, bursa inspected, infected tissue removed, and joint lavaged with antibiotic solution. Postoperative antibiotic therapy implemented.

9. Patient with chronic olecranon bursitis and severe infection on the extreme moving joint underwent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa excised, necrotic tissue removed, and joint irrigated with antimicrobial solution. Postoperative antibiotic treatment initiated.

10. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe infection on the extreme moving joint associated with olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and infected tissue meticulously debrided. Postoperative antibiotic regimen initiated, and wound care instructions given.

1. Patient presented with severe inflammation and erythema of the extreme moving joint associated with olecranon bursitis. Surgical intervention performed under general anesthesia, including open bursectomy, extensive debridement, and joint irrigation. Postoperative anti-inflammatory medications initiated for inflammation control.

2. Surgical intervention in the form of arthroscopic bursectomy and debridement performed for severe inflammation and edema of the extreme moving joint associated with refractory olecranon bursitis. Regional anesthesia provided, bursa inspected, inflamed tissue removed, and joint lavaged. Postoperative anti-inflammatory therapy implemented.

3. Patient with septic olecranon bursitis and severe joint inflammation underwent urgent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa opened, infected material drained, and inflamed tissue meticulously removed. Postoperative anti-inflammatory treatment initiated.

4. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe joint inflammation and swelling associated with chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and inflamed tissue meticulously debrided. Postoperative anti-inflammatory regimen initiated.

5. Patient presented with chronic olecranon bursitis, severe joint inflammation, and edema necessitating surgical intervention. Under general anesthesia, open bursectomy, debridement, and joint irrigation performed. Postoperative anti-inflammatory medications prescribed for inflammation control.

6. Surgical intervention in the form of arthroscopic bursectomy, debridement, and joint irrigation performed for severe joint inflammation and erythema associated with refractory olecranon bursitis. Regional anesthesia administered, bursa inspected, inflamed tissue removed, and joint lavaged. Postoperative anti-inflammatory therapy implemented.

7. Patient with septic olecranon bursitis and severe joint inflammation underwent surgical intervention with open bursectomy, debridement, and joint washout. General anesthesia administered, bursa opened, infected material drained, and inflamed tissue meticulously removed. Postoperative anti-inflammatory treatment initiated.

8. Surgical intervention with endoscopic bursectomy and thorough debridement performed for severe joint inflammation and swelling associated with chronic olecranon bursitis. Regional anesthesia provided, endoscope inserted, bursa removed, and inflamed tissue meticulously debrided. Postoperative anti-inflammatory regimen initiated.

9. Patient presented with chronic olecranon bursitis, severe joint inflammation, and edema necessitating surgical intervention. Under general anesthesia, open bursectomy, debridement, and joint irrigation performed. Postoperative anti-inflammatory medications prescribed for inflammation control.

10. Surgical intervention in the form of arthroscopic bursectomy, debridement, and joint irrigation performed for severe joint inflammation and erythema associated with refractory olecranon bursitis. Regional anesthesia administered, bursa inspected, inflamed tissue removed, and joint lavaged. Postoperative anti-inflammatory therapy implemented.

1. Patient diagnosed with mild olecranon bursitis advised conservative management with rest, ice, compression, and elevation (RICE) technique. Scheduled for a follow-up appointment in two weeks to assess improvement and consider further interventions if necessary.

2. Patient diagnosed with moderate olecranon bursitis prescribed a course of nonsteroidal anti-inflammatory drugs (NSAIDs) and physical therapy. Follow-up scheduled in four weeks to evaluate response to treatment and discuss additional options if needed.

3. Patient diagnosed with severe olecranon bursitis and persistent symptoms referred for a corticosteroid injection. Scheduled for a follow-up visit in one week to assess the response to the injection and discuss further management options if necessary.

4. Patient diagnosed with chronic olecranon bursitis and significant functional limitations referred to an orthopedic specialist for evaluation. A follow-up appointment scheduled in two weeks to review the specialist's recommendations and determine the course of treatment.

5. Patient diagnosed with acute infectious olecranon bursitis prescribed a course of oral antibiotics and instructed to monitor for signs of improvement or worsening. Advised to follow up in one week for reassessment and adjustment of the treatment plan if needed.

6. Patient diagnosed with recurrent olecranon bursitis referred for an ultrasound-guided aspiration and corticosteroid injection. Follow-up scheduled in two weeks to evaluate the response to the intervention and consider further management options if necessary.

7. Patient diagnosed with severe olecranon bursitis and associated bone erosion referred for a surgical consultation. Scheduled for a follow-up appointment in one week to discuss the surgical options, risks, and benefits, and to plan the intervention.

8. Patient diagnosed with moderate olecranon bursitis advised a trial of a customized splint and physical therapy. Follow-up scheduled in four weeks to assess the response to conservative management and determine the need for additional interventions.

9. Patient diagnosed with chronic olecranon bursitis and persistent pain referred for a diagnostic ultrasound and aspiration. Follow-up appointment scheduled in two weeks to review the results, evaluate the response to the procedure, and discuss further treatment options.

10. Patient diagnosed with severe infectious olecranon bursitis admitted for intravenous antibiotics and close monitoring. A follow-up appointment scheduled upon discharge to assess the response to treatment and ensure adequate healing of the infection.