## M71.1 Other infective bursitis

1. Patient presented with symptoms consistent with other infective bursitis. Surgical exploration revealed a purulent collection within the bursa. The bursa was thoroughly irrigated, and debridement of necrotic tissue was performed. Cultures were obtained, and the patient was started on broad-spectrum antibiotics. Postoperative care included immobilization and elevation of the affected limb. The patient was instructed to monitor for signs of infection and to follow up for wound evaluation.

2. Operative intervention was undertaken for other infective bursitis in the patient. Intraoperatively, an abscess was identified within the bursa. Incision and drainage were performed, and copious irrigation with saline was carried out. Necrotic tissue was debrided, and specimens were collected for culture analysis. The patient was initiated on appropriate antibiotic therapy postoperatively, and the affected area was immobilized. Instructions were provided for wound care and scheduled follow-up.

3. The patient underwent surgery for other infective bursitis. Intraoperatively, a purulent collection was discovered in the affected bursa. The bursa was meticulously irrigated with sterile saline, and debridement of devitalized tissue was accomplished. Cultures were obtained, and empirical antibiotic treatment was initiated. The patient was advised on proper wound care, elevation, and immobilization. Follow-up appointments were scheduled to monitor progress and assess the need for further intervention.

4. Surgical intervention was performed to address other infective bursitis in the patient. Intraoperatively, an abscess was identified within the bursa and was subsequently drained. Thorough irrigation with sterile solution was conducted, and any necrotic tissue was debrided. The patient was started on appropriate antibiotics postoperatively and given instructions on wound care and symptom monitoring. Follow-up appointments were scheduled to ensure proper healing and address any complications if necessary.

5. The patient underwent surgical management for other infective bursitis. Intraoperatively, purulent material was found within the bursa and was evacuated through incision and drainage. Adequate irrigation with sterile fluid was performed, and meticulous debridement of necrotic tissue was carried out. Specimens were collected for culture analysis, and the patient received antibiotic therapy. Postoperatively, the patient was educated about wound care and instructed to follow up for evaluation of the affected area.

6. Operative intervention was performed for other infective bursitis. Intraoperatively, an abscess was discovered within the bursa and promptly drained. The bursal cavity was thoroughly irrigated, and any necrotic tissue was debrided. Cultures were obtained, and the patient was initiated on broad-spectrum antibiotics. Postoperatively, the patient received instructions on wound care and immobilization techniques. Follow-up appointments were scheduled to monitor the patient's progress and assess the need for further intervention.

7. The patient underwent surgical exploration for other infective bursitis. Intraoperatively, a purulent collection was found within the bursa and was subsequently drained. Adequate irrigation with sterile solution was performed, and necrotic tissue was debrided. Specimens were sent for culture analysis, and the patient was started on appropriate antibiotic therapy. Postoperative instructions were given regarding wound care, elevation, and immobilization. Follow-up appointments were arranged to assess healing and address any concerns.

8. Surgical intervention was carried out to address other infective bursitis in the patient. Intraoperatively, an abscess was identified within the bursa and drained accordingly. The bursa was thoroughly irrigated, and necrotic tissue was debrided. Cultures were obtained, and the patient was started on empirical antibiotic treatment. The

patient received postoperative instructions on wound care, elevation, and immobilization. Follow-up visits were scheduled to monitor the patient's condition and provide necessary care.

9. The patient underwent surgical treatment for other infective bursitis. Intraoperatively, a purulent collection was found within the bursa and promptly drained. Thorough irrigation with sterile solution was performed, and any necrotic tissue was debrided. Specimens were collected for culture analysis, and the patient was initiated on appropriate antibiotic therapy. The patient received instructions on wound care and follow-up appointments were scheduled for monitoring and assessment.

10. Operative intervention was performed for other infective bursitis in the patient. Intraoperatively, an abscess was discovered within the bursa and was drained. The bursa was meticulously irrigated with sterile solution, and necrotic tissue was debrided. Cultures were obtained, and the patient was started on broad-spectrum antibiotics. Postoperatively, the patient was educated on wound care measures and advised to attend follow-up visits for assessment and further management as needed.

1. The patient underwent surgical intervention for other infective bursitis. Intraoperatively, a purulent collection was identified within the bursa and was drained. Thorough irrigation with sterile saline was performed, and debridement of necrotic tissue was carried out. Specimens were collected for culture analysis, and appropriate antibiotic therapy was initiated postoperatively. The patient was provided with instructions regarding wound care and advised to follow up for evaluation and monitoring.

2. Operative management was undertaken for other infective bursitis in the patient. Intraoperatively, an abscess was encountered within the bursa and was promptly drained. Adequate irrigation with sterile fluid was performed, and necrotic tissue was debrided. Cultures were obtained, and targeted antibiotic treatment was initiated. Postoperatively, the patient was educated on wound care techniques and scheduled for follow-up visits to assess healing progress and address any concerns.

3. Surgical exploration was performed for other infective bursitis in the patient. Intraoperatively, purulent material was discovered within the bursa and was drained accordingly. Thorough irrigation with sterile solution was carried out, and debridement of necrotic tissue was performed. Specimens were sent for culture analysis, and the patient received appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and follow-up appointments were scheduled to monitor the patient's condition.

4. The patient underwent surgical treatment for other infective bursitis. Intraoperatively, an abscess was found within the bursa and was drained. Thorough irrigation with sterile solution was performed, and necrotic tissue was debrided meticulously. Cultures were obtained, and the patient was started on targeted antibiotic therapy. Postoperatively, the patient received instructions on wound care and was advised to attend regular follow-up visits for assessment and further management.

5. Operative intervention was performed to address other infective bursitis in the patient. Intraoperatively, a purulent collection was identified within the bursa and was drained appropriately. The bursa was thoroughly irrigated, and necrotic tissue was debrided meticulously. Cultures were obtained, and the patient was initiated on appropriate antibiotic treatment. Postoperatively, wound care instructions were given, and follow-up appointments were scheduled for monitoring and evaluation.

6. The patient underwent surgical exploration for other infective bursitis. Intraoperatively, an abscess was identified within the bursa and was promptly drained. Adequate irrigation with sterile fluid was carried out, and meticulous debridement of necrotic tissue was performed. Specimens were collected for culture analysis, and the patient was started on targeted antibiotic therapy. The patient received postoperative instructions on wound care and was scheduled for follow-up visits to assess healing progress and address any concerns.

7. Surgical intervention was performed to treat other infective bursitis in the patient. Intraoperatively, a purulent collection was found within the bursa and was drained accordingly. Thorough irrigation with sterile solution was conducted, and necrotic tissue was debrided meticulously. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and the patient was advised to attend scheduled follow-up visits for evaluation and further management.

8. The patient underwent operative management for other infective bursitis. Intraoperatively, an abscess was encountered within the bursa and was drained promptly. Thorough irrigation with sterile saline was performed, and debridement of necrotic tissue was carried out meticulously. Specimens were collected for culture analysis, and

the patient was started on targeted antibiotic therapy. Postoperatively, instructions regarding wound care were given, and follow-up appointments were scheduled for monitoring and assessment.

9. Operative intervention was undertaken for other infective bursitis in the patient. Intraoperatively, a purulent collection was identified within the bursa and was drained appropriately. The bursa was thoroughly irrigated using sterile solution, and meticulous debridement of necrotic tissue was performed. Cultures were obtained for analysis, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits.

10. Surgical exploration was performed for other infective bursitis in the patient. Intraoperatively, an abscess was discovered within the bursa and promptly drained. Thorough irrigation with sterile fluid was carried out, and meticulous debridement of necrotic tissue was performed. Specimens were collected for culture analysis, and the patient received appropriate antibiotic therapy. Postoperatively, wound care instructions were given, and follow-up appointments were scheduled to monitor the patient's progress and address any concerns.

1. The patient underwent surgical intervention for other infective bursitis under local anesthesia. Intraoperatively, an abscess was identified within the bursa and drained. Adequate irrigation with sterile solution was performed, and meticulous debridement of necrotic tissue was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were given, and the patient was scheduled for follow-up visits to monitor healing progress.

2. Operative management was undertaken for other infective bursitis in the patient under regional anesthesia. Intraoperatively, a purulent collection was discovered within the bursa and drained accordingly. Thorough irrigation with sterile fluid was performed, and necrotic tissue was debrided. Specimens were collected for culture analysis, and targeted antibiotic treatment was initiated. The patient received postoperative instructions on wound care and was scheduled for regular follow-up appointments.

3. The patient underwent surgical treatment for other infective bursitis under general anesthesia. Intraoperatively, an abscess was found within the bursa and promptly drained. Thorough irrigation with sterile solution was carried out, and necrotic tissue was debrided meticulously. Cultures were obtained, and appropriate antibiotic therapy was initiated postoperatively. The patient was instructed on wound care measures and scheduled for follow-up visits to assess healing and address any concerns.

4. Surgical exploration was performed for other infective bursitis in the patient under local anesthesia. Intraoperatively, a purulent collection was identified within the bursa and drained appropriately. Thorough irrigation with sterile solution was conducted, and meticulous debridement of necrotic tissue was performed. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits for monitoring.

5. The patient underwent operative intervention for other infective bursitis under regional anesthesia. Intraoperatively, an abscess was encountered within the bursa and drained promptly. Adequate irrigation with sterile fluid was performed, and necrotic tissue was debrided meticulously. Cultures were obtained, and the patient was started on appropriate antibiotic therapy. Postoperatively, wound care instructions were given, and follow-up appointments were scheduled to monitor healing progress.

6. Operative intervention was performed to address other infective bursitis in the patient under general anesthesia. Intraoperatively, a purulent collection was identified within the bursa and drained accordingly. Thorough irrigation with sterile solution was carried out, and necrotic tissue was debrided meticulously. Specimens were collected for culture analysis, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and follow-up appointments were scheduled for monitoring and evaluation.

7. Surgical intervention was performed to treat other infective bursitis in the patient under local anesthesia. Intraoperatively, a purulent collection was found within the bursa and drained accordingly. Thorough irrigation with sterile solution was performed, and necrotic tissue was debrided meticulously. Cultures were obtained, and the patient was initiated on targeted antibiotic therapy. Postoperatively, wound care instructions were given, and the patient was scheduled for regular follow-up visits for assessment and further management.

8. The patient underwent surgical exploration for other infective bursitis under regional anesthesia. Intraoperatively, an abscess was identified within the bursa and was promptly drained. Adequate irrigation with sterile fluid was carried out, and meticulous debridement of necrotic tissue was performed. Specimens were collected for

culture analysis, and the patient was started on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and follow-up appointments were scheduled for monitoring and evaluation.

9. Operative intervention was undertaken for other infective bursitis in the patient under general anesthesia. Intraoperatively, a purulent collection was identified within the bursa and drained appropriately. The bursa was thoroughly irrigated using sterile solution, and meticulous debridement of necrotic tissue was performed. Cultures were obtained, and the patient was initiated on targeted antibiotic therapy. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits for assessment and further management.

10. Surgical intervention was performed to address other infective bursitis in the patient under local anesthesia. Intraoperatively, an abscess was encountered within the bursa and was drained promptly. Thorough irrigation with sterile saline was performed, and debridement of necrotic tissue was carried out meticulously. Specimens were collected for culture analysis, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, instructions regarding wound care were given, and follow-up appointments were scheduled for monitoring and assessment.

1. The patient underwent surgical intervention for other infective bursitis with associated bone erosion. Intraoperatively, a purulent collection was identified within the bursa, and extensive debridement was performed, including removal of necrotic tissue and bone fragments. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, the patient received instructions on wound care and immobilization. Regular follow-up visits were scheduled to monitor the bursal and bone healing.

2. Operative management was performed for other infective bursitis with bone erosion in the patient. Intraoperatively, an abscess was encountered within the bursa, and thorough debridement of necrotic tissue and involved bone was carried out. Copious irrigation with sterile fluid was performed. Specimens were collected for culture analysis, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits to assess bursal and bone healing.

3. The patient underwent surgical treatment for other infective bursitis with bone erosion. Intraoperatively, a purulent collection was found within the bursa, along with erosion of adjacent bone. Extensive debridement was performed to remove necrotic tissue and affected bone fragments. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, the patient received instructions on wound care, immobilization, and weight-bearing restrictions. Regular follow-up appointments were scheduled to monitor healing progress and bone restoration.

4. Surgical exploration was performed for other infective bursitis with associated bone erosion in the patient. Intraoperatively, an abscess was identified within the bursa, along with erosive changes in the underlying bone. Extensive debridement was performed to remove infected tissue and affected bone fragments. Adequate irrigation with sterile fluid was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. The patient received postoperative instructions on wound care, immobilization, and the importance of compliance with antibiotic therapy. Regular follow-up visits were scheduled for assessment of bursal and bone healing.

5. The patient underwent operative intervention for other infective bursitis with bone erosion. Intraoperatively, a purulent collection was discovered within the bursa, with evidence of adjacent bone erosion. Extensive debridement of necrotic tissue and affected bone was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, along with instructions for weight-bearing restrictions and follow-up visits to monitor bursal and bone healing.

6. Operative intervention was performed to address other infective bursitis with bone erosion in the patient. Intraoperatively, an abscess was identified within the bursa, with concurrent erosion of adjacent bone. Extensive debridement of infected tissue and involved bone was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, the patient received instructions on wound care, immobilization, and the importance of adherence to antibiotic therapy. Regular follow-up appointments were scheduled to assess bursal and bone healing.

7. Surgical intervention was performed to treat other infective bursitis with bone erosion in the patient. Intraoperatively, a purulent collection was found within the bursa, with evidence of underlying bone erosion. Extensive debridement was performed to remove infected tissue and affected bone fragments

. Thorough irrigation with sterile solution was performed. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were given, along with instructions for immobilization and weight-bearing restrictions. Regular follow-up visits were scheduled for monitoring of bursal and bone healing.

8. The patient underwent surgical exploration for other infective bursitis with bone erosion. Intraoperatively, an abscess was encountered within the bursa, with concurrent erosion of underlying bone. Extensive debridement of infected tissue and affected bone was performed meticulously. Thorough irrigation with sterile fluid was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, along with instructions for immobilization and compliance with antibiotic therapy. Regular follow-up appointments were scheduled for assessment of bursal and bone healing.

9. Operative intervention was undertaken for other infective bursitis with bone erosion in the patient. Intraoperatively, a purulent collection was identified within the bursa, with associated bone erosion. Extensive debridement of infected tissue and involved bone fragments was performed. Thorough irrigation with sterile solution was conducted. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, along with instructions for immobilization and weight-bearing restrictions. Regular follow-up visits were scheduled to monitor bursal and bone healing.

10. Surgical intervention was performed to address other infective bursitis with bone erosion in the patient. Intraoperatively, an abscess was encountered within the bursa, with concurrent erosion of adjacent bone. Extensive debridement was performed to remove infected tissue and affected bone fragments. Adequate irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, along with instructions for immobilization, elevation, and regular follow-up visits for assessment of bursal and bone healing.

1. The patient underwent surgical intervention for other infective bursitis with severe bone pain. Intraoperatively, a purulent collection was identified within the bursa, and extensive debridement was performed to alleviate the source of infection and relieve pressure on the affected bone. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, the patient received instructions on wound care, pain management, and rehabilitation. Regular follow-up visits were scheduled to assess healing progress and address any ongoing pain concerns.

2. Operative management was performed for other infective bursitis with severe bone pain in the patient. Intraoperatively, an abscess was encountered within the bursa, and meticulous debridement was performed to alleviate pressure on the underlying bone and relieve pain. Copious irrigation with sterile fluid was carried out. Specimens were collected for culture analysis, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, along with a tailored pain management plan. Regular follow-up appointments were scheduled to monitor healing progress and address pain management needs.

3. The patient underwent surgical treatment for other infective bursitis with severe bone pain. Intraoperatively, a purulent collection was found within the bursa, with concurrent severe bone pain. Extensive debridement was performed to alleviate pressure on the affected bone and relieve pain. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, the patient received instructions on wound care, pain management, and the importance of adhering to antibiotic therapy. Regular follow-up visits were scheduled to assess healing progress and address ongoing pain concerns.

4. Surgical exploration was performed for other infective bursitis with severe bone pain in the patient. Intraoperatively, an abscess was identified within the bursa, with associated severe bone pain. Extensive debridement was performed to alleviate pressure on the underlying bone and provide pain relief. Adequate irrigation with sterile fluid was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. The patient received postoperative instructions on wound care, pain management, and rehabilitation. Regular follow-up visits were scheduled for assessment of healing progress and ongoing pain management.

5. The patient underwent operative intervention for other infective bursitis with severe bone pain under regional anesthesia. Intraoperatively, a purulent collection was discovered within the bursa, with concurrent severe bone pain. Extensive debridement was performed to alleviate pressure on the affected bone and relieve pain. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, along with a tailored pain management plan. Regular follow-up visits were scheduled to monitor healing progress and address ongoing pain concerns.

6. Operative intervention was performed to address other infective bursitis with severe bone pain in the patient. Intraoperatively, an abscess was identified within the bursa, with associated severe bone pain. Extensive debridement was performed to alleviate pressure on the affected bone and provide pain relief. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, the patient received instructions on wound care, pain management, and rehabilitation. Regular follow-up appointments were scheduled to assess healing progress and address ongoing pain concerns.

7. Surgical intervention was performed to treat other infective bursitis with severe bone pain in the patient. Intraoperatively, a purulent collection was found within

the bursa, with concurrent severe bone pain. Extensive debridement was performed to alleviate pressure on the underlying bone and provide pain relief. Thorough irrigation with sterile solution was performed. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were given, along with a tailored pain management plan. Regular follow-up visits were scheduled for assessment of healing progress and ongoing pain management.

8. The patient underwent surgical exploration for other infective bursitis with severe bone pain. Intraoperatively, an abscess was encountered within the bursa, with associated severe bone pain. Extensive debridement was performed to alleviate pressure on the affected bone and provide pain relief. Thorough irrigation with sterile fluid was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, along with a tailored pain management plan. Regular follow-up appointments were scheduled to assess healing progress and address ongoing pain concerns.

9. Operative intervention was undertaken for other infective bursitis with severe bone pain in the patient. Intraoperatively, a purulent collection was identified within the bursa, with concurrent severe bone pain. Extensive debridement was performed to alleviate pressure on the affected bone and provide pain relief. Thorough irrigation with sterile solution was conducted. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, the patient received instructions on wound care, pain management, and rehabilitation. Regular follow-up visits were scheduled to monitor healing progress and address ongoing pain concerns.

10. Surgical intervention was performed to address other infective bursitis with severe bone pain in the patient. Intraoperatively, an abscess was encountered within the bursa, with associated severe bone pain. Extensive debridement was performed to alleviate pressure on the affected bone and provide pain relief. Adequate irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, along with a tailored pain management plan. Regular follow-up visits were scheduled to assess healing progress and address ongoing pain concerns.

1. The patient underwent surgical intervention for other infective bursitis. Intraoperatively, a purulent collection was identified within the bursa and was drained meticulously. Extensive debridement of necrotic tissue was performed, followed by thorough irrigation using sterile solution. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits to monitor healing and assess the need for further intervention.

2. Operative management was performed for other infective bursitis in the patient. Intraoperatively, an abscess was encountered within the bursa, and appropriate drainage was performed. Meticulous debridement of necrotic tissue was carried out, followed by thorough irrigation with sterile fluid. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were given, and the patient was scheduled for regular follow-up visits for further assessment and intervention, if necessary.

3. The patient underwent surgical treatment for other infective bursitis. Intraoperatively, a purulent collection was found within the bursa and was drained meticulously. Extensive debridement of necrotic tissue was performed, and thorough irrigation with sterile solution was carried out. Specimens were collected for culture analysis, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and the need for further surgical intervention was assessed during regular follow-up visits.

4. Surgical exploration was performed to address other infective bursitis in the patient. Intraoperatively, an abscess was identified within the bursa and drained appropriately. Meticulous debridement of necrotic tissue was carried out, followed by thorough irrigation with sterile fluid. Cultures were obtained, and targeted antibiotic therapy was initiated. The patient received postoperative wound care instructions and was scheduled for regular follow-up visits to evaluate the need for additional surgical intervention.

5. The patient underwent operative intervention for other infective bursitis. Intraoperatively, a purulent collection was discovered within the bursa and was drained meticulously. Extensive debridement of necrotic tissue was performed, and thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing and assess the necessity for further surgical intervention.

6. Operative intervention was performed to address other infective bursitis in the patient. Intraoperatively, an abscess was encountered within the bursa and drained promptly. Meticulous debridement of necrotic tissue was performed, followed by thorough irrigation with sterile solution. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and the need for additional surgical intervention was evaluated during regular follow-up visits.

7. Surgical intervention was performed to treat other infective bursitis in the patient. Intraoperatively, a purulent collection was found within the bursa and drained meticulously. Extensive debridement of necrotic tissue was carried out, and thorough irrigation with sterile fluid was performed. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up appointments were scheduled to monitor healing and evaluate the requirement for further surgical intervention.

8. The patient underwent surgical exploration for other infective bursitis. Intraoperatively, an abscess was identified within the bursa and drained appropriately. Meticulous

debridement of necrotic tissue was performed, followed by thorough irrigation with sterile solution. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient received postoperative wound care instructions, and regular follow-up visits were scheduled to assess healing and determine the need for additional surgical intervention.

9. Operative intervention was undertaken for other infective bursitis in the patient. Intraoperatively, a purulent collection was discovered within the bursa and was drained meticulously. Extensive debridement of necrotic tissue was performed, and thorough irrigation with sterile solution was conducted. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress and assess the need for further surgical intervention.

10. Surgical intervention was performed to address other infective bursitis in the patient. Intraoperatively, an abscess was encountered within the bursa and drained promptly. Meticulous debridement of necrotic tissue was performed, followed by thorough irrigation with sterile solution. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress and evaluate the requirement for additional surgical intervention.

1. The patient underwent surgical intervention for other infective bursitis. Intraoperatively, a purulent collection was identified within the bursa and was drained meticulously. Extensive debridement of necrotic tissue and infected bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits to monitor healing and assess response to antibiotic therapy.

2. Operative management was performed for other infective bursitis in the patient. Intraoperatively, an abscess was encountered within the bursa, and appropriate drainage was performed. Meticulous debridement of necrotic tissue and eroded bursal wall was carried out. Thorough irrigation with sterile fluid was performed. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing and evaluate the need for further interventions.

3. The patient underwent surgical treatment for other infective bursitis. Intraoperatively, a purulent collection was found within the bursa and was drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Specimens were collected for culture analysis, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits to monitor healing progress and assess the need for additional interventions.

4. Surgical exploration was performed to address other infective bursitis in the patient. Intraoperatively, an abscess was identified within the bursa and drained appropriately. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile fluid was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient received postoperative wound care instructions, and regular follow-up visits were scheduled to assess healing progress and evaluate the need for further interventions.

5. The patient underwent operative intervention for other infective bursitis. Intraoperatively, a purulent collection was discovered within the bursa and was drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing progress and assess the need for additional interventions.

6. Operative intervention was performed to address other infective bursitis in the patient. Intraoperatively, an abscess was encountered within the bursa and drained promptly. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up appointments were scheduled to assess healing progress and evaluate the need for further interventions.

7. Surgical intervention was performed to treat other infective bursitis in the patient. Intraoperatively, a purulent collection was found within the bursa and drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was carried out. Thorough irrigation with sterile fluid was performed. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were

scheduled to monitor healing progress and evaluate the need for further interventions.

8. The patient underwent surgical exploration for other infective bursitis. Intraoperatively, an abscess was identified within the bursa and drained appropriately. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient received postoperative wound care instructions, and regular follow-up visits were scheduled to assess healing progress and evaluate the need for additional interventions.

9. Operative intervention was undertaken for other infective bursitis in the patient. Intraoperatively, a purulent collection was discovered within the bursa and was drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was conducted. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress and assess the need for further interventions.

10. Surgical intervention was performed to address other infective bursitis in the patient. Intraoperatively, an abscess was encountered within the bursa and drained promptly. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress and evaluate the need for additional interventions.

1. The patient underwent surgical intervention for other infective bursitis with severe infection on the extreme moving joint. Intraoperatively, a purulent collection was identified within the bursa, involving the highly mobile joint. Meticulous debridement of necrotic tissue and infected bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits to monitor healing and assess joint function.

2. Operative management was performed for other infective bursitis with severe infection on the extreme moving joint in the patient. Intraoperatively, an abscess was encountered within the bursa, extending to the highly mobile joint. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile fluid was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing progress and assess joint mobility.

3. The patient underwent surgical treatment for other infective bursitis with severe infection on the extreme moving joint. Intraoperatively, a purulent collection was found within the bursa, involving the highly mobile joint. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Specimens were collected for culture analysis, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress and assess joint functionality.

4. Surgical exploration was performed to address other infective bursitis with severe infection on the extreme moving joint in the patient. Intraoperatively, an abscess was identified within the bursa, extending to the highly mobile joint. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile fluid was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient received postoperative wound care instructions, and regular follow-up visits were scheduled to assess healing progress and evaluate joint range of motion.

5. The patient underwent operative intervention for other infective bursitis with severe infection on the extreme moving joint. Intraoperatively, a purulent collection was discovered within the bursa, involving the highly mobile joint. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing progress and assess joint mobility.

6. Operative intervention was performed to address other infective bursitis with severe infection on the extreme moving joint in the patient. Intraoperatively, an abscess was encountered within the bursa, extending to the highly mobile joint. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up appointments were scheduled to assess healing progress and evaluate joint functionality.

7. Surgical intervention was performed to treat other infective bursitis with severe infection on the extreme moving joint in the patient. Intraoperatively, a purulent collection was found within the bursa,

involving the highly mobile joint. Meticulous debridement of necrotic tissue and compromised bursal wall was carried out. Thorough irrigation with sterile fluid was performed. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing progress, assess joint function, and evaluate the need for additional interventions.

8. The patient underwent surgical exploration for other infective bursitis with severe infection on the extreme moving joint. Intraoperatively, an abscess was identified within the bursa, extending to the highly mobile joint. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient received postoperative wound care instructions, and regular follow-up visits were scheduled to assess healing progress, joint mobility, and determine the need for further interventions.

9. Operative intervention was undertaken for other infective bursitis with severe infection on the extreme moving joint in the patient. Intraoperatively, a purulent collection was discovered within the bursa, involving the highly mobile joint. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was conducted. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress, assess joint functionality, and evaluate the need for further interventions.

10. Surgical intervention was performed to address other infective bursitis with severe infection on the extreme moving joint in the patient. Intraoperatively, an abscess was encountered within the bursa, extending to the highly mobile joint. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress, evaluate joint range of motion, and determine the need for additional interventions.

1. The patient underwent surgical intervention for other infective bursitis with severe inflammation. Intraoperatively, a purulent and inflamed bursa was identified and drained meticulously. Extensive debridement of necrotic tissue and infected bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and the patient was scheduled for regular follow-up visits to monitor healing and assess the resolution of inflammation.

2. Operative management was performed for other infective bursitis with marked inflammation in the patient. Intraoperatively, an inflamed bursa with purulent collection was encountered and drained appropriately. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile fluid was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing progress and evaluate the resolution of inflammation.

3. The patient underwent surgical treatment for other infective bursitis with significant inflammation. Intraoperatively, an inflamed bursa with purulent collection was found and drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Specimens were collected for culture analysis, and targeted antibiotic therapy was initiated. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress and assess the resolution of inflammation.

4. Surgical exploration was performed to address other infective bursitis with severe inflammation in the patient. Intraoperatively, an inflamed bursa with abscess formation was identified and drained promptly. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile fluid was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient received postoperative wound care instructions, and regular follow-up visits were scheduled to assess healing progress and evaluate the resolution of inflammation.

5. The patient underwent operative intervention for other infective bursitis with pronounced inflammation. Intraoperatively, an inflamed bursa with purulent collection was discovered and drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing progress and assess the resolution of inflammation.

6. Operative intervention was performed to address other infective bursitis with severe inflammation in the patient. Intraoperatively, an inflamed bursa with abscess formation was encountered and drained promptly. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up appointments were scheduled to assess healing progress and evaluate the resolution of inflammation.

7. Surgical intervention was performed to treat other infective bursitis with marked inflammation in the patient. Intraoperatively, an inflamed bursa with purulent collection was found and drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was carried out. Thorough irrigation with sterile fluid was performed. Cultures were obtained, and targeted antibiotic therapy was initiated

. Postoperatively, wound care instructions were given, and regular follow-up visits were scheduled to monitor healing progress, assess the resolution of inflammation, and evaluate the need for additional interventions.

8. The patient underwent surgical exploration for other infective bursitis with significant inflammation. Intraoperatively, an inflamed bursa with abscess formation was identified and drained meticulously. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient received postoperative wound care instructions, and regular follow-up visits were scheduled to assess healing progress, evaluate the resolution of inflammation, and determine the need for further interventions.

9. Operative intervention was undertaken for other infective bursitis with severe inflammation in the patient. Intraoperatively, an inflamed bursa with purulent collection was discovered and drained meticulously. Extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was conducted. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress, assess the resolution of inflammation, and evaluate the need for further interventions.

10. Surgical intervention was performed to address other infective bursitis with pronounced inflammation in the patient. Intraoperatively, an inflamed bursa with abscess formation was encountered and drained promptly. Meticulous debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. Postoperatively, wound care instructions were provided, and regular follow-up visits were scheduled to monitor healing progress, evaluate the resolution of inflammation, and determine the need for additional interventions.

1. The patient underwent surgical intervention for other infective bursitis. Intraoperatively, extensive debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient's postoperative follow-ups will be determined based on the severity of the diagnosis, with more frequent visits recommended for severe cases to monitor healing progress and assess response to treatment.

2. Operative management was performed for other infective bursitis. Intraoperatively, meticulous debridement of necrotic tissue and eroded bursal wall was carried out. Thorough irrigation with sterile fluid was performed. Cultures were obtained, and targeted antibiotic therapy was initiated. The frequency of postoperative follow-ups will be determined based on the severity of the diagnosis, with closer monitoring recommended for severe cases to evaluate healing progress and modify treatment if necessary.

3. The patient underwent surgical treatment for other infective bursitis. Intraoperatively, thorough debridement of necrotic tissue and infected bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The frequency of postoperative follow-up visits will be determined based on the severity of the diagnosis, with more frequent assessments recommended for severe cases to monitor healing progress and ensure optimal response to treatment.

4. Surgical exploration was performed to address other infective bursitis. Intraoperatively, meticulous debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The patient's postoperative follow-up visits will be tailored based on the severity of the diagnosis, with more frequent evaluations recommended for severe cases to monitor healing progress, assess treatment response, and adjust therapeutic strategies if needed.

5. The patient underwent operative intervention for other infective bursitis. Intraoperatively, extensive debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The frequency of postoperative follow-up visits will be determined based on the severity of the diagnosis, with more frequent assessments advised for severe cases to closely monitor healing progress and ensure optimal response to treatment.

6. Operative intervention was performed to address other infective bursitis. Intraoperatively, meticulous debridement of necrotic tissue and infected bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. The frequency of postoperative follow-up appointments will be determined based on the severity of the diagnosis, with more frequent evaluations recommended for severe cases to monitor healing progress, assess treatment response, and adjust therapeutic approaches as necessary.

7. Surgical intervention was performed to treat other infective bursitis. Intraoperatively, thorough debridement of necrotic tissue and compromised bursal wall was carried out. Thorough irrigation with sterile fluid was performed. Cultures were obtained, and targeted antibiotic therapy was initiated. The patient's postoperative follow-ups will be tailored based on the severity of the diagnosis, with closer monitoring advised for severe cases to assess healing progress, evaluate treatment response, and make any necessary modifications to the therapeutic regimen.

8. The patient underwent surgical exploration for other infective bursitis. Intraoperatively, extensive debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation

with sterile solution was carried out. Cultures were obtained, and appropriate antibiotic therapy was initiated. The frequency of postoperative follow-up visits will be determined based on the severity of the diagnosis, with more frequent assessments recommended for severe cases to closely monitor healing progress, assess treatment response, and make any adjustments to the management plan.

9. Operative intervention was undertaken for other infective bursitis. Intraoperatively, meticulous debridement of necrotic tissue and compromised bursal wall was performed. Thorough irrigation with sterile solution was conducted. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. The frequency of postoperative follow-up visits will be determined based on the severity of the diagnosis, with more frequent evaluations advised for severe cases to monitor healing progress, assess treatment response, and determine the need for further interventions.

10. Surgical intervention was performed to address other infective bursitis. Intraoperatively, extensive debridement of necrotic tissue and eroded bursal wall was performed. Thorough irrigation with sterile solution was carried out. Cultures were obtained, and the patient was initiated on appropriate antibiotic therapy. The frequency of postoperative follow-up visits will be tailored based on the severity of the diagnosis, with closer monitoring recommended for severe cases to assess healing progress, evaluate treatment response, and determine the need for additional interventions.

## 

## M71.2 Synovial cyst of popliteal space [Baker]

Operative Note 1:

Procedure: Excision of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position and prepped and draped in a sterile manner. A curvilinear incision was made over the popliteal fossa, and the subcutaneous tissue was dissected. The cyst was identified and carefully dissected from the surrounding structures. It was excised in its entirety, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. A sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 2:

Procedure: Aspiration and Sclerotherapy of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Using ultrasound guidance, a 22-gauge needle was inserted into the cyst, and its contents were aspirated. Following aspiration, a mixture of 3% hypertonic saline and 0.5% sodium tetradecyl sulfate was injected into the cyst cavity. The needle was withdrawn, and pressure was applied to prevent leakage. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 3:

Procedure: Excision and Repair of Synovial Cyst of Popliteal Space with Graft

Anesthesia: General

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the subcutaneous tissue was dissected. The cyst was carefully dissected and excised, ensuring complete removal. A fascial defect was identified and repaired using a synthetic graft. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 4:

Procedure: Arthroscopic Decompression of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Standard arthroscopic portals were established. The cyst was visualized using an arthroscope, and an arthroscopic shaver was used to carefully decompress the cyst. The cyst contents were evacuated, and the cyst wall was debrided. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 5:

Procedure: Open Resection and Closure of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the subcutaneous tissue was dissected. The cyst was carefully dissected from the surrounding structures and excised in its entirety. Hemostasis was achieved, and the wound was closed in layers using interrupted sutures. A sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 6:

Procedure: Endoscopic Excision of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. Two small incisions were made, and endoscopic instruments were inserted. The cyst was visualized using an endoscope, and it was carefully dissected and excised. Hemostasis was achieved,

and the incisions were closed with sutures. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 7:

Procedure: Mini-incision Excision of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was positioned in the supine position, and the popliteal fossa was prepped and draped in a sterile manner. A small oblique incision was made over the cyst. The cyst was identified and dissected from the surrounding tissues. It was excised in its entirety through the mini-incision. Hemostasis was achieved, and the wound was closed with sutures. A sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 8:

Procedure: Fenestration and Drainage of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A small incision was made over the cyst, and the cyst wall was fenestrated using a scalpel. The cyst contents were evacuated, and a drain was placed to allow for continuous drainage. The incision was closed with sutures. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 9:

Procedure: Percutaneous Radiofrequency Ablation of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, a radiofrequency probe was inserted into the cyst. Radiofrequency energy was applied to ablate the cyst wall and its lining. The probe was withdrawn, and a sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 10:

Procedure: Arthroscopic Excision and Debridement of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. The cyst was carefully excised using arthroscopic instruments, and any associated loose bodies were removed. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 11:

Procedure: Percutaneous Aspiration and Steroid Injection of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, a needle was inserted into the cyst, and its contents were aspirated. Following aspiration, a mixture of local anesthetic and corticosteroid was injected into the cyst cavity. The needle was withdrawn, and pressure was applied to prevent leakage. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 12:

Procedure: Endovascular Embolization of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in a supine position, and the affected leg was prepped and draped in a sterile manner. A catheter was inserted into the femoral artery and advanced to the site of the cyst. Embolic agents were selectively injected into the feeding vessels of the cyst, causing its occlusion. Angiography confirmed successful embolization. The catheter was removed, and hemostasis was achieved at the access site. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 13:

Procedure: Arthroscopic Cyst Decompression and Synovectomy of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. The cyst wall was incised, and the cyst contents were evacuated. A thorough synovectomy was performed to remove any diseased synovial tissue. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 14:

Procedure: Open Cyst Marsupialization of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the cyst was carefully dissected from the surrounding tissues. A marsupialization procedure was performed by creating a large opening in the cyst wall and suturing it to the adjacent healthy tissue. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 15:

Procedure: Percutaneous Laser Ablation of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, a laser fiber was inserted into the cyst. Laser energy was delivered to ablate the cyst wall and its lining. The fiber was withdrawn, and a sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 16:

Procedure: Partial Excision and Drainage of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and a portion of the cyst wall was excised. The cyst contents were evacuated, and a drain was placed to facilitate ongoing drainage. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 17:

Procedure: Synovial Cyst of Popliteal Space Excision with End-to-End Anastomosis

Anesthesia: General

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the cyst was carefully dissected from the surrounding tissues. Both ends of the cyst were resected, and an end-to-end anastomosis was performed to restore continuity. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 18:

Procedure: Percutaneous Chemical Ablation of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, a sclerosing agent, such as ethanol or polidocanol, was injected into the cyst. The chemical agent induced sclerosis of the cyst wall, leading to its obliteration. The injection site was compressed, and a sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 19:

Procedure: Excision of Recurrent Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the recurrent cyst, and the subcutaneous tissue was dissected. The cyst was carefully dissected from the surrounding structures and excised completely. Close attention was paid to identifying any recurrent or residual cysts. Hemostasis was achieved, and the wound was closed in layers using absorbable sutures. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 20:

Procedure: Percutaneous Radiofrequency Ablation and Aspiration of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, a radiofrequency probe was inserted into the cyst and used to ablate the cyst wall. Following ablation, the cyst contents were aspirated. The probe was withdrawn, and a sterile dressing was applied. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 21:

Procedure: Excision and Repair of Synovial Cyst of Popliteal Space with Graft

Anesthesia: General with moderate sedation

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the subcutaneous tissue was dissected. The cyst was carefully dissected and excised, ensuring complete removal. A fascial defect was identified and repaired using a synthetic graft. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well with moderate sedation, and no immediate complications were noted.

Operative Note 22:

Procedure: Aspiration and Sclerotherapy of Synovial Cyst of Popliteal Space

Anesthesia: Local with minimal sedation

The patient was positioned in a supine position, and the popliteal fossa was prepped and draped in a sterile manner. Using ultrasound guidance, a 22-gauge needle was inserted into the cyst, and its contents were aspirated. Following aspiration, a mixture of 3% hypertonic saline and 0.5% sodium tetradecyl sulfate was injected into the cyst cavity. The needle was withdrawn, and pressure was applied to prevent leakage. The patient tolerated the procedure well with minimal sedation, and no immediate complications were observed.

Operative Note 23:

Procedure: Arthroscopic Decompression of Synovial Cyst of Popliteal Space

Anesthesia: General with deep sedation

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Standard arthroscopic portals were established. The cyst was visualized using an arthroscope, and an arthroscopic shaver was used to carefully decompress the cyst. The cyst contents were evacuated, and the cyst wall was debrided. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well with deep sedation, and no immediate complications were observed.

Operative Note 24:

Procedure: Open Resection and Closure of Synovial Cyst of Popliteal Space

Anesthesia: General with light sedation

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the subcutaneous tissue was dissected. The cyst was carefully dissected from the surrounding structures and excised in its entirety. Hemostasis was achieved, and the wound was closed in layers using interrupted sutures. The patient tolerated the procedure well with light sedation, and no immediate complications were noted.

Operative Note 25:

Procedure: Endoscopic Excision of Synovial Cyst of Popliteal Space

Anesthesia: General with minimal sedation

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. Two small incisions were made, and endoscopic instruments were inserted. The cyst was visualized using an endoscope, and it was carefully dissected and excised. Hemostasis was achieved, and the incisions were closed with sutures. The patient tolerated the procedure well with minimal sedation, and no immediate complications were observed.

Operative Note 26:

Procedure: Open Cyst Marsupialization of Synovial Cyst of Popliteal Space

Anesthesia: General with deep sedation

The patient was positioned in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the cyst

was carefully dissected from the surrounding tissues. A marsupialization procedure was performed by creating a large opening in the cyst wall and suturing it to the adjacent healthy tissue. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well with deep sedation, and no immediate complications were noted.

Operative Note 27:

Procedure: Percutaneous Aspiration and Steroid Injection of Synovial Cyst of Popliteal Space

Anesthesia: Local with minimal sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, a needle was inserted into the cyst, and its contents were aspirated. Following aspiration, a mixture of local anesthetic and corticosteroid was injected into the cyst cavity. The needle was withdrawn, and pressure was applied to prevent leakage. The patient tolerated the procedure well with minimal sedation, and no immediate complications were observed.

Operative Note 28:

Procedure: Arthroscopic Excision and Debridement of Synovial Cyst of Popliteal Space

Anesthesia: General with moderate sedation

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. The cyst was carefully excised using arthroscopic instruments, and any associated loose bodies were removed. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well with moderate sedation, and no immediate complications were observed.

Operative Note 29:

Procedure: Percutaneous Radiofrequency Ablation of Synovial Cyst of Popliteal Space

Anesthesia: Local with deep sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, a radiofrequency probe was inserted into the cyst. Radiofrequency energy was applied to ablate the cyst wall and its lining. The probe was withdrawn, and a sterile dressing was applied. The patient tolerated the procedure well with deep sedation, and no immediate complications were noted.

Operative Note 30:

Procedure: Mini-incision Excision of Synovial Cyst of Popliteal Space

Anesthesia: General with light sedation

The patient was positioned in the supine position, and the popliteal fossa was prepped and draped in a sterile manner. A small oblique incision was made over the cyst. The cyst was identified and dissected from the surrounding tissues. It was excised in its entirety through the mini-incision. Hemostasis was achieved, and the wound was closed with sutures. A sterile dressing was applied. The patient tolerated the procedure well with light sedation, and no immediate complications were noted.

Operative Note 31:

Procedure: Open Excision and Bone Grafting for Synovial Cyst of Popliteal Space with Bone Erosion

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully dissected, and the surrounding bone erosion was identified. The eroded bone was debrided, and a bone graft was harvested from the iliac crest. The graft was placed to fill the defect, restoring bone integrity. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 32:

Procedure: Arthroscopic Debridement and Bone Erosion Repair of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. The cyst was excised, and the eroded bone was carefully debrided using arthroscopic instruments. Bone grafting was performed to fill the defect, promoting bone healing. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 33:

Procedure: Percutaneous Aspiration and Bone Erosion Assessment of Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, a needle was inserted into the cyst, and its contents were aspirated. Following aspiration, the eroded bone was assessed using a probe. The extent of bone erosion was documented. The needle was withdrawn, and pressure was applied to prevent leakage. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 34:

Procedure: Open Excision and Bone Substitute Placement for Synovial Cyst of Popliteal Space with Bone Erosion

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully dissected, and the eroded bone was identified and debrided. A bone substitute material was placed to fill the defect, promoting bone healing. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 35:

Procedure: Arthroscopic Synovectomy and Bone Erosion Repair of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue, and the eroded bone was addressed using arthroscopic instruments. Bone grafting was performed to repair the bone erosion. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 36:

Procedure: Open Cyst Marsupialization and Bone Erosion Repair of Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was positioned in the prone position, and the

popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully dissected, and the eroded bone was identified. Marsupialization of the cyst was performed by creating a large opening in the cyst wall and suturing it to the adjacent healthy tissue. Bone grafting was performed to address the bone erosion. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 37:

Procedure: Percutaneous Bone Grafting for Synovial Cyst of Popliteal Space with Bone Erosion

Anesthesia: Local

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, a bone graft was inserted percutaneously into the site of bone erosion. The bone graft was carefully positioned to fill the defect, promoting bone healing. The graft placement was confirmed using fluoroscopy. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 38:

Procedure: Excision and Reconstruction with Synthetic Bone Substitute for Synovial Cyst of Popliteal Space with Bone Erosion

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was dissected, and the eroded bone was debrided. A synthetic bone substitute was used to reconstruct the bone defect. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 39:

Procedure: Arthroscopic Bone Erosion Repair and Synovial Cyst Excision of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the eroded bone was visualized using an arthroscope. Bone grafting was performed to repair the bone erosion, and the synovial cyst was excised using arthroscopic instruments. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 40:

Procedure: Open Excision and Bone Erosion Reconstruction for Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully dissected, and the eroded bone was addressed. Reconstruction of the bone erosion was performed using autograft or allograft. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 41:

Procedure: Open Excision and Joint Denervation for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully dissected, and the surrounding structures were inspected. Severe bone pain was noted, and joint denervation was performed to alleviate pain. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 42:

Procedure: Arthroscopic Synovectomy and Osteotomy for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. Additionally, an osteotomy was performed to correct any underlying bone abnormalities contributing to severe bone pain. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 43:

Procedure: Percutaneous Radiofrequency Ablation and Bone Grafting for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, radiofrequency ablation was performed to target the sensory nerves associated with severe bone pain. Following ablation, bone grafting was performed to address any underlying bone abnormalities. The patient tolerated the procedure well with moderate sedation, and no immediate complications were observed.

Operative Note 44:

Procedure: Open Excision and Joint Fusion for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully excised, and severe bone pain was noted. Joint fusion was performed to immobilize the affected joint and alleviate pain. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 45:

Procedure: Arthroscopic Bone Erosion Repair and Nerve Decompression for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst and associated bone erosion were visualized using an arthroscope. Bone grafting was performed to repair the bone erosion. Additionally, nerve decompression was performed to alleviate severe bone pain. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 46:

Procedure: Percutaneous Bone Grafting and Neurolysis for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, bone grafting

was performed to address the bone abnormalities contributing to severe bone pain. Additionally, neurolysis was performed to release any entrapped nerves and alleviate pain. The patient tolerated the procedure well with moderate sedation, and no immediate complications were observed.

Operative Note 47:

Procedure: Open Excision and Nerve Decompression for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully excised, and severe bone pain was noted. Nerve decompression was performed to relieve the pressure on the affected nerves. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 48:

Procedure: Arthroscopic Synovectomy and Neurolysis for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. Additionally, neurolysis was performed to release any entrapped nerves and alleviate severe bone pain. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 49:

Procedure: Percutaneous Nerve Block and Bone Grafting for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: Local with deep sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, a nerve block was performed to numb the affected nerves and alleviate severe bone pain. Following the nerve block, bone grafting was performed to address any underlying bone abnormalities. The patient tolerated the procedure well with deep sedation, and no immediate complications were observed.

Operative Note 50:

Procedure: Open Excision and Nerve Ablation for Synovial Cyst of Popliteal Space with Severe Bone Pain

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully excised, and severe bone pain was noted. Nerve ablation was performed to disrupt the pain signals and alleviate pain. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 51:

Procedure: Percutaneous Fenestration and Sclerotherapy for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, percutaneous fenestration of the cyst was performed to create an opening. Sclerotherapy was then administered to promote cyst closure. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well with moderate sedation. No immediate complications were observed.

Operative Note 52:

Procedure: Arthroscopic Synovectomy and Joint Lavage for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. The joint was then lavaged with a sterile solution to clean and flush out debris. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 53:

Procedure: Open Excision and Capsular Release for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully dissected, and surgical intervention in the form of capsular release was performed to release any contractures or adhesions. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 54:

Procedure: Arthroscopic Debridement and Microfracture for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Debridement of the cyst and surrounding tissues was performed. Microfracture was then performed to stimulate the formation of new bone in the affected area. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 55:

Procedure: Percutaneous Aspiration and Joint Injection for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, the cyst was aspirated using a needle, and its contents were removed. Following aspiration, a joint injection was performed using a corticosteroid and local anesthetic to alleviate symptoms. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well with moderate sedation. No immediate complications were observed.

Operative Note 56:

Procedure: Open Excision and Tendon Repair for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully dissected, and surgical intervention in the form of tendon repair was performed to address any tendon

involvement. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 57:

Procedure: Arthroscopic Synovectomy and Joint Reconstruction for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. Additionally, joint reconstruction procedures, such as ligament repair or reconstruction, were performed to address any joint instability. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 58:

Procedure: Percutaneous Decompression and Joint Distraction for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, percutaneous decompression of the cyst was performed to relieve pressure and compression on surrounding structures. Joint distraction was then applied to promote joint space restoration and alleviate symptoms. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well with moderate sedation. No immediate complications were observed.

Operative Note 59:

Procedure: Open Excision and Soft Tissue Reconstruction for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully excised, and surgical intervention in the form of soft tissue reconstruction, such as tendon or ligament repair, was performed to address any associated damage. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 60:

Procedure: Arthroscopic Synovectomy and Cartilage Restoration for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. Cartilage restoration procedures, such as microfracture or autologous chondrocyte implantation, were performed to address any cartilage damage. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 61:

Procedure: Percutaneous Cyst Drainage and Endoscopic Decompression for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, percutaneous cyst drainage was performed using a needle to remove the cyst fluid. Subsequently, endoscopic decompression was performed to alleviate pressure and compression on surrounding structures. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well with moderate sedation. No immediate complications were observed.

Operative Note 62:

Procedure: Open Excision and Vascular Reconstruction for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully excised, and surgical intervention in the form of vascular reconstruction was performed to address any associated vascular compromise. The cyst was completely excised, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 63:

Procedure: Arthroscopic Synovectomy and Meniscal Repair for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. Additionally, meniscal repair was performed to address any meniscal tears. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 64:

Procedure: Percutaneous Cyst Aspiration and Nerve Decompression for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, the cyst was aspirated using a needle to remove its contents. Following aspiration, nerve decompression was performed to alleviate symptoms associated with nerve impingement. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well with moderate sedation. No immediate complications were observed.

Operative Note 65:

Procedure: Open Excision and Osteochondral Autograft Transplantation for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully excised, and surgical intervention in the form of osteochondral autograft transplantation was performed to address any cartilage and bone defects. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 66:

Procedure: Arthroscopic Synovectomy and Ligament Reconstruction for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. Additionally, lig

ament reconstruction procedures were performed to address any ligamentous instability. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 67:

Procedure: Percutaneous Cyst Aspiration and Joint Debridement for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, the cyst was aspirated using a needle to remove its contents. Following aspiration, joint debridement was performed to remove any debris or damaged tissues. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well with moderate sedation. No immediate complications were observed.

Operative Note 68:

Procedure: Open Excision and Tendon Transfer for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, extending down to the bone. The cyst was carefully excised, and surgical intervention in the form of tendon transfer was performed to address any tendon abnormalities or deficiencies. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 69:

Procedure: Arthroscopic Synovectomy and Microfracture for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the cyst was visualized using an arthroscope. Synovectomy was performed to remove the diseased synovial tissue. Microfracture was then performed to promote the formation of new bone and cartilage. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 70:

Procedure: Percutaneous Cyst Drainage and Joint Fusion for Synovial Cyst of Popliteal Space with Surgical Intervention

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, percutaneous cyst drainage was performed using a needle to remove the cyst fluid. Following drainage, joint fusion was performed to address joint instability and provide long-term stabilization. The surgical intervention successfully addressed the cyst, and the patient tolerated the procedure well with moderate sedation. No immediate complications were observed.

Operative Note 71:

Procedure: Emergency Surgical Debridement and Drainage for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. An emergency incision was made over the infected joint, and thorough surgical debridement was performed to remove necrotic tissue and infected material. The joint was extensively irrigated with a sterile solution. A drainage system was placed to facilitate continuous drainage of the infected fluid. The wound was left open for further monitoring and subsequent wound closure. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 72:

Procedure: Arthroscopic Synovectomy and Antibiotic Spacer Placement for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the infected joint was visualized using an arthroscope. Synovectomy was performed to remove the infected synovial tissue. An antibiotic-loaded spacer was then placed within the joint to provide localized antibiotic delivery. The surgical intervention successfully addressed the infected cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 73:

Procedure: Open Excision and Wound Debridement for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. A curvilinear incision was made over the infected joint, extending down to the bone. The cyst was carefully excised, and extensive wound debridement was performed to remove infected tissue and promote healing. The wound was left open for subsequent wound care and management. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 74:

Procedure: Percutaneous Drainage and Antibiotic Infusion for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, percutaneous drainage of the infected cyst was performed using a needle to evacuate the purulent fluid. Subsequently, an antibiotic solution was infused into the cyst cavity to deliver localized antibiotic treatment. The procedure was well-tolerated by the patient with moderate sedation, and no immediate complications were observed.

Operative Note 75:

Procedure: Open Excision, Debridement, and Joint Lavage for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. A curvilinear incision was made over the infected joint, extending down to the bone. The cyst was excised, and thorough debridement of the infected tissues was performed. The joint was lavaged with copious amounts of sterile solution to flush out bacteria and debris. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 76:

Procedure: Arthroscopic Synovectomy and Abscess Drainage for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: General

The patient was placed in the supine

position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the infected joint was visualized using an arthroscope. Synovectomy was performed to remove the infected synovial tissue. An abscess within the joint was identified and drained. The surgical intervention successfully addressed the infected cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 77:

Procedure: Percutaneous Aspiration, Irrigation, and Antibiotic Injection for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under fluoroscopic guidance, percutaneous aspiration of the infected cyst was performed using a needle to remove purulent fluid. The joint was then extensively irrigated with a sterile solution. Antibiotics were injected into the joint to deliver localized antibiotic therapy. The patient tolerated the procedure well with moderate sedation, and no immediate complications were observed.

Operative Note 78:

Procedure: Open Excision and Joint Resection for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. A curvilinear incision was made over the infected joint, extending down to the bone. The cyst was excised, and joint resection was performed to remove infected joint surfaces. The wound was thoroughly irrigated and left open for subsequent wound care. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 79:

Procedure: Arthroscopic Synovectomy and Vacuum-Assisted Closure for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the infected joint was visualized using an arthroscope. Synovectomy was performed to remove the infected synovial tissue. Vacuum-assisted closure (VAC) therapy was applied to the wound to promote healing and control infection. The surgical intervention successfully addressed the infected cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 80:

Procedure: Percutaneous Drainage and Antibiotic Bead Placement for Synovial Cyst of Popliteal Space with Severe Infection on the Extreme Moving Joint

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, percutaneous drainage of the infected cyst was performed using a needle to evacuate the purulent fluid. Antibiotic-impregnated beads were then placed into the cyst cavity to provide sustained local antibiotic release. The procedure was well-tolerated by the patient with moderate sedation, and no immediate complications were observed.

Operative Note 81:

Procedure: Arthroscopic Synovectomy and Corticosteroid Injection for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the inflamed synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the inflamed synovial tissue. Following synovectomy, a corticosteroid injection was administered into the joint to reduce inflammation. The surgical intervention successfully addressed the inflamed cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 82:

Procedure: Open Excision and Inflammatory Tissue Debridement for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the inflamed cyst, extending down to the bone. The cyst was carefully excised, and inflammatory tissue debridement was performed to remove diseased and inflamed tissue. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 83:

Procedure: Percutaneous Cyst Aspiration and Anti-inflammatory Medication Injection for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, percutaneous cyst aspiration was performed using a needle to remove the inflammatory fluid. Subsequently, an injection of anti-inflammatory medication was administered into the cyst cavity. The procedure was well-tolerated by the patient with moderate sedation, and no immediate complications were observed.

Operative Note 84:

Procedure: Arthroscopic Synovectomy and Biologic Treatment for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the inflamed synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the inflamed synovial tissue. Biologic treatment, such as platelet-rich plasma (PRP) or stem cell therapy, was administered to promote tissue healing and reduce inflammation. The surgical intervention successfully addressed the inflamed cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 85:

Procedure: Open Excision and Adjunctive Anti-inflammatory Therapy for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the inflamed cyst, extending down to the bone. The cyst was excised, and adjunctive anti-inflammatory therapy, such as local corticosteroid injection or nonsteroidal anti-inflammatory drugs (NSAIDs), was administered to reduce inflammation. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 86:

Procedure: Percutaneous Cyst Drainage and Topical Anti-inflammatory Medication Application for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was pre

pped and draped in a sterile manner. Under fluoroscopic guidance, percutaneous cyst drainage was performed using a needle to remove the inflammatory fluid. Topical anti-inflammatory medication was then applied to the cyst cavity to provide localized anti-inflammatory effects. The patient tolerated the procedure well with moderate sedation, and no immediate complications were observed.

Operative Note 87:

Procedure: Arthroscopic Synovectomy and Cold Compression Therapy for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the inflamed synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the inflamed synovial tissue. Cold compression therapy was applied postoperatively to reduce inflammation and provide pain relief. The surgical intervention successfully addressed the inflamed cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 88:

Procedure: Open Excision and Inflammatory Cyst Wall Removal for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the prone position, and the popliteal fossa was prepped and draped in a sterile manner. A curvilinear incision was made over the inflamed cyst, extending down to the bone. The cyst was carefully excised, and the inflammatory cyst wall was meticulously removed to eliminate the source of inflammation. The wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 89:

Procedure: Percutaneous Cyst Aspiration and Systemic Anti-inflammatory Medication Administration for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, percutaneous cyst aspiration was performed using a needle to remove the inflammatory fluid. Systemic anti-inflammatory medication was then administered to reduce inflammation throughout the body. The procedure was well-tolerated by the patient with moderate sedation, and no immediate complications were observed.

Operative Note 90:

Procedure: Arthroscopic Synovectomy and Intra-articular Steroid Injection for Inflamed Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the inflamed synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the inflamed synovial tissue. An intra-articular steroid injection was administered into the joint to alleviate inflammation and pain. The surgical intervention successfully addressed the inflamed cyst, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 91:

Procedure: Open Excision and Synovial Cyst Resection for Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and meticulous dissection was performed to expose the synovial cyst. The cyst was excised along with the surrounding synovial tissue. Hemostasis was achieved, and the wound was closed in layers. Postoperative follow-up will depend on the histopathological examination results to determine the further course of treatment. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 92:

Procedure: Arthroscopic Synovectomy and Cyst Fenestration for Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the synovial tissue, and cyst fenestration was performed to create openings for fluid drainage. The joint was thoroughly irrigated, and the portals were closed. Postoperative follow-up will depend on the patient's symptomatic improvement and imaging findings. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 93:

Procedure: Percutaneous Aspiration and Injection for Synovial Cyst of Popliteal Space

Anesthesia: Local

The patient was placed in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, percutaneous aspiration of the cystic fluid was performed using a needle. The aspirated fluid was sent for analysis. Subsequently, a corticosteroid or hyaluronic acid injection was administered into the cyst cavity. The patient was advised for a follow-up examination after a week to assess the response to treatment and determine the need for further interventions. No immediate complications were observed.

Operative Note 94:

Procedure: Arthroscopic Synovectomy and Joint Lavage for Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the synovial tissue, and thorough joint lavage was performed to flush out debris and inflammatory factors. The joint was inspected for any signs of damage or instability. Postoperative follow-up will depend on the patient's symptoms and joint examination findings. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 95:

Procedure: Open Excision and Microscopic Examination for Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and the cyst was carefully excised along with surrounding tissue. The excised specimen was sent for microscopic examination to determine the nature and severity of the cyst. Postoperative follow-up will depend on the histopathological results and the patient's clinical presentation. The wound was closed in layers, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 96:

Procedure: Arthroscopic Synovectomy and Joint Debridement for Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the synovial tissue, and joint debridement was performed to remove any loose bodies or damaged tissue. The joint was thoroughly irrigated, and the portals were closed. Postoperative follow-up will depend on the patient's symptomatic improvement and the need for further interventions. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 97:

Procedure: Percutaneous Aspiration and Antibiotic Injection for Infected Synovial Cyst of Popliteal Space

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, percutaneous aspiration of the infected cyst was performed using a needle to remove the purulent fluid. The aspirated fluid was sent for culture and sensitivity testing. Subsequently, antibiotics were injected into the cyst cavity. Postoperative follow-up will depend on the culture results and the patient's response to treatment. The procedure was well-tolerated by the patient with moderate sedation, and no immediate complications were observed.

Operative Note 98:

Procedure: Arthroscopic Synovectomy and Biopsy for Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the knee was prepped and draped in a sterile manner. Arthroscopic portals were established, and the synovial cyst was visualized using an arthroscope. Synovectomy was performed to remove the synovial tissue, and multiple biopsies were taken from different areas of the synovium. The biopsied samples were sent for histopathological examination to determine the underlying cause and severity of the condition. Postoperative follow-up will depend on the biopsy results and the patient's clinical presentation. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 99:

Procedure: Open Excision and Adjunctive Therapy for Recurrent Synovial Cyst of Popliteal Space

Anesthesia: General

The patient was placed in the supine position, and the affected knee was prepped and draped in a sterile manner. A curvilinear incision was made over the cyst, and meticulous dissection was performed to expose the recurrent synovial cyst. The cyst was excised, and additional adjunctive therapies, such as radiofrequency ablation or cryotherapy, were applied to prevent recurrence. Postoperative follow-up will depend on the patient's recovery and the need for further interventions. The wound was closed in layers, and the patient tolerated the procedure well. No immediate complications were noted.

Operative Note 100:

Procedure: Percutaneous Cyst Aspiration and Physical Therapy Referral for Synovial Cyst of Popliteal Space

Anesthesia: Local with moderate sedation

The patient was positioned in a prone position, and the popliteal fossa was prepped and draped in a sterile manner. Under ultrasound guidance, percutaneous cyst aspiration was performed using a needle to remove the cystic fluid. The patient was then referred to physical therapy for further management and rehabilitation to address any underlying biomechanical issues contributing to the cyst formation. Postoperative follow-up will depend on the patient's response to physical therapy and the resolution of symptoms. The procedure was well-tolerated by the patient with moderate sedation, and no immediate complications were observed.

## M71.3 Other bursal cyst

Operative Note 1:

Patient underwent excision of an other bursal cyst. A curvilinear incision was made over the cyst. The cyst was carefully dissected from the surrounding tissues and excised. Hemostasis was achieved, and the wound was closed in layers. The specimen was sent for histopathological analysis.

Operative Note 2:

Excision of an other bursal cyst was performed using a longitudinal incision. The cyst was carefully isolated and removed from the adjacent structures. Hemostasis was ensured, and the wound was closed meticulously. The excised cyst was sent for pathological examination.

Operative Note 3:

Patient underwent a surgical procedure to excise an other bursal cyst. An elliptical incision was made over the cyst, and dissection was carried out to separate the cyst from the surrounding tissues. The cyst was completely excised, and the wound was closed with appropriate sutures. The excised cyst was submitted for histopathological evaluation.

Operative Note 4:

An other bursal cyst excision was performed on the patient. A transverse incision was made over the cyst, and meticulous dissection was carried out to remove the cyst intact. Hemostasis was achieved, and the wound was closed in layers. The excised cyst was sent for pathological examination.

Operative Note 5:

Excision of an other bursal cyst was performed using a midline incision. The cyst was identified and carefully dissected away from the surrounding tissues. The cyst capsule was completely removed, and hemostasis was ensured. The wound was closed using appropriate sutures. The excised cyst was sent for histopathological analysis.

Operative Note 6:

Patient underwent excision of an other bursal cyst. A curvilinear incision was made directly over the cyst. The cyst was meticulously dissected and excised. Hemostasis was achieved using electrocautery, and the wound was closed with interrupted sutures. The excised cyst was submitted for pathological examination.

Operative Note 7:

An other bursal cyst was excised from the patient. A transverse incision was made over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed in layers. The excised cyst was sent for histopathological evaluation.

Operative Note 8:

Excision of an other bursal cyst was performed through a midline incision. The cyst was identified and carefully dissected from the surrounding tissues. It was completely excised, and hemostasis was ensured. The wound was closed using interrupted sutures. The excised cyst was sent for pathological examination.

Operative Note 9:

Patient underwent surgical excision of an other bursal cyst. An elliptical incision was made over the cyst, and meticulous dissection was carried out to remove the cyst. Hemostasis was achieved using bipolar electrocautery, and the wound was closed with sutures. The excised cyst was submitted for histopathological analysis.

Operative Note 10:

Excision of an other bursal cyst was performed through a curvilinear incision. The cyst was carefully dissected away from the adjacent structures and completely excised. Hemostasis was achieved, and the wound was closed meticulously. The excised cyst was sent for histopathological examination.

Operative Note 11:

The patient underwent excision of an other bursal cyst. A vertical incision was made directly over the cyst, and dissection was performed to isolate the cyst from the surrounding tissues. The cyst was carefully excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed using sutures. The excised cyst was sent for histopathological analysis.

Operative Note 12:

Excision of an other bursal cyst was carried out through a transverse incision. The cyst was identified and meticulously dissected from the adjacent structures. It was completely excised, and hemostasis was achieved using electrocautery. The wound was closed in layers using absorbable sutures. The excised cyst was submitted for pathological evaluation.

Operative Note 13:

Patient underwent surgical excision of an other bursal cyst. An oblique incision was made over the cyst, and careful dissection was performed to separate the cyst from the surrounding tissues. The cyst was excised in its entirety, and meticulous hemostasis was achieved. The wound was closed with sutures, and the excised cyst was sent for histopathological examination.

Operative Note 14:

An other bursal cyst excision was performed using a midline longitudinal incision. The cyst was identified, carefully dissected, and completely excised. Hemostasis was achieved, and the wound was closed using interrupted sutures. The excised cyst was sent for pathological analysis.

Operative Note 15:

Excision of an other bursal cyst was performed through a curvilinear incision. The cyst was dissected free from the surrounding tissues and completely excised. Hemostasis was ensured, and the wound was closed in layers using absorbable sutures. The excised cyst was submitted for histopathological evaluation.

Operative Note 16:

Patient underwent surgical excision of an other bursal cyst. A vertical midline incision was made directly over the cyst. The cyst was meticulously dissected and removed intact. Hemostasis was achieved, and the wound was closed using subcuticular sutures. The excised cyst was sent for histopathological analysis.

Operative Note 17:

Excision of an other bursal cyst was performed through a transverse incision. The cyst was carefully isolated and excised, ensuring complete removal. Hemostasis was achieved using bipolar electrocautery, and the wound was closed in layers with absorbable sutures. The excised cyst was sent for pathological examination.

Operative Note 18:

An other bursal cyst was excised from the patient using a curvilinear incision. The cyst was meticulously dissected away from the adjacent structures and completely excised. Hemostasis was ensured, and the wound was closed using interrupted sutures. The excised cyst was sent for histopathological evaluation.

Operative Note 19:

Excision of an other bursal cyst was performed through a midline incision. The cyst was identified, carefully dissected, and completely excised. Hemostasis was achieved, and the wound was closed meticulously using subcuticular sutures. The excised cyst was sent for pathological analysis.

Operative Note 20:

Patient underwent surgical excision of an other bursal cyst. A longitudinal incision was made directly over the cyst. The cyst was dissected and excised meticulously. Hemostasis was achieved using electrocautery, and the wound was closed with absorbable sutures. The excised cyst was submitted for histopathological examination.

Operative Note 21:

The patient underwent excision of an other bursal cyst under general anesthesia. A curvilinear incision was made over the cyst. The cyst was carefully dissected and excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and anesthesia was smoothly reversed. The excised cyst was sent for histopathological analysis.

Operative Note 22:

Excision of an other bursal cyst was performed under local anesthesia with sedation. A transverse incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised. The patient remained comfortable throughout the procedure, and vital signs were stable. The wound was closed, and the excised cyst was sent for pathological examination.

Operative Note 23:

Patient underwent surgical excision of an other bursal cyst under spinal anesthesia. An elliptical incision was made over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and anesthesia was reversed. The excised cyst was submitted for histopathological evaluation.

Operative Note 24:

An other bursal cyst excision was performed on the patient under regional anesthesia. A transverse incision was made over the cyst, and meticulous dissection was carried out to remove the cyst intact. Hemostasis was achieved, and the wound was closed in layers. The patient remained stable throughout the procedure, and the excised cyst was sent for pathological examination.

Operative Note 25:

Excision of an other bursal cyst was performed under general anesthesia with reduced dosage. A midline incision was made over the cyst, and careful dissection was performed. The cyst was completely excised. The patient maintained stable vital signs throughout the procedure, and anesthesia was smoothly reversed. The excised cyst was sent for histopathological analysis.

Operative Note 26:

Patient underwent excision of an other bursal cyst under local anesthesia. A curvilinear incision was made directly over the cyst. The cyst was meticulously dissected and excised. Hemostasis was achieved, and the wound was closed using sutures. The patient remained comfortable and cooperative during the procedure. The excised cyst was sent for pathological examination.

Operative Note 27:

An other bursal cyst was excised from the patient under general anesthesia with increased dosage. A transverse incision was made over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed in layers. The patient remained stable throughout the procedure, and the excised cyst was sent for histopathological evaluation.

Operative Note 28:

Excision of an other bursal cyst was performed under local anesthesia with conscious sedation. The cyst was identified, carefully dissected, and completely excised. Hemostasis was achieved using bipolar electrocautery, and the wound was closed in layers with absorbable sutures. The patient remained relaxed and comfortable throughout the procedure. The excised cyst was sent for pathological examination.

Operative Note 29:

Patient underwent surgical excision of an other bursal cyst under general anesthesia with moderate dosage. A vertical incision was made directly over the cyst, and meticulous dissection was carried out to remove the cyst intact. Hemostasis was achieved, and the wound was closed using sutures. The patient's vital signs remained stable, and anesthesia was smoothly reversed. The excised cyst was submitted for histopathological analysis.

Operative Note 30:

Excision of an other bursal cyst was performed through a curvilinear incision under regional anesthesia. The cyst was carefully isolated and excised,

ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers with absorbable sutures. The patient tolerated the procedure well, and vital signs remained stable throughout. The excised cyst was sent for pathological examination.

Operative Note 31:

The patient underwent excision of an other bursal cyst with bone erosion. A curvilinear incision was made over the cyst, extending to the affected area of bone. The cyst was carefully dissected, and bone erosion was visualized and addressed appropriately. The cyst and eroded bone were excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The excised specimen, including the cyst and eroded bone, was sent for histopathological analysis.

Operative Note 32:

Excision of an other bursal cyst with associated bone erosion was performed. A transverse incision was made over the cyst, extending to the eroded bone. Careful dissection was performed, addressing the bone erosion as necessary. The cyst and eroded bone were completely excised. Hemostasis was achieved, and the wound was closed meticulously. The excised specimen, comprising the cyst and eroded bone, was submitted for pathological examination.

Operative Note 33:

Patient underwent surgical excision of an other bursal cyst with bone erosion. An elliptical incision was made over the cyst, extending to the eroded bone. Meticulous dissection was performed to remove the cyst and address the underlying bone erosion. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen, including the cyst and eroded bone, was sent for histopathological evaluation.

Operative Note 34:

An other bursal cyst with bone erosion was excised from the patient. A curvilinear incision was made over the cyst, extending to the eroded bone. The cyst was meticulously dissected, and the eroded bone was addressed and debrided. Complete excision of the cyst and eroded bone was performed. Hemostasis was achieved, and the wound was closed in layers. The excised specimen, including the cyst and eroded bone, was sent for pathological analysis.

Operative Note 35:

Excision of an other bursal cyst with bone erosion was performed through a midline incision. The cyst was identified, carefully dissected, and the eroded bone was visualized. Appropriate measures were taken to address the bone erosion. The cyst and eroded bone were completely excised. Hemostasis was achieved, and the wound was closed using interrupted sutures. The excised specimen, comprising the cyst and eroded bone, was submitted for histopathological examination.

Operative Note 36:

Patient underwent excision of an other bursal cyst with associated bone erosion. A transverse incision was made over the cyst, extending to the eroded bone. Meticulous dissection was performed to remove the cyst and address the bone erosion. Hemostasis was achieved, and the wound was closed meticulously. The excised specimen, including the cyst and eroded bone, was sent for pathological evaluation.

Operative Note 37:

An other bursal cyst with bone erosion was excised from the patient. A curvilinear incision was made directly over the cyst, extending to the eroded bone. The cyst was carefully dissected, and the eroded bone was addressed and debrided. Complete excision of the cyst and eroded bone was performed. Hemostasis was achieved, and the wound was closed using absorbable sutures. The excised specimen, comprising the cyst and eroded bone, was sent for histopathological analysis.

Operative Note 38:

Excision of an other bursal cyst with bone erosion was performed through a midline incision. The cyst was identified, carefully dissected, and the eroded bone was visualized. Appropriate measures were taken to address the bone erosion, including debridement. The cyst and er

oded bone were completely excised. Hemostasis was achieved, and the wound was closed in layers. The excised specimen, including the cyst and eroded bone, was submitted for pathological examination.

Operative Note 39:

Patient underwent surgical excision of an other bursal cyst with bone erosion. An elliptical incision was made over the cyst, extending to the eroded bone. Meticulous dissection was performed to remove the cyst and address the underlying bone erosion. Hemostasis was achieved, and the wound was closed with sutures. The excised specimen, including the cyst and eroded bone, was sent for histopathological evaluation.

Operative Note 40:

An other bursal cyst with bone erosion was excised from the patient. A curvilinear incision was made over the cyst, extending to the eroded bone. The cyst was meticulously dissected, and the eroded bone was addressed and debrided. Complete excision of the cyst and eroded bone was performed. Hemostasis was achieved, and the wound was closed meticulously. The excised specimen, comprising the cyst and eroded bone, was sent for pathological examination.

Operative Note 41:

The patient presented with severe bone pain associated with an other bursal cyst. Excision of the cyst was performed under general anesthesia. A curvilinear incision was made over the cyst, extending to the affected bone. Careful dissection was carried out to remove the cyst, addressing the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The excised cyst was sent for histopathological analysis. The patient reported relief from severe bone pain postoperatively.

Operative Note 42:

Excision of an other bursal cyst with severe bone pain was performed. The procedure was conducted under local anesthesia with sedation. A transverse incision was made over the cyst, and meticulous dissection was performed. The cyst was completely excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed appropriately. The excised cyst was sent for pathological examination.

Operative Note 43:

Patient underwent surgical excision of an other bursal cyst with severe bone pain. The procedure was performed under spinal anesthesia. An elliptical incision was made over the cyst, and careful dissection was carried out, addressing the severe bone pain. The cyst was excised completely. Hemostasis was achieved, and the wound was closed meticulously. The excised cyst was submitted for histopathological evaluation.

Operative Note 44:

An other bursal cyst with severe bone pain was excised from the patient. The procedure was performed under regional anesthesia. A curvilinear incision was made over the cyst, and meticulous dissection was performed. The cyst was completely excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The excised cyst was sent for pathological examination.

Operative Note 45:

Excision of an other bursal cyst with severe bone pain was performed under general anesthesia. A midline incision was made over the cyst, and careful dissection was carried out. The cyst was completely excised, alleviating the severe bone pain. Hemostasis was achieved, and the wound was closed appropriately. The excised cyst was sent for histopathological analysis. The patient reported significant improvement in bone pain postoperatively.

Operative Note 46:

Patient underwent excision of an other bursal cyst with severe bone pain. The procedure was performed under local anesthesia. A curvilinear incision was made directly over the cyst, and meticulous dissection was performed. The cyst was excised completely, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures. The excised cyst was sent for pathological examination.

Operative Note 47:

An other bursal cyst with severe bone pain was excised from the patient. The procedure was performed under general anesthesia with reduced dosage. A transverse incision was made over the cyst, and careful dissection was carried out. The cyst was completely excised, alleviating the severe bone pain. Hemostasis was achieved, and the wound was closed meticulously. The excised cyst was sent for histopathological evaluation.

Operative Note 48:

Excision of an other bursal cyst with severe bone pain was performed under local anesthesia with conscious sedation. The cyst was identified, carefully dissected, and completely excised, providing relief from the severe bone pain. Hemostasis was achieved using bipolar electrocautery, and the wound was closed in layers with absorbable sutures. The patient reported immediate reduction in bone pain postoperatively.

Operative Note 49:

Patient underwent surgical excision of an other bursal cyst with severe bone pain. The procedure was performed under general anesthesia with increased dosage. A vertical incision

was made directly over the cyst, and meticulous dissection was carried out. The cyst was completely excised, alleviating the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures. The excised cyst was submitted for histopathological analysis.

Operative Note 50:

Excision of an other bursal cyst with severe bone pain was performed through a curvilinear incision under regional anesthesia. The cyst was carefully isolated and excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The patient reported significant improvement in bone pain immediately after the procedure. The excised cyst was sent for pathological examination.

Operative Note 51:

The patient underwent a surgical intervention for the excision of an other bursal cyst. A curvilinear incision was made over the cyst, and careful dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the surgical intervention well, and postoperative instructions were provided for wound care and pain management. The excised cyst was sent for histopathological analysis.

Operative Note 52:

A surgical intervention was performed for the excision of an other bursal cyst. Under general anesthesia, a transverse incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components. Hemostasis was achieved, and the wound was closed in layers. The patient's vital signs remained stable throughout the surgical intervention, and anesthesia was smoothly reversed. The excised cyst was submitted for pathological examination.

Operative Note 53:

Patient underwent a surgical intervention for the excision of an other bursal cyst. An elliptical incision was made over the cyst, and careful dissection was performed to remove the cyst completely. The surgical intervention was performed under local anesthesia with sedation. Hemostasis was achieved, and the wound was closed meticulously. The patient remained comfortable and cooperative during the surgical intervention. Postoperative instructions were provided, and the excised cyst was sent for pathological evaluation.

Operative Note 54:

A surgical intervention was performed for the excision of an other bursal cyst. Under spinal anesthesia, a curvilinear incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components. Hemostasis was achieved, and the wound was closed using sutures. The patient tolerated the surgical intervention well, and anesthesia was reversed. The excised cyst was sent for histopathological examination.

Operative Note 55:

Patient underwent a surgical intervention for the excision of an other bursal cyst. The procedure was performed under regional anesthesia. A transverse incision was made over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed meticulously. The patient remained stable throughout the surgical intervention, and the excised cyst was sent for pathological analysis.

Operative Note 56:

A surgical intervention was performed for the excision of an other bursal cyst. Under general anesthesia with reduced dosage, a midline incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components. Hemostasis was achieved, and the wound was closed appropriately. The patient tolerated the surgical intervention well, and postoperative pain management was initiated. The excised cyst was sent for histopathological analysis.

Operative Note 57:

Patient underwent a surgical intervention for the excision of an other bursal cyst. The procedure was performed under local anesthesia. A curvilinear incision was made directly over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed using sutures. The patient remained comfortable and cooperative during the surgical intervention. Postoperative instructions were provided, and the excised cyst was sent for pathological examination.

Operative Note 58:

A surgical intervention was performed for the excision of an other bursal cyst. Under general anesthesia with increased dosage, a transverse incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components. Hemostasis was achieved

, and the wound was closed meticulously. The patient tolerated the surgical intervention well, and anesthesia was smoothly reversed. The excised cyst was sent for histopathological evaluation.

Operative Note 59:

Patient underwent a surgical intervention for the excision of an other bursal cyst. The procedure was performed under regional anesthesia with conscious sedation. An elliptical incision was made over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed using sutures. The patient remained stable throughout the surgical intervention, and postoperative pain management was initiated. The excised cyst was sent for pathological analysis.

Operative Note 60:

A surgical intervention was performed for the excision of an other bursal cyst. Under general anesthesia, a curvilinear incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the surgical intervention well, and postoperative instructions were provided for wound care and pain management. The excised cyst was sent for histopathological examination.

Operative Note 61:

The patient underwent a surgical intervention for the excision of an other bursal cyst with severe bone pain. Under general anesthesia, a curvilinear incision was made over the cyst, extending to the affected bone. Careful dissection was performed to remove the cyst completely, addressing the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the surgical intervention well, and postoperative pain management was initiated. The excised cyst was sent for histopathological analysis.

Operative Note 62:

A surgical intervention was performed for the excision of an other bursal cyst with bone erosion and severe bone pain. Under regional anesthesia, a transverse incision was made over the cyst, and meticulous dissection was carried out. The cyst and eroded bone were excised completely, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed meticulously. The patient remained stable throughout the surgical intervention, and postoperative instructions were provided for wound care and pain management. The excised specimen, comprising the cyst and eroded bone, was sent for pathological examination.

Operative Note 63:

Patient underwent a surgical intervention for the excision of an other bursal cyst with severe bone pain. The procedure was performed under local anesthesia with sedation. A curvilinear incision was made directly over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed using sutures. The patient remained comfortable and cooperative during the surgical intervention. Postoperative pain management was initiated, and the excised cyst was sent for pathological examination.

Operative Note 64:

A surgical intervention was performed for the excision of an other bursal cyst with severe bone pain. Under spinal anesthesia, a transverse incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components and relieving the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures. The patient tolerated the surgical intervention well, and postoperative pain management was initiated. The excised cyst was sent for histopathological evaluation.

Operative Note 65:

Patient underwent a surgical intervention for the excision of an other bursal cyst with bone erosion and severe bone pain. The procedure was performed under general anesthesia with reduced dosage. A curvilinear incision was made over the cyst, and meticulous dissection was carried out. The cyst and eroded bone were completely excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed appropriately. The patient tolerated the surgical intervention well, and postoperative pain management was initiated. The excised specimen, comprising the cyst and eroded bone, was sent for pathological examination.

Operative Note 66:

A surgical intervention was performed for the excision of an other bursal cyst with severe bone pain. Under local anesthesia, a transverse incision was made over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed meticulously. The patient remained comfortable and cooperative during the surgical intervention. Postoperative pain management was initiated, and the excised cyst was sent for pathological examination.

Operative Note 67:

Patient underwent a surgical intervention for the excision of an other bursal cyst with bone erosion and severe bone pain. The procedure was performed under general anesthesia with increased dosage. An elliptical incision was made over the cyst, and meticulous dissection was carried out. The cyst and eroded bone were completely excised, providing relief from the severe bone pain. Hemostasis was achieved, and the wound was closed using

sutures. The patient tolerated the surgical intervention well, and postoperative pain management was initiated. The excised specimen, comprising the cyst and eroded bone, was sent for histopathological analysis.

Operative Note 68:

A surgical intervention was performed for the excision of an other bursal cyst with severe bone pain. Under regional anesthesia with conscious sedation, a curvilinear incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components and relieving the severe bone pain. Hemostasis was achieved, and the wound was closed meticulously. The patient remained stable throughout the surgical intervention, and postoperative pain management was initiated. The excised cyst was sent for histopathological examination.

Operative Note 69:

Patient underwent a surgical intervention for the excision of an other bursal cyst with bone erosion and severe bone pain. The procedure was performed under general anesthesia. A transverse incision was made over the cyst, and careful dissection was performed to remove the cyst completely. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the surgical intervention well, and postoperative pain management was initiated. The excised specimen, comprising the cyst and eroded bone, was sent for pathological examination.

Operative Note 70:

A surgical intervention was performed for the excision of an other bursal cyst with severe bone pain. Under local anesthesia with sedation, a curvilinear incision was made over the cyst, and meticulous dissection was carried out. The cyst was completely excised, ensuring the removal of all cystic components and relieving the severe bone pain. Hemostasis was achieved, and the wound was closed using sutures. The patient remained comfortable and cooperative during the surgical intervention. Postoperative pain management was initiated, and the excised cyst was sent for histopathological analysis.

Operative Note 71:

The patient presented with a severe infection on the extreme moving joint associated with an other bursal cyst. A surgical intervention was performed under general anesthesia. An oblique incision was made over the joint, and thorough debridement was carried out to remove infected tissues. The bursal cyst was excised completely. Copious irrigation with saline was done, and appropriate antibiotic irrigation was administered. The wound was left open for secondary intention healing. Postoperative instructions for wound care and antibiotic therapy were provided.

Operative Note 72:

A surgical intervention was performed for the treatment of a severe infection on the extreme moving joint with an associated other bursal cyst. Under regional anesthesia, an extended longitudinal incision was made over the joint, providing adequate exposure. The infected tissues were meticulously debrided, and the bursal cyst was excised completely. The joint was thoroughly irrigated with antibiotic solution. A drain was placed, and the wound was closed in layers. The patient was started on appropriate intravenous antibiotics and observed closely for signs of infection.

Operative Note 73:

Patient underwent a surgical intervention for the management of a severe infection on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia. A curvilinear incision was made over the joint, and extensive debridement was carried out to remove necrotic and infected tissues. The bursal cyst was excised completely. Copious irrigation with antibiotic solution was performed, and a drain was inserted. The wound was closed using sutures. Postoperative intravenous antibiotic therapy was initiated, and close monitoring for any signs of infection was ensured.

Operative Note 74:

A surgical intervention was performed for the treatment of a severe infection on the extreme moving joint in conjunction with an other bursal cyst. Under local anesthesia with sedation, a transverse incision was made over the joint, and meticulous debridement was performed to remove infected tissues. The bursal cyst was completely excised. Thorough irrigation with antibiotic solution was carried out, and a drain was placed. The wound was closed appropriately. The patient was started on oral antibiotic therapy and instructed for regular follow-up visits.

Operative Note 75:

Patient underwent a surgical intervention for the management of a severe infection on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia with reduced dosage. An elliptical incision was made over the joint, and meticulous debridement was carried out to remove infected tissues. The bursal cyst was excised completely. Copious irrigation with antibiotic solution was performed, and a drain was inserted. The wound was closed in layers. Postoperative intravenous antibiotic therapy was initiated, and the patient was monitored closely for any signs of infection.

Operative Note 76:

A surgical intervention was performed for the treatment of a severe infection on the extreme moving joint in association with an other bursal cyst. Under regional anesthesia with conscious sedation, a curvilinear incision was made over the joint, and thorough debridement was performed to remove infected tissues. The bursal cyst was completely excised. The joint was irrigated extensively with antibiotic solution, and a drain was placed. The wound was closed meticulously. Postoperative oral antibiotic therapy and close monitoring for signs of infection were initiated.

Operative Note 77:

Patient underwent a surgical intervention for the management of a severe infection on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia with increased dosage. A transverse incision was made over the joint, and meticulous debridement was carried out to remove infected tissues. The bursal cyst was excised completely. Thorough irrigation with antibiotic solution was performed, and a drain was placed. The wound was closed appropriately.

Postoperative intravenous antibiotic therapy was initiated, and the patient was closely monitored for any signs of infection.

Operative Note 78:

A surgical intervention was performed for the treatment of a severe infection on the extreme moving joint associated with an other bursal cyst. Under local anesthesia, a curvilinear incision was made directly over the joint, and thorough debridement was performed to remove infected tissues. The bursal cyst was completely excised. Copious irrigation with antibiotic solution was performed, and a drain was inserted. The wound was closed using sutures. Postoperative oral antibiotic therapy and regular follow-up visits were prescribed.

Operative Note 79:

Patient underwent a surgical intervention for the management of a severe infection on the extreme moving joint along with an other bursal cyst. The procedure was performed under regional anesthesia. An oblique incision was made over the joint, and meticulous debridement was carried out to remove infected tissues. The bursal cyst was excised completely. Thorough irrigation with antibiotic solution was performed, and a drain was placed. The wound was closed meticulously. Postoperative intravenous antibiotic therapy and close monitoring for any signs of infection were ensured.

Operative Note 80:

A surgical intervention was performed for the treatment of a severe infection on the extreme moving joint associated with an other bursal cyst. Under general anesthesia, a longitudinal incision was made over the joint, providing optimal exposure. Thorough debridement of infected tissues was performed, and the bursal cyst was excised completely. Copious irrigation with antibiotic solution was done, and a drain was inserted. The wound was closed in layers. The patient was started on intravenous antibiotic therapy and instructed for regular wound care. Close monitoring for any signs of infection was emphasized.

Operative Note 81:

The patient presented with a severe infection and inflammation on the extreme moving joint along with an other bursal cyst. A surgical intervention was performed under general anesthesia. An oblique incision was made over the joint, and thorough debridement was carried out to remove infected and inflamed tissues. The bursal cyst was excised completely. Copious irrigation with saline was done, and appropriate antibiotic irrigation was administered. The wound was left open for secondary intention healing. Postoperative instructions for wound care, antibiotic therapy, and anti-inflammatory medications were provided.

Operative Note 82:

A surgical intervention was performed for the treatment of a severe infection and intense inflammation on the extreme moving joint associated with an other bursal cyst. Under regional anesthesia, an extended longitudinal incision was made over the joint, providing adequate exposure. The infected and inflamed tissues were meticulously debrided, and the bursal cyst was excised completely. The joint was thoroughly irrigated with saline solution. A drain was placed, and the wound was closed in layers. The patient was started on appropriate intravenous antibiotics, anti-inflammatory medication, and observed closely for signs of infection and inflammation.

Operative Note 83:

Patient underwent a surgical intervention for the management of a severe infection and significant inflammation on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia. A curvilinear incision was made over the joint, and extensive debridement was carried out to remove necrotic, infected, and inflamed tissues. The bursal cyst was excised completely. Copious irrigation with saline solution was performed, and a drain was inserted. The wound was closed using sutures. Postoperative intravenous antibiotic therapy, anti-inflammatory medication, and close monitoring for any signs of infection and inflammation were initiated.

Operative Note 84:

A surgical intervention was performed for the treatment of a severe infection and pronounced inflammation on the extreme moving joint in conjunction with an other bursal cyst. Under local anesthesia with sedation, a transverse incision was made over the joint, and meticulous debridement was performed to remove infected and inflamed tissues. The bursal cyst was completely excised. Thorough irrigation with saline solution was carried out, and a drain was placed. The wound was closed appropriately. The patient was started on oral antibiotic therapy, anti-inflammatory medication, and instructed for regular follow-up visits.

Operative Note 85:

Patient underwent a surgical intervention for the management of a severe infection and severe inflammation on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia with reduced dosage. An elliptical incision was made over the joint, and meticulous debridement was carried out to remove infected and inflamed tissues. The bursal cyst was completely excised. Copious irrigation with saline solution was performed, and a drain was inserted. The wound was closed in layers. Postoperative intravenous antibiotic therapy, anti-inflammatory medication, and close monitoring for any signs of infection and inflammation were initiated.

Operative Note 86:

A surgical intervention was performed for the treatment of a severe infection and significant inflammation on the extreme moving joint in association with an other bursal cyst. Under regional anesthesia with conscious sedation, a curvilinear incision was made over the joint, and thorough debridement was performed to remove infected and inflamed tissues. The bursal cyst was completely excised. The joint was irrigated extensively with saline solution, and a drain was placed. The wound was closed meticulously. Postoperative oral antibiotic therapy, anti-inflammatory medication, and close monitoring for signs of infection and inflammation were initiated.

Operative Note 87:

Patient underwent a surgical intervention for the management of a severe infection and pronounced inflammation on the extreme moving joint along with an

other bursal cyst. The procedure was performed under general anesthesia with increased dosage. A transverse incision was made over the joint, and meticulous debridement was carried out to remove infected and inflamed tissues. The bursal cyst was completely excised. Thorough irrigation with saline solution was performed, and a drain was placed. The wound was closed appropriately. Postoperative intravenous antibiotic therapy, anti-inflammatory medication, and close monitoring for any signs of infection and inflammation were initiated.

Operative Note 88:

A surgical intervention was performed for the treatment of a severe infection and intense inflammation on the extreme moving joint associated with an other bursal cyst. Under local anesthesia, a curvilinear incision was made directly over the joint, and thorough debridement was performed to remove infected and inflamed tissues. The bursal cyst was completely excised. Copious irrigation with saline solution was performed, and a drain was inserted. The wound was closed using sutures. Postoperative oral antibiotic therapy, anti-inflammatory medication, and regular follow-up visits were prescribed.

Operative Note 89:

Patient underwent a surgical intervention for the management of a severe infection and significant inflammation on the extreme moving joint along with an other bursal cyst. The procedure was performed under regional anesthesia. An oblique incision was made over the joint, and meticulous debridement was carried out to remove infected and inflamed tissues. The bursal cyst was completely excised. Thorough irrigation with saline solution was performed, and a drain was placed. The wound was closed meticulously. Postoperative intravenous antibiotic therapy, anti-inflammatory medication, and close monitoring for any signs of infection and inflammation were ensured.

Operative Note 90:

A surgical intervention was performed for the treatment of a severe infection and pronounced inflammation on the extreme moving joint associated with an other bursal cyst. Under general anesthesia, a longitudinal incision was made over the joint, providing optimal exposure. Thorough debridement of infected and inflamed tissues was performed, and the bursal cyst was excised completely. Copious irrigation with saline solution was done, and a drain was inserted. The wound was closed in layers. The patient was started on intravenous antibiotic therapy, anti-inflammatory medication, and instructed for regular wound care. Close monitoring for any signs of infection and inflammation was emphasized.

Operative Note 91:

The patient presented with a severe infection and inflammation on the extreme moving joint associated with an other bursal cyst. A surgical intervention was performed under general anesthesia. An oblique incision was made over the joint, and thorough debridement was carried out to remove infected and inflamed tissues. The bursal cyst was excised completely. Copious irrigation with saline was done, and appropriate antibiotic irrigation was administered. The wound was closed, and postoperative instructions for wound care and pain management were provided. Follow-up visits will be scheduled based on the severity of the infection and the patient's response to treatment.

Operative Note 92:

A surgical intervention was performed for the treatment of a severe infection and intense inflammation on the extreme moving joint along with an other bursal cyst. Under regional anesthesia, an extended longitudinal incision was made over the joint, providing adequate exposure. The infected and inflamed tissues were meticulously debrided, and the bursal cyst was excised completely. The joint was thoroughly irrigated with saline solution. A drain was placed, and the wound was closed in layers. Postoperative instructions for wound care, antibiotic therapy, and pain management were given. Follow-up visits will be scheduled based on the severity of the inflammation and the patient's response to treatment.

Operative Note 93:

Patient underwent a surgical intervention for the management of a severe infection and significant inflammation on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia. A curvilinear incision was made over the joint, and extensive debridement was carried out to remove necrotic, infected, and inflamed tissues. The bursal cyst was excised completely. Copious irrigation with saline solution was performed, and a drain was inserted. The wound was closed using sutures. Postoperative instructions for wound care, antibiotic therapy, pain management, and follow-up visits were provided, with the frequency determined by the severity of the infection and inflammation.

Operative Note 94:

A surgical intervention was performed for the treatment of a severe infection and pronounced inflammation on the extreme moving joint in conjunction with an other bursal cyst. Under local anesthesia with sedation, a transverse incision was made over the joint, and meticulous debridement was performed to remove infected and inflamed tissues. The bursal cyst was completely excised. Thorough irrigation with saline solution was carried out, and a drain was placed. The wound was closed appropriately. Postoperative instructions for wound care, oral antibiotic therapy, pain management, and follow-up visits were given, with the frequency determined by the severity of the infection and inflammation.

Operative Note 95:

Patient underwent a surgical intervention for the management of a severe infection and severe inflammation on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia with reduced dosage. An elliptical incision was made over the joint, and meticulous debridement was carried out to remove infected and inflamed tissues. The bursal cyst was completely excised. Copious irrigation with saline solution was performed, and a drain was inserted. The wound was closed in layers. Postoperative instructions for wound care, intravenous antibiotic therapy, pain management, and follow-up visits were provided, with the frequency determined by the severity of the infection and inflammation.

Operative Note 96:

A surgical intervention was performed for the treatment of a severe infection and significant inflammation on the extreme moving joint in association with an other bursal cyst. Under regional anesthesia with conscious sedation, a curvilinear incision was made over the joint, and thorough debridement was performed to remove infected and inflamed tissues. The bursal cyst was completely excised. The joint was irrigated extensively with saline solution, and a drain was placed

. The wound was closed meticulously. Postoperative instructions for wound care, oral antibiotic therapy, pain management, and follow-up visits were given, with the frequency determined by the severity of the infection and inflammation.

Operative Note 97:

Patient underwent a surgical intervention for the management of a severe infection and pronounced inflammation on the extreme moving joint along with an other bursal cyst. The procedure was performed under general anesthesia with increased dosage. A transverse incision was made over the joint, and meticulous debridement was carried out to remove infected and inflamed tissues. The bursal cyst was completely excised. Thorough irrigation with saline solution was performed, and a drain was placed. The wound was closed appropriately. Postoperative instructions for wound care, intravenous antibiotic therapy, pain management, and follow-up visits were provided, with the frequency determined by the severity of the infection and inflammation.

Operative Note 98:

A surgical intervention was performed for the treatment of a severe infection and intense inflammation on the extreme moving joint associated with an other bursal cyst. Under local anesthesia, a curvilinear incision was made directly over the joint, and thorough debridement was performed to remove infected and inflamed tissues. The bursal cyst was completely excised. Copious irrigation with saline solution was performed, and a drain was inserted. The wound was closed using sutures. Postoperative instructions for wound care, oral antibiotic therapy, pain management, and follow-up visits were prescribed, with the frequency determined by the severity of the infection and inflammation.

Operative Note 99:

Patient underwent a surgical intervention for the management of a severe infection and significant inflammation on the extreme moving joint along with an other bursal cyst. The procedure was performed under regional anesthesia. An oblique incision was made over the joint, and meticulous debridement was carried out to remove infected and inflamed tissues. The bursal cyst was completely excised. Thorough irrigation with saline solution was performed, and a drain was placed. The wound was closed meticulously. Postoperative instructions for wound care, intravenous antibiotic therapy, pain management, and follow-up visits were initiated, with the frequency determined by the severity of the infection and inflammation.

Operative Note 100:

A surgical intervention was performed for the treatment of a severe infection and pronounced inflammation on the extreme moving joint associated with an other bursal cyst. Under general anesthesia, a longitudinal incision was made over the joint, providing optimal exposure. Thorough debridement of infected and inflamed tissues was performed, and the bursal cyst was excised completely. Copious irrigation with saline solution was done, and a drain was inserted. The wound was closed in layers. The patient was started on intravenous antibiotic therapy, pain management, and instructed for regular wound care. Follow-up visits will be scheduled based on the severity of the infection and inflammation, and the patient's response to treatment.

## M71.4 Calcium deposit in bursa

1. Patient underwent a minimally invasive arthroscopic procedure to remove a calcium deposit in the bursa. The bursa was accessed using two small incisions, and the deposit was carefully extracted using specialized instruments. The procedure was successful, and the patient was advised to follow postoperative instructions for optimal recovery.

2. A calcium deposit in the bursa was addressed through an open surgical approach. A longitudinal incision was made over the affected area, and the deposit was meticulously excised. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided to the patient to ensure proper healing and rehabilitation.

3. In this operative note, a calcium deposit in the bursa was treated using ultrasound-guided needle aspiration. The bursal fluid containing the deposit was aspirated under sterile conditions, and the procedure was performed with precision. The patient experienced minimal discomfort, and post-procedure instructions were given for a smooth recovery.

4. Patient underwent a percutaneous ultrasound-guided lavage procedure for a calcium deposit in the bursa. A small incision was made, and a lavage catheter was introduced under ultrasound guidance. Saline solution was used to flush out the deposit, and the area was thoroughly irrigated. The patient tolerated the procedure well and was discharged with postoperative care instructions.

5. A calcium deposit in the bursa was treated with extracorporeal shock wave therapy (ESWT). The affected area was identified using imaging guidance, and shock waves were delivered to the deposit. The therapy was well-tolerated, and the patient was advised to follow post-treatment instructions for optimal results.

6. Patient underwent a minimally invasive endoscopic procedure to address a calcium deposit in the bursa. Through small incisions, an endoscope was inserted to visualize the affected area. The deposit was then carefully fragmented and removed using specialized instruments. The procedure was successful, and the patient was instructed regarding postoperative care.

7. A calcium deposit in the bursa was treated using ultrasound-guided percutaneous needling and lavage. Under sterile conditions, a needle was introduced into the deposit, and lavage was performed to disintegrate and flush out the calcium deposit. The procedure was well-tolerated, and the patient was discharged with post-procedure care instructions.

8. In this operative note, a calcium deposit in the bursa was managed through a corticosteroid injection. Under ultrasound guidance, the injection was carefully administered into the bursa to reduce inflammation and dissolve the deposit. The patient experienced immediate relief, and post-injection instructions were given for follow-up care.

9. Patient underwent an open bursectomy procedure to address a calcium deposit in the bursa. An incision was made over the affected area, and the bursa was carefully dissected and excised. The deposit was removed, and meticulous hemostasis was achieved. The wound was closed in layers, and the patient was provided with postoperative care instructions.

10. A calcium deposit in the bursa was addressed through a minimally invasive percutaneous ultrasound-guided aspiration and lavage procedure. The deposit was aspirated using a fine needle, and lavage was performed to remove any remaining particles. The patient tolerated the procedure well and was discharged with post-procedure instructions for recovery.

1. Patient underwent an arthroscopic debridement procedure to address a calcium deposit in the bursa. Through small incisions, a surgical camera and instruments were inserted to visualize and remove the deposit. The affected area was thoroughly cleaned, and the bursa was irrigated. The patient was given postoperative instructions for a smooth recovery.

2. A calcium deposit in the bursa was managed through a minimally invasive ultrasound-guided aspiration and steroid injection. Under sterile conditions, the deposit was aspirated using a needle, followed by the injection of a corticosteroid to reduce inflammation. The patient experienced immediate relief, and post-procedure care was discussed.

3. Patient underwent a minimally invasive extracorporeal shock wave lithotripsy (ESWL) procedure to treat a calcium deposit in the bursa. Shock waves were focused on the deposit, fragmenting it into smaller pieces that could be reabsorbed by the body. The patient tolerated the procedure well and was advised on post-ESWL care.

4. In this operative note, a calcium deposit in the bursa was addressed through a combination of arthroscopic debridement and lavage. The deposit was carefully removed using specialized instruments, and the area was thoroughly irrigated to ensure complete removal. The patient was provided with postoperative instructions for optimal recovery.

5. Patient underwent an open bursectomy with calcium deposit excision procedure to alleviate symptoms. An incision was made, and the bursa was excised along with the deposit. Hemostasis was achieved, and the wound was closed using sutures. Postoperative care instructions were given to the patient.

6. A calcium deposit in the bursa was treated with a minimally invasive ultrasound-guided percutaneous needle fenestration. The deposit was punctured using a needle, allowing the release of its contents and reducing its size. The patient experienced relief, and post-procedure care was discussed.

7. Patient underwent an endoscopic bursectomy procedure with calcium deposit removal. An endoscope was inserted through small incisions, providing visualization and access to the bursa. The deposit was meticulously dissected and removed using specialized instruments. The patient received postoperative instructions for a smooth recovery.

8. A calcium deposit in the bursa was addressed through ultrasound-guided barbotage. Under sterile conditions, a needle was inserted into the deposit, and a saline solution was injected and withdrawn to dislodge and remove the deposit. The patient tolerated the procedure well and was discharged with post-procedure care instructions.

9. Patient underwent a percutaneous needle aspiration with lavage procedure to manage a calcium deposit in the bursa. Using ultrasound guidance, the deposit was aspirated with a needle, followed by a thorough lavage to flush out any remaining particles. The patient was provided with post-procedure instructions for recovery.

10. In this operative note, a calcium deposit in the bursa was treated using a minimally invasive ultrasound-guided needle fragmentation technique. The deposit was fragmented into smaller pieces using a needle, facilitating its absorption by the body. The patient experienced relief, and post-procedure care was discussed.

1. Patient underwent a minimally invasive arthroscopic procedure with local anesthesia to remove a calcium deposit in the bursa. The bursa was accessed using two small incisions, and the deposit was carefully extracted. The patient remained conscious throughout the procedure, experiencing minimal discomfort. Postoperative instructions were provided for optimal recovery.

2. A calcium deposit in the bursa was addressed through an open surgical approach under general anesthesia. A longitudinal incision was made over the affected area, and the deposit was meticulously excised. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were given to the patient to ensure proper healing and rehabilitation.

3. In this operative note, a calcium deposit in the bursa was treated using ultrasound-guided needle aspiration with local anesthesia. The bursal fluid containing the deposit was aspirated under sterile conditions, and the procedure was performed with precision. The patient experienced minimal discomfort, and post-procedure instructions were given for a smooth recovery.

4. Patient underwent a percutaneous ultrasound-guided lavage procedure with regional anesthesia for a calcium deposit in the bursa. A small incision was made, and a lavage catheter was introduced under ultrasound guidance. Saline solution was used to flush out the deposit, and the area was thoroughly irrigated. The patient tolerated the procedure well and was discharged with postoperative care instructions.

5. A calcium deposit in the bursa was treated with extracorporeal shock wave therapy (ESWT) under conscious sedation. The affected area was identified using imaging guidance, and shock waves were delivered to the deposit. The therapy was well-tolerated, and the patient was advised to follow post-treatment instructions for optimal results.

6. Patient underwent a minimally invasive endoscopic procedure with general anesthesia to address a calcium deposit in the bursa. Through small incisions, an endoscope was inserted to visualize the affected area. The deposit was then carefully fragmented and removed using specialized instruments. The procedure was successful, and the patient was instructed regarding postoperative care.

7. A calcium deposit in the bursa was treated using ultrasound-guided percutaneous needling and lavage with spinal anesthesia. Under sterile conditions, a needle was introduced into the deposit, and lavage was performed to disintegrate and flush out the calcium deposit. The procedure was well-tolerated, and the patient was discharged with post-procedure care instructions.

8. In this operative note, a calcium deposit in the bursa was managed through a corticosteroid injection with local anesthesia. Under ultrasound guidance, the injection was carefully administered into the bursa to reduce inflammation and dissolve the deposit. The patient experienced immediate relief, and post-injection instructions were given for follow-up care.

9. Patient underwent an open bursectomy procedure with general anesthesia to address a calcium deposit in the bursa. An incision was made over the affected area, and the bursa was carefully dissected and excised. The deposit was removed, and meticulous hemostasis was achieved. The wound was closed in layers, and the patient was provided with postoperative care instructions.

10. A calcium deposit in the bursa was addressed through a minimally invasive percutaneous ultrasound-guided aspiration and lavage procedure with conscious sedation. The deposit was aspirated using a fine needle, and lavage was performed to remove any remaining particles. The patient tolerated the procedure well and was discharged with post-procedure instructions for recovery.

1. Patient underwent an arthroscopic procedure with local anesthesia to address a calcium deposit in the bursa with associated bone erosion. The bursa was accessed through small incisions, and the deposit was meticulously removed. Additionally, bone debridement was performed to address the erosion. Postoperative instructions were provided to ensure proper healing and rehabilitation.

2. A calcium deposit in the bursa with bone erosion was managed through an open surgical approach under general anesthesia. An incision was made over the affected area, and the deposit, as well as the eroded bone, were carefully excised. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were given for optimal recovery.

3. In this operative note, a calcium deposit in the bursa with bone erosion was treated using ultrasound-guided needle aspiration with local anesthesia. The deposit was aspirated under sterile conditions, and the procedure was performed with precision. Additionally, the eroded bone was addressed through debridement. Post-procedure instructions were given for a smooth recovery.

4. Patient underwent a percutaneous ultrasound-guided lavage procedure with regional anesthesia to treat a calcium deposit in the bursa with bone erosion. A small incision was made, and a lavage catheter was introduced under ultrasound guidance. The deposit was flushed out, and the eroded bone was addressed through debridement. The patient tolerated the procedure well and was discharged with postoperative care instructions.

5. A calcium deposit in the bursa with associated bone erosion was treated with extracorporeal shock wave therapy (ESWT) under conscious sedation. Shock waves were delivered to the deposit and the eroded bone to stimulate healing and regeneration. The therapy was well-tolerated, and the patient was advised to follow post-treatment instructions for optimal results.

6. Patient underwent a minimally invasive endoscopic procedure with general anesthesia to address a calcium deposit in the bursa with bone erosion. Through small incisions, an endoscope was inserted to visualize the affected area. The deposit was carefully removed, and bone debridement was performed to address the erosion. Postoperative care instructions were provided.

7. A calcium deposit in the bursa with bone erosion was treated using ultrasound-guided percutaneous needling and lavage with spinal anesthesia. The deposit was punctured, and the bursal fluid, along with the eroded bone particles, were flushed out through lavage. The procedure was well-tolerated, and the patient was discharged with post-procedure care instructions.

8. In this operative note, a calcium deposit in the bursa with bone erosion was managed through a corticosteroid injection with local anesthesia. The injection was carefully administered into the bursa to reduce inflammation and dissolve the deposit, and bone debridement was performed to address the erosion. The patient experienced relief, and post-injection instructions were given for follow-up care.

9. Patient underwent an open bursectomy procedure with general anesthesia to address a calcium deposit in the bursa with bone erosion. An incision was made over the affected area, and the bursa, along with the deposit and eroded bone, were carefully dissected and excised. Meticulous hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were provided.

10. A calcium deposit in the bursa with bone erosion was addressed through a minimally invasive percutaneous ultrasound-guided aspiration and lavage procedure with conscious sedation. The deposit was aspirated using a fine needle, and lavage was performed to remove any remaining particles. Additionally, bone debridement was performed to address the erosion. The patient tolerated the procedure well and was discharged with post-procedure instructions

for recovery.

1. Patient underwent an arthroscopic procedure with local anesthesia to address a calcium deposit in the bursa with severe bone pain. The deposit was meticulously removed, and the surrounding area was thoroughly inspected. Postoperative pain management strategies were discussed with the patient to ensure relief during the recovery period.

2. A calcium deposit in the bursa with severe bone pain was managed through an open surgical approach under general anesthesia. The deposit was carefully excised, and the eroded bone was addressed through debridement. Pain control measures, including medication and physical therapy, were discussed with the patient for optimal pain management.

3. In this operative note, a calcium deposit in the bursa with severe bone pain was treated using ultrasound-guided needle aspiration with local anesthesia. The deposit was aspirated, and the procedure was performed with precision. Adequate pain management strategies, such as medication and physical therapy, were discussed with the patient post-procedure.

4. Patient underwent a percutaneous ultrasound-guided lavage procedure with regional anesthesia to treat a calcium deposit in the bursa with severe bone pain. The deposit was thoroughly flushed out, and the eroded bone was addressed through debridement. Pain control measures, including medication and rehabilitation exercises, were discussed with the patient.

5. A calcium deposit in the bursa with severe bone pain was treated with extracorporeal shock wave therapy (ESWT) under conscious sedation. The shock waves were targeted at the deposit and the affected bone area to alleviate pain and stimulate healing. Post-treatment pain management strategies were discussed with the patient.

6. Patient underwent a minimally invasive endoscopic procedure with general anesthesia to address a calcium deposit in the bursa with severe bone pain. The deposit was carefully removed, and bone debridement was performed to address the eroded bone. A comprehensive pain management plan, including medication and physical therapy, was discussed with the patient.

7. A calcium deposit in the bursa with severe bone pain was treated using ultrasound-guided percutaneous needling and lavage with spinal anesthesia. The deposit was punctured, and the bursal fluid, along with the eroded bone particles, were flushed out through lavage. Effective pain control measures were discussed with the patient post-procedure.

8. In this operative note, a calcium deposit in the bursa with severe bone pain was managed through a corticosteroid injection with local anesthesia. The injection was carefully administered into the bursa to reduce inflammation and dissolve the deposit. Adequate pain management strategies, such as medication and physical therapy, were discussed with the patient.

9. Patient underwent an open bursectomy procedure with general anesthesia to address a calcium deposit in the bursa with severe bone pain. The deposit, as well as the eroded bone, were meticulously excised. Pain control measures, including medication and rehabilitation exercises, were discussed with the patient to ensure comfort during the recovery period.

10. A calcium deposit in the bursa with severe bone pain was addressed through a minimally invasive percutaneous ultrasound-guided aspiration and lavage procedure with conscious sedation. The deposit was aspirated, and the affected area was lavaged to remove any remaining particles. A comprehensive pain management plan, including medication and physical therapy, was discussed with the patient for optimal pain relief.

1. Patient underwent a surgical intervention, specifically an arthroscopic excision, to address a calcium deposit in the bursa with severe bone pain. The deposit was meticulously removed using specialized instruments, and the affected area was thoroughly inspected. Postoperative pain management strategies were discussed to ensure a comfortable recovery.

2. A surgical intervention, namely an open bursectomy, was performed under general anesthesia to treat a calcium deposit in the bursa associated with severe bone pain. An incision was made over the affected area, and the deposit, along with the eroded bone, was carefully excised. The wound was closed with sutures, and postoperative pain control measures were discussed with the patient.

3. In this operative note, a calcium deposit in the bursa with severe bone pain was addressed through a surgical intervention called ultrasound-guided needle aspiration and lavage. The deposit was aspirated, and thorough lavage was performed to remove any remaining particles. Adequate pain management strategies were discussed with the patient post-procedure.

4. Patient underwent a surgical intervention, specifically an arthroscopic debridement, to manage a calcium deposit in the bursa associated with severe bone pain. The deposit was meticulously debrided using specialized instruments, and the surrounding area was thoroughly irrigated. Postoperative pain control measures were discussed to ensure a smooth recovery.

5. A surgical intervention, an open bone grafting procedure, was performed under general anesthesia to address a calcium deposit in the bursa with severe bone pain and erosion. The deposit was meticulously excised, and bone grafts were inserted to promote healing and restore the affected area. Postoperative pain management strategies were discussed with the patient.

6. In this operative note, a surgical intervention called endoscopic calcific deposit removal was performed to treat a calcium deposit in the bursa with severe bone pain. An endoscope was inserted through small incisions, allowing visualization and removal of the deposit. The procedure was successful, and postoperative pain control measures were discussed with the patient.

7. Patient underwent a surgical intervention, specifically an open resection, to manage a calcium deposit in the bursa with severe bone pain. The deposit, along with the eroded bone, was meticulously resected, and thorough hemostasis was achieved. The wound was closed with sutures, and postoperative pain management strategies were discussed.

8. A surgical intervention, an arthroscopic lavage and curettage, was performed under general anesthesia to treat a calcium deposit in the bursa with severe bone pain. The deposit was thoroughly lavaged to remove any loose particles, followed by careful curettage of the affected area. Postoperative pain control measures were discussed with the patient.

9. In this operative note, a surgical intervention known as extracorporeal shock wave lithotripsy (ESWL) was performed to manage a calcium deposit in the bursa with severe bone pain. Shock waves were focused on the deposit, fragmenting it into smaller pieces that could be reabsorbed by the body. The patient was provided with postoperative pain management instructions.

10. Patient underwent a surgical intervention, specifically an open bone grafting with excision, to address a calcium deposit in the bursa with severe bone pain. The deposit was meticulously excised, and bone grafts were placed to promote healing and restore the affected area. Postoperative pain control measures, including medication and physical therapy, were discussed with the patient.

1. A surgical intervention, an open debridement and repair, was performed under general anesthesia to address a calcium deposit in the bursa with severe bone pain. The deposit was carefully excised, and the eroded bone was meticulously debrided. Repair of the affected area was carried out using sutures and other appropriate techniques. Postoperative pain management strategies were discussed with the patient.

2. Patient underwent a surgical intervention, specifically an arthroscopic microfracture procedure, to treat a calcium deposit in the bursa with severe bone pain and erosion. Microfracture was performed to stimulate the formation of new cartilage in the affected area. The deposit was also meticulously removed. Postoperative pain control measures were discussed for the patient's comfort.

3. In this operative note, a surgical intervention called open reduction and internal fixation (ORIF) was performed to manage a calcium deposit in the bursa with severe bone pain. The deposit was carefully excised, and the fractured bone fragments were aligned and fixed with plates, screws, or other appropriate devices. Postoperative pain management strategies were discussed with the patient.

4. Patient underwent a surgical intervention, specifically a bursectomy with arthroscopic debridement, to address a calcium deposit in the bursa with severe bone pain. The bursa was carefully excised, and the deposit and eroded bone were meticulously debrided. Postoperative pain control measures, including medication and physical therapy, were discussed with the patient.

5. A surgical intervention, an open osteotomy, was performed under general anesthesia to treat a calcium deposit in the bursa with severe bone pain and erosion. The deposit was meticulously excised, and a corrective osteotomy was performed to realign the affected bone. Postoperative pain management strategies were discussed with the patient.

6. In this operative note, a surgical intervention known as arthroscopic subacromial decompression was performed to manage a calcium deposit in the bursa with severe bone pain. The deposit was meticulously removed, and the subacromial space was decompressed to relieve pressure on the affected area. Postoperative pain control measures were discussed with the patient.

7. Patient underwent a surgical intervention, specifically a bursal excision with bone grafting, to address a calcium deposit in the bursa with severe bone pain and erosion. The bursa, along with the deposit, was meticulously excised, and a bone graft was placed to facilitate healing and restore the affected area. Postoperative pain management strategies were discussed.

8. A surgical intervention, an open excision and curettage, was performed under general anesthesia to treat a calcium deposit in the bursa with severe bone pain. The deposit was carefully excised, and the affected area was thoroughly curetted to remove any remaining particles. Postoperative pain control measures were discussed with the patient.

9. In this operative note, a surgical intervention called arthroscopic acromioplasty was performed to manage a calcium deposit in the bursa with severe bone pain. The deposit was meticulously removed, and the acromion was reshaped to alleviate impingement on the affected area. Postoperative pain management strategies were discussed with the patient.

10. Patient underwent a surgical intervention, specifically an open resection with bone augmentation, to address a calcium deposit in the bursa with severe bone pain. The deposit was carefully excised, and bone augmentation techniques, such as bone grafting or synthetic bone substitutes, were employed to restore the affected area. Postoperative pain control measures were discussed.

1. A surgical intervention, an emergency arthrotomy, was performed under general anesthesia to address a severe infection in the extreme moving joint associated with a calcium deposit. The joint was opened, and thorough debridement of infected tissues was performed. The calcium deposit was excised, and appropriate antibiotics were administered. Postoperative infection management strategies were discussed with the patient.

2. Patient underwent a surgical intervention, specifically a joint washout and debridement, to treat a severe infection in the extreme moving joint with a concomitant calcium deposit. The joint was thoroughly irrigated to remove infectious material, and debridement was performed to eliminate the deposit and infected tissues. Adequate antibiotic therapy and wound care instructions were provided for effective infection control.

3. In this operative note, a surgical intervention known as open drainage and excision was performed to manage a severe infection in the extreme moving joint with a calcium deposit. The joint was opened, and purulent material was drained. The deposit and infected tissues were excised, and appropriate antibiotics were administered. Postoperative infection control measures were discussed with the patient.

4. Patient underwent a surgical intervention, specifically a joint aspiration and lavage, to address a severe infection in the extreme moving joint with a concurrent calcium deposit. The joint was aspirated to remove infected fluid, followed by thorough lavage to flush out remaining contaminants. The deposit was excised, and appropriate antibiotic therapy was initiated. Postoperative infection management strategies were discussed.

5. A surgical intervention, an emergency arthroscopic debridement, was performed under general anesthesia to treat a severe infection in the extreme moving joint associated with a calcium deposit. Arthroscopic instruments were used to access and debride infected tissues, including the deposit. Postoperative infection control measures, such as antibiotic administration and wound care instructions, were provided.

6. In this operative note, a surgical intervention called open joint resection was performed to manage a severe infection in the extreme moving joint with a calcium deposit. The infected joint was opened, and extensive resection of infected tissues, including the deposit, was performed. Appropriate antibiotic therapy was initiated, and postoperative infection control strategies were discussed.

7. Patient underwent a surgical intervention, specifically an emergency joint irrigation and debridement, to address a severe infection in the extreme moving joint with a concomitant calcium deposit. The joint was thoroughly irrigated to remove infectious material, and debridement was performed to eliminate the deposit and infected tissues. Appropriate antibiotic therapy and postoperative infection management instructions were provided.

8. A surgical intervention, an open joint washout and excision, was performed under general anesthesia to treat a severe infection in the extreme moving joint with a concurrent calcium deposit. The joint was meticulously washed out to remove infected material, and the deposit, along with infected tissues, was excised. Postoperative infection control measures were discussed with the patient.

9. In this operative note, a surgical intervention known as arthroscopic lavage with deposit excision was performed to manage a severe infection in the extreme moving joint associated with a calcium deposit. The joint was irrigated to remove infected material, and the deposit was meticulously excised. Adequate antibiotic therapy and postoperative infection control strategies were discussed.

10. Patient underwent a surgical intervention, specifically an emergency joint exploration and debridement, to address a severe infection in the extreme moving joint with a calcium deposit. The joint was explored to identify and remove infected tissues, including the deposit. Appropriate antibiotic therapy was initiated, and postoperative infection management instructions were provided.

1. A surgical intervention, an arthroscopic synovectomy, was performed under general anesthesia to address severe inflammation in the extreme moving joint associated with a calcium deposit. The inflamed synovial tissue was meticulously excised, and the deposit was also removed. Postoperative anti-inflammatory measures and rehabilitation strategies were discussed with the patient.

2. Patient underwent a surgical intervention, specifically an open joint debridement and anti-inflammatory injection, to treat severe inflammation in the extreme moving joint with a concomitant calcium deposit. The joint was thoroughly debrided to remove inflamed tissues, and an anti-inflammatory medication was injected to alleviate the inflammation. Postoperative anti-inflammatory management strategies were discussed.

3. In this operative note, a surgical intervention called joint irrigation and corticosteroid injection was performed to manage severe inflammation in the extreme moving joint associated with a calcium deposit. The joint was irrigated to remove inflammatory substances, and a corticosteroid injection was administered for targeted anti-inflammatory effects. Postoperative anti-inflammatory measures were discussed with the patient.

4. Patient underwent a surgical intervention, specifically an arthroscopic lavage with anti-inflammatory medication application, to address severe inflammation in the extreme moving joint with a concurrent calcium deposit. The joint was lavaged to remove inflammatory debris, and an anti-inflammatory medication was applied to reduce inflammation. Postoperative anti-inflammatory management strategies were discussed.

5. A surgical intervention, an open joint exploration and inflammation control procedure, was performed under general anesthesia to treat severe inflammation in the extreme moving joint with a calcium deposit. The joint was explored to identify and address inflamed tissues, and appropriate anti-inflammatory measures were applied. Postoperative anti-inflammatory management strategies were discussed with the patient.

6. In this operative note, a surgical intervention known as joint aspiration with anti-inflammatory washout was performed to manage severe inflammation in the extreme moving joint associated with a calcium deposit. The joint was aspirated to remove inflammatory fluid, followed by a thorough washout with an anti-inflammatory solution. Postoperative anti-inflammatory measures were discussed with the patient.

7. Patient underwent a surgical intervention, specifically an open joint debridement with anti-inflammatory medication infiltration, to address severe inflammation in the extreme moving joint with a concurrent calcium deposit. The joint was meticulously debrided to remove inflamed tissues, and an anti-inflammatory medication was infiltrated to reduce inflammation. Postoperative anti-inflammatory management strategies were discussed.

8. A surgical intervention, an arthroscopic anti-inflammatory intervention, was performed under general anesthesia to treat severe inflammation in the extreme moving joint with a calcium deposit. The inflamed tissues were meticulously addressed using specialized arthroscopic techniques, and appropriate anti-inflammatory measures were applied. Postoperative anti-inflammatory management strategies were discussed.

9. In this operative note, a surgical intervention called open joint synovectomy with anti-inflammatory medication administration was performed to manage severe inflammation in the extreme moving joint associated with a calcium deposit. The synovial tissue was excised to eliminate inflammation, and an anti-inflammatory medication was administered for localized effect. Postoperative anti-inflammatory measures were discussed with the patient.

10. Patient underwent a surgical intervention, specifically an arthroscopic irrigation and anti-inflammatory medication injection, to address severe inflammation in the extreme moving joint with a calcium deposit. The joint was irrigated to remove inflammatory substances, and an anti-inflammatory medication was injected for targeted relief. Postoperative anti-inflammatory management strategies were discussed with the patient.

1. The patient's diagnosis of a calcium deposit in the bursa with severe inflammation requires close follow-up to monitor the response to conservative treatment, including pain management and physical therapy. If symptoms persist or worsen, surgical intervention may be considered.

2. Given the severity of the diagnosis, the patient will require frequent follow-up visits to assess the response to anti-inflammatory medications and physical therapy. If conservative measures prove ineffective, surgical intervention, such as arthroscopic debridement or excision, may be recommended.

3. The severity of the diagnosis necessitates regular follow-up appointments to evaluate the patient's response to prescribed anti-inflammatory medications and activity modifications. If symptoms persist or worsen, further imaging and potential surgical intervention may be indicated.

4. Due to the severity of the diagnosis, the patient will be closely monitored with follow-up visits to assess the response to anti-inflammatory medications, pain management strategies, and physical therapy. Surgical intervention may be considered if conservative treatment fails to provide adequate relief.

5. Given the severity of the diagnosis, the patient's follow-up plan includes regular evaluations to assess the effectiveness of prescribed medications, rest, and physical therapy. If the condition does not improve, surgical intervention, such as an arthroscopic procedure or joint washout, may be recommended.

6. The patient's severe diagnosis requires frequent follow-up appointments to evaluate the response to anti-inflammatory medications and activity modifications. If symptoms persist or worsen, further intervention, such as corticosteroid injections or surgical excision, may be considered.

7. Given the severity of the diagnosis, the patient's follow-up plan involves regular assessments to monitor the response to conservative measures, including pain management, physical therapy, and anti-inflammatory medications. If symptoms persist, a consultation with a specialist may be recommended for potential surgical intervention.

8. Due to the severity of the diagnosis, the patient's follow-up care includes regular evaluations to assess the response to prescribed medications, rest, and physical therapy. If the symptoms do not improve, further interventions, such as joint aspiration or surgical debridement, may be considered.

9. Given the severity of the diagnosis, the patient's follow-up plan involves close monitoring of symptoms and response to prescribed anti-inflammatory medications. If conservative treatment does not alleviate the symptoms, a consultation with a specialist to discuss surgical options may be necessary.

10. The patient's diagnosis of a severe calcium deposit in the bursa requires frequent follow-up visits to assess the response to anti-inflammatory medications and physical therapy. If the symptoms persist or worsen, further diagnostic evaluation and potential surgical intervention may be recommended.

## M71.5 Other bursitis, not elsewhere classified

Operative Note 1:

Patient underwent a surgical procedure for other bursitis. A longitudinal incision was made over the affected bursa. The bursa was exposed and excised, followed by meticulous hemostasis. The wound was closed in layers with absorbable sutures. The patient tolerated the procedure well and was transferred to the recovery area in stable condition. Postoperative instructions were provided, and follow-up was scheduled.

Operative Note 2:

Surgical intervention was performed for other bursitis. An oblique incision was made to access the affected bursa. The bursa was carefully dissected and completely excised. Hemostasis was achieved using electrocautery. Closure of the wound was achieved with absorbable sutures. The patient recovered uneventfully and was discharged with appropriate postoperative care instructions.

Operative Note 3:

Patient underwent surgical management for other bursitis. A curvilinear incision was made over the site of the bursa. The bursa was identified, dissected, and excised in its entirety. Hemostasis was achieved with bipolar electrocautery. The wound was closed in layers using absorbable sutures. The patient was extubated and transferred to the post-anesthesia care unit in stable condition.

Operative Note 4:

Surgical procedure was performed for other bursitis. A transverse incision was made to expose the affected bursa. The bursa was carefully dissected and excised, ensuring complete removal. Hemostasis was obtained using pressure and local hemostatic agents. The wound was closed with interrupted sutures. The patient was observed postoperatively and discharged with appropriate wound care instructions.

Operative Note 5:

Patient underwent surgical intervention for other bursitis. An elliptical incision was made over the affected bursa. The bursa was dissected, excised, and sent for pathological examination. Hemostasis was achieved using electrocautery. The wound was closed with subcuticular sutures. The patient recovered well and was discharged with follow-up instructions.

Operative Note 6:

Surgical management was performed for other bursitis. A midline incision was made to access the affected bursa. The bursa was carefully dissected, excised, and sent for histopathological analysis. Hemostasis was achieved using a combination of electrocautery and local hemostatic agents. The wound was closed with interrupted sutures. Postoperatively, the patient was stable and transferred to the surgical ward.

Operative Note 7:

Patient underwent surgical treatment for other bursitis. A longitudinal incision was made over the bursa. The bursa was identified, dissected, and excised, ensuring complete removal. Hemostasis was achieved using electrocautery. The wound was closed in layers with absorbable sutures. The patient recovered without complications and was discharged with appropriate postoperative care instructions.

Operative Note 8:

Surgical procedure was performed for other bursitis. A transverse incision was made over the site of the bursa. The bursa was carefully dissected, excised, and sent for pathological examination. Hemostasis was obtained using bipolar electrocautery. The wound was closed with interrupted sutures. The patient was monitored postoperatively and discharged in stable condition.

Operative Note 9:

Patient underwent surgical intervention for other bursitis. An oblique incision was made to access the affected bursa. The bursa was identified, dissected, and completely excised. Hemostasis was achieved using pressure and electrocautery. The wound was closed in layers using absorbable sutures

. The patient recovered well and was discharged with appropriate wound care instructions.

Operative Note 10:

Surgical management was performed for other bursitis. A curvilinear incision was made over the affected bursa. The bursa was carefully dissected, excised, and sent for pathological examination. Hemostasis was achieved with bipolar electrocautery. The wound was closed with subcuticular sutures. The patient was observed postoperatively and discharged with appropriate follow-up plans.

Operative Note 11:

Patient underwent surgical intervention for other bursitis. A transverse incision was made to expose the affected bursa. The bursa was carefully dissected and partially excised to alleviate symptoms. Hemostasis was achieved using local hemostatic agents. The wound was closed with adhesive strips. The patient tolerated the procedure well and was discharged with postoperative instructions and a follow-up appointment.

Operative Note 12:

Surgical procedure was performed for other bursitis. A midline incision was made over the site of the bursa. The bursa was identified, aspirated, and injected with a corticosteroid solution. Hemostasis was obtained using pressure. The wound was closed with adhesive skin closure strips. The patient experienced immediate relief and was discharged with appropriate post-procedure care instructions.

Operative Note 13:

Patient underwent surgical management for other bursitis. An oblique incision was made to access the affected bursa. The bursa was meticulously dissected, drained, and irrigated. A drain was placed for continuous drainage. The wound was closed with interrupted sutures. The patient was started on prophylactic antibiotics and transferred to the recovery area in stable condition.

Operative Note 14:

Surgical intervention was performed for other bursitis. A curvilinear incision was made over the affected bursa. The bursa was opened, and the inflamed tissue was debrided. The bursa was then irrigated with a saline solution. Hemostasis was achieved using electrocautery. The wound was closed in layers with absorbable sutures. The patient tolerated the procedure well and was discharged with appropriate instructions.

Operative Note 15:

Patient underwent surgical treatment for other bursitis. A longitudinal incision was made over the bursa. The bursa was identified, aspirated, and injected with a mixture of local anesthetic and corticosteroids. Hemostasis was achieved with pressure. The wound was closed with adhesive strips. The patient reported immediate relief and was discharged with post-injection care instructions.

Operative Note 16:

Surgical procedure was performed for other bursitis. A transverse incision was made to expose the affected bursa. The bursa was carefully dissected, drained, and irrigated with a sterile saline solution. A drain was placed for continuous drainage. The wound was closed with interrupted sutures. The patient was monitored postoperatively and discharged with appropriate wound care instructions.

Operative Note 17:

Patient underwent surgical intervention for other bursitis. An elliptical incision was made over the site of the bursa. The bursa was identified, aspirated, and injected with a combination of local anesthetic and corticosteroids. Hemostasis was achieved using pressure and bipolar electrocautery. The wound was closed with subcuticular sutures. The patient tolerated the procedure well and was discharged with post-injection precautions.

Operative Note 18:

Surgical management was performed for other bursitis. A midline incision was made to access the affected bursa. The bursa was carefully dissected, drained, and irrigated with a sterile saline solution. Hemostasis was achieved using electrocautery. The wound was closed with adhesive strips. The patient recovered without complications and was discharged with appropriate wound care instructions.

Operative Note 19:

Patient underwent surgical intervention for other bursitis. An oblique incision was made to access the affected bursa. The bursa was meticulously dissected, drained, and irrigated with antibiotic solution. Hemostasis was obtained using pressure and local hemostatic agents. The

wound was closed in layers with absorbable sutures. The patient was observed postoperatively and discharged with appropriate follow-up plans.

Operative Note 20:

Surgical procedure was performed for other bursitis. A curvilinear incision was made over the affected bursa. The bursa was opened, and the inflamed tissue was excised. The bursa was thoroughly irrigated with a saline solution. Hemostasis was achieved using electrocautery. The wound was closed with interrupted sutures. The patient tolerated the procedure well and was discharged with appropriate postoperative care instructions.

Operative Note 21:

Patient underwent surgical treatment for other bursitis under local anesthesia. A longitudinal incision was made over the bursa. The bursa was identified, dissected, and excised. Hemostasis was achieved using local hemostatic agents. The wound was closed with absorbable sutures. The patient remained comfortable throughout the procedure, and postoperative instructions were provided prior to discharge.

Operative Note 22:

Surgical intervention was performed for other bursitis under regional anesthesia. An oblique incision was made to access the affected bursa. The bursa was carefully dissected and partially excised. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with adhesive skin closure strips. The patient remained stable throughout the procedure and was transferred to the recovery area.

Operative Note 23:

Patient underwent surgical management for other bursitis under general anesthesia. A transverse incision was made over the site of the bursa. The bursa was identified, dissected, and completely excised. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient was extubated and transferred to the post-anesthesia care unit in stable condition.

Operative Note 24:

Surgical procedure was performed for other bursitis under monitored anesthesia care (MAC). A curvilinear incision was made over the affected bursa. The bursa was carefully dissected, drained, and irrigated. Hemostasis was achieved using local hemostatic agents. The wound was closed with adhesive strips. The patient remained comfortable and responsive throughout the procedure.

Operative Note 25:

Patient underwent surgical intervention for other bursitis under spinal anesthesia. An elliptical incision was made over the bursa. The bursa was identified, aspirated, and injected with a corticosteroid solution. Hemostasis was achieved using pressure. The wound was closed with absorbable sutures. The patient experienced adequate anesthesia and was transferred to the recovery area in a stable condition.

Operative Note 26:

Surgical management was performed for other bursitis under general anesthesia with light sedation. A midline incision was made to access the affected bursa. The bursa was carefully dissected, excised, and sent for pathological examination. Hemostasis was achieved using electrocautery. The wound was closed with subcuticular sutures. The patient maintained stable vital signs throughout the procedure.

Operative Note 27:

Patient underwent surgical treatment for other bursitis under local anesthesia with intravenous sedation. A longitudinal incision was made over the affected bursa. The bursa was identified, dissected, and excised. Hemostasis was achieved using local hemostatic agents. The wound was closed with absorbable sutures. The patient remained comfortable and cooperative throughout the procedure.

Operative Note 28:

Surgical intervention was performed for other bursitis under general anesthesia with deep sedation. An oblique incision was made to access the affected bursa. The bursa was carefully dissected and partially excised. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with adhesive skin closure strips. The patient maintained stable hemodynamics throughout the procedure.

Operative Note 29:

Patient underwent surgical management for other bursitis under regional anesthesia with conscious sedation. A transverse incision was made over the site of the bursa. The bursa was identified, dissected, and completely excised. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient

remained responsive and comfortable throughout the procedure.

Operative Note 30:

Surgical procedure was performed for other bursitis under general anesthesia with moderate sedation. A curvilinear incision was made over the affected bursa. The bursa was carefully dissected, drained, and irrigated. Hemostasis was achieved using local hemostatic agents. The wound was closed with adhesive strips. The patient maintained stable vital signs and adequate depth of sedation throughout the procedure.

Operative Note 31:

Patient underwent surgical treatment for other bursitis with associated bone erosion. A longitudinal incision was made over the bursa. The bursa and the eroded bone were identified and excised. Meticulous hemostasis was achieved using electrocautery and bone wax. The wound was closed in layers with absorbable sutures. The patient tolerated the procedure well and was transferred to the recovery area for postoperative monitoring.

Operative Note 32:

Surgical intervention was performed for other bursitis with significant bone erosion. An oblique incision was made to access the affected bursa and the eroded bone. The bursa and bone were carefully excised, ensuring complete removal. Hemostasis was achieved using bone wax and local hemostatic agents. The wound was closed with interrupted sutures. The patient's postoperative recovery was uneventful, and appropriate follow-up was arranged.

Operative Note 33:

Patient underwent surgical management for other bursitis with evident bone erosion. A transverse incision was made over the site of the bursa and the eroded bone. The bursa and bone were excised, and meticulous hemostasis was obtained using bone wax and bipolar electrocautery. The wound was closed with subcuticular sutures. The patient recovered well from the procedure and was discharged with postoperative care instructions.

Operative Note 34:

Surgical procedure was performed for other bursitis with associated bone erosion. A curvilinear incision was made over the affected bursa and the eroded bone. The bursa and bone were carefully dissected, excised, and sent for pathological examination. Hemostasis was achieved using bone wax and pressure. The wound was closed with interrupted sutures. The patient's condition remained stable throughout the procedure, and appropriate postoperative management was initiated.

Operative Note 35:

Patient underwent surgical intervention for other bursitis with bone erosion. An elliptical incision was made over the bursa and the eroded bone. The bursa and bone were identified, carefully excised, and sent for histopathological analysis. Hemostasis was achieved using bone wax and electrocautery. The wound was closed in layers with absorbable sutures. The patient's recovery was uneventful, and follow-up was scheduled.

Operative Note 36:

Surgical management was performed for other bursitis with bone erosion. A midline incision was made to access the affected bursa and the eroded bone. The bursa and bone were meticulously excised, ensuring complete removal. Hemostasis was achieved using bone wax and local hemostatic agents. The wound was closed with adhesive skin closure strips. The patient's condition remained stable throughout the procedure, and appropriate postoperative instructions were provided.

Operative Note 37:

Patient underwent surgical treatment for other bursitis with bone erosion. A longitudinal incision was made over the affected bursa and the eroded bone. The bursa and bone were identified, excised, and sent for pathological examination. Hemostasis was achieved using bone wax and pressure. The wound was closed with absorbable sutures. The patient tolerated the procedure well and was transferred to the recovery area for further monitoring.

Operative Note 38:

Surgical intervention was performed for other bursitis with significant bone erosion. An oblique incision was made to access the affected bursa and the eroded bone. The bursa and bone were carefully excised, ensuring complete removal. Hemostasis was achieved using bone wax and bipolar electrocautery. The wound was closed with subcuticular sutures. The patient's recovery was uncomplicated, and

appropriate postoperative care was provided.

Operative Note 39:

Patient underwent surgical management for other bursitis with evident bone erosion. A transverse incision was made over the site of the bursa and the eroded bone. The bursa and bone were excised, and meticulous hemostasis was obtained using bone wax and local hemostatic agents. The wound was closed with interrupted sutures. The patient's postoperative course was smooth, and they were discharged with appropriate instructions.

Operative Note 40:

Surgical procedure was performed for other bursitis with associated bone erosion. A curvilinear incision was made over the affected bursa and the eroded bone. The bursa and bone were carefully dissected, excised, and sent for pathological examination. Hemostasis was achieved using bone wax and pressure. The wound was closed with adhesive strips. The patient's condition remained stable throughout the procedure, and appropriate postoperative care was administered.

Operative Note 41:

Patient underwent surgical treatment for other bursitis with severe bone pain. A longitudinal incision was made over the bursa and the affected bone. The bursa and bone were meticulously excised, ensuring complete removal. Hemostasis was achieved using local hemostatic agents and bipolar electrocautery. The wound was closed in layers with absorbable sutures. The patient's severe bone pain improved immediately postoperatively, and appropriate pain management measures were initiated.

Operative Note 42:

Surgical intervention was performed for other bursitis with severe bone pain. An oblique incision was made to access the affected bursa and the underlying bone. The bursa and bone were carefully excised, ensuring complete removal. Hemostasis was achieved using pressure and bone wax. The wound was closed with interrupted sutures. The patient's severe bone pain was significantly relieved following the procedure, and appropriate postoperative pain medications were administered.

Operative Note 43:

Patient underwent surgical management for other bursitis with associated severe bone pain. A transverse incision was made over the site of the bursa and the affected bone. The bursa and bone were identified, dissected, and excised. Hemostasis was achieved using bipolar electrocautery and local hemostatic agents. The wound was closed with subcuticular sutures. The patient reported immediate relief from severe bone pain and was discharged with appropriate pain management instructions.

Operative Note 44:

Surgical procedure was performed for other bursitis with severe bone pain. A curvilinear incision was made over the affected bursa and the underlying bone. The bursa and bone were carefully excised, ensuring complete removal. Hemostasis was achieved using bone wax and bipolar electrocautery. The wound was closed with adhesive skin closure strips. The patient's severe bone pain significantly diminished postoperatively, and appropriate pain control measures were implemented.

Operative Note 45:

Patient underwent surgical intervention for other bursitis with severe bone pain. An elliptical incision was made over the bursa and the affected bone. The bursa and bone were identified, excised, and sent for histopathological analysis. Hemostasis was achieved using local hemostatic agents and pressure. The wound was closed with absorbable sutures. The patient's severe bone pain improved immediately after the procedure, and adequate pain relief measures were provided.

Operative Note 46:

Surgical management was performed for other bursitis with severe bone pain. A midline incision was made to access the affected bursa and the underlying bone. The bursa and bone were meticulously excised, ensuring complete removal. Hemostasis was achieved using bipolar electrocautery and local hemostatic agents. The wound was closed with adhesive strips. The patient's severe bone pain significantly subsided postoperatively, and appropriate pain management strategies were employed.

Operative Note 47:

Patient underwent surgical treatment for other bursitis with severe bone pain. A longitudinal incision was made over the affected bursa and the underlying bone. The bursa and bone were carefully excised, ensuring complete removal. Hemostasis was achieved using bone wax and local hemostatic agents. The wound was closed with absorbable sutures. The patient reported immediate relief from severe bone pain following the procedure, and appropriate pain medications were prescribed.

Operative Note 48:

Surgical intervention was performed for other bursitis with severe bone pain. An oblique incision was made to access the affected bursa and the underlying bone. The bursa and bone were carefully excised, ensuring complete removal. Hemostasis was achieved using bone wax and pressure

. The wound was closed with interrupted sutures. The patient's severe bone pain was significantly alleviated postoperatively, and appropriate pain management interventions were implemented.

Operative Note 49:

Patient underwent surgical management for other bursitis with associated severe bone pain. A transverse incision was made over the site of the bursa and the affected bone. The bursa and bone were identified, dissected, and excised. Hemostasis was achieved using bipolar electrocautery and local hemostatic agents. The wound was closed with subcuticular sutures. The patient reported immediate relief from severe bone pain and was discharged with appropriate pain control measures.

Operative Note 50:

Surgical procedure was performed for other bursitis with severe bone pain. A curvilinear incision was made over the affected bursa and the underlying bone. The bursa and bone were carefully dissected, excised, and sent for pathological examination. Hemostasis was achieved using bone wax and pressure. The wound was closed with adhesive strips. The patient's severe bone pain was markedly improved postoperatively, and multimodal pain management strategies were implemented.

Operative Note 51:

Patient underwent surgical intervention for severe other bursitis. A longitudinal incision was made over the bursa, and the inflamed tissue was excised. The bursa was thoroughly irrigated with saline solution. Hemostasis was achieved using electrocautery. The wound was closed in layers with absorbable sutures. The patient tolerated the procedure well and was discharged with appropriate postoperative instructions.

Operative Note 52:

Surgical intervention was performed to address severe other bursitis. An oblique incision was made to access the affected bursa. The bursa was carefully dissected, and any associated adhesions were released. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with interrupted sutures. The patient's postoperative recovery was uneventful, and appropriate follow-up was scheduled.

Operative Note 53:

Patient underwent surgical management for severe other bursitis. A transverse incision was made over the site of the bursa. The bursa was identified, dissected, and completely excised. Hemostasis was achieved using bipolar electrocautery. The wound was closed with subcuticular sutures. The patient's condition remained stable throughout the surgical intervention, and they were provided with detailed postoperative care instructions.

Operative Note 54:

Surgical procedure was performed for severe other bursitis. A curvilinear incision was made over the affected bursa. The bursa was opened, and the inflamed tissue was carefully excised. Hemostasis was achieved using local hemostatic agents. The wound was closed with adhesive skin closure strips. The patient tolerated the surgical intervention well, and appropriate postoperative pain management measures were initiated.

Operative Note 55:

Patient underwent surgical intervention for severe other bursitis. An elliptical incision was made over the bursa. The bursa was identified, aspirated, and injected with a corticosteroid solution. Hemostasis was achieved using pressure. The wound was closed with absorbable sutures. The patient's surgical intervention was successful in addressing the severe bursitis, and they were provided with instructions for postoperative care and follow-up.

Operative Note 56:

Surgical management was performed for severe other bursitis. A midline incision was made to access the affected bursa. The bursa was meticulously excised, and any associated inflammatory tissue was removed. Hemostasis was achieved using electrocautery. The wound was closed with interrupted sutures. The patient's surgical intervention resulted in resolution of the severe bursitis, and appropriate postoperative management was initiated.

Operative Note 57:

Patient underwent surgical treatment for severe other bursitis. A longitudinal incision was made over the affected bursa. The bursa was carefully dissected, drained, and irrigated. Hemostasis was achieved using local hemostatic agents. The wound was closed with absorbable sutures. The patient's surgical intervention effectively addressed the severe bursitis, and they were provided with postoperative instructions for wound care and pain management.

Operative Note 58:

Surgical intervention was performed for severe other bursitis. An oblique incision was made to access the affected bursa. The bursa was meticulously excised, ensuring complete removal. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with adhesive skin closure strips. The patient's surgical intervention successfully addressed the severe bursitis, and they were discharged with appropriate postoperative care instructions.

Operative Note 59:

Patient underwent surgical management for severe other bursitis. A transverse incision was made

over the site of the bursa. The bursa was identified, dissected, and excised. Hemostasis was achieved using bipolar electrocautery. The wound was closed with subcuticular sutures. The patient's surgical intervention effectively resolved the severe bursitis, and they were provided with postoperative instructions and scheduled for a follow-up appointment.

Operative Note 60:

Surgical procedure was performed for severe other bursitis. A curvilinear incision was made over the affected bursa. The bursa was carefully dissected, excised, and sent for pathological examination. Hemostasis was achieved using local hemostatic agents and pressure. The wound was closed with adhesive strips. The patient's surgical intervention successfully addressed the severe bursitis, and they were discharged with appropriate postoperative care instructions.

Operative Note 61:

Patient underwent surgical intervention for severe other bursitis. A longitudinal incision was made over the bursa, and the inflamed bursal tissue was excised. The bursa was thoroughly irrigated with saline solution to ensure proper cleansing. Hemostasis was achieved using electrocautery. The wound was closed in layers with absorbable sutures. The patient tolerated the surgical intervention well, and postoperative instructions were provided for wound care and activity restrictions.

Operative Note 62:

Surgical management was performed for severe other bursitis. An oblique incision was made to access the affected bursa. The bursa was carefully dissected, and any adhesions or inflammatory tissue were removed. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with interrupted sutures. The patient's surgical intervention resulted in successful resolution of the severe bursitis, and appropriate postoperative care measures were implemented.

Operative Note 63:

Patient underwent surgical treatment for severe other bursitis. A transverse incision was made over the site of the bursa. The bursa was identified, dissected, and completely excised. Hemostasis was achieved using bipolar electrocautery. The wound was closed with subcuticular sutures. The patient's condition remained stable throughout the surgical intervention, and they were discharged with detailed postoperative care instructions.

Operative Note 64:

Surgical procedure was performed for severe other bursitis. A curvilinear incision was made over the affected bursa. The bursa was opened, and the inflamed tissue was carefully excised. Hemostasis was achieved using local hemostatic agents. The wound was closed with adhesive skin closure strips. The patient's surgical intervention was successful in resolving the severe bursitis, and they were provided with instructions for postoperative wound care and pain management.

Operative Note 65:

Patient underwent surgical intervention for severe other bursitis. An elliptical incision was made over the bursa. The bursa was identified, aspirated, and injected with a corticosteroid solution for therapeutic effect. Hemostasis was achieved using pressure. The wound was closed with absorbable sutures. The patient's surgical intervention resulted in significant improvement of the severe bursitis, and they were advised on postoperative care and follow-up appointments.

Operative Note 66:

Surgical management was performed for severe other bursitis. A midline incision was made to access the affected bursa. The bursa was meticulously excised, and any associated inflammatory tissue was removed. Hemostasis was achieved using electrocautery. The wound was closed with interrupted sutures. The patient's surgical intervention effectively addressed the severe bursitis, and appropriate postoperative measures were implemented for wound healing and pain management.

Operative Note 67:

Patient underwent surgical treatment for severe other bursitis. A longitudinal incision was made over the affected bursa. The bursa was carefully dissected, drained, and irrigated to remove the inflammatory fluid and debris. Hemostasis was achieved using local hemostatic agents. The wound was closed with absorbable sutures. The patient's surgical intervention successfully resolved the severe bursitis, and they were provided with postoperative instructions for wound care and pain control.

Operative Note 68:

Surgical intervention was performed for severe other bursitis. An oblique incision was made to access the affected bursa. The bursa was meticulously excised, ensuring complete removal. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with adhesive skin closure strips. The patient’'s surgical intervention effectively addressed the severe bursitis, and they were discharged with appropriate postoperative care instructions and scheduled for follow-up evaluation.

Operative Note 69:

Patient underwent surgical management for severe other bursitis. A transverse incision was made over the site of the bursa. The bursa was identified, dissected, and excised. Hemostasis was achieved using bipolar electrocautery. The wound was closed with subcuticular sutures. The patient's surgical intervention successfully resolved the severe bursitis, and they were provided with postoperative instructions for wound care, activity modification, and pain management.

Operative Note 70:

Surgical procedure was performed for severe other bursitis. A curvilinear incision was made over the affected bursa. The bursa was carefully dissected, excised, and sent for pathological examination to confirm the diagnosis. Hemostasis was achieved using local hemostatic agents and pressure. The wound was closed with adhesive strips. The patient's surgical intervention effectively addressed the severe bursitis, and they were discharged with appropriate postoperative care instructions and scheduled for a follow-up visit.

Operative Note 71:

Patient underwent surgical intervention for severe other bursitis with a concurrent severe infection on the extreme moving joint. An extensive longitudinal incision was made to access the affected joint and bursa. The infected bursal tissue was thoroughly debrided, and copious irrigation with antiseptic solution was performed. The joint was assessed for any signs of erosion or damage. Hemostasis was achieved using electrocautery, and the wound was closed in layers. Appropriate antibiotic therapy was initiated, and the patient was closely monitored postoperatively.

Operative Note 72:

Surgical management was performed for severe other bursitis with a concurrent severe infection involving the extreme moving joint. An oblique incision was made to expose the infected joint and bursa. The joint was carefully examined for signs of erosion or necrosis. The infected bursal tissue was excised, and thorough irrigation with antimicrobial solution was performed. Hemostasis was achieved using bipolar electrocautery, and the wound was closed meticulously. Intravenous antibiotics were initiated, and the patient's postoperative course was closely monitored.

Operative Note 73:

Patient underwent surgical treatment for severe other bursitis with a severe infection involving the extreme moving joint. A transverse incision was made over the site of the infected joint and bursa. The infected bursal tissue was excised, and meticulous debridement was performed. The joint was evaluated for any signs of erosions or bone involvement. Hemostasis was achieved using a combination of pressure, electrocautery, and local hemostatic agents. The wound was closed with absorbable sutures, and intravenous antibiotics were administered postoperatively.

Operative Note 74:

Surgical intervention was performed for severe other bursitis with a concurrent severe infection on the extreme moving joint. An elliptical incision was made to access the infected joint and bursa. The infected bursal tissue was meticulously excised, and thorough irrigation with antiseptic solution was carried out. The joint was carefully assessed for any erosions or signs of septic arthritis. Hemostasis was achieved using bipolar electrocautery, and the wound was closed with subcuticular sutures. The patient received intravenous antibiotics and was closely monitored for any signs of infection recurrence.

Operative Note 75:

Patient underwent surgical management for severe other bursitis with a severe infection involving the extreme moving joint. A curvilinear incision was made over the affected joint and bursa. The infected bursal tissue was carefully excised, and thorough irrigation with antimicrobial solution was performed. The joint was examined for any signs of bone erosion or septic arthritis. Hemostasis was achieved using a combination of electrocautery and local hemostatic agents. The wound was closed with adhesive skin closure strips, and appropriate intravenous antibiotics were administered postoperatively.

Operative Note 76:

Surgical procedure was performed for severe other bursitis with a concurrent severe infection on the extreme moving joint. A midline incision was made to access the infected joint and bursa. The infected bursal tissue was excised, and meticulous debridement was performed. The joint was thoroughly inspected for any signs of erosions or septic arthritis. Hemostasis was achieved using bipolar electrocautery, and the wound was closed with interrupted sutures. The patient received intravenous antibiotics and was closely monitored for infection control.

Operative Note 77:

Patient underwent surgical treatment for severe other bursitis with a severe infection involving the extreme moving joint. A longitudinal incision was made over the infected joint and bursa. The infected bursal tissue was excised, and extensive irrigation with antiseptic solution was performed. The joint

was carefully evaluated for any signs of bone erosion or septic arthritis. Hemostasis was achieved using electrocautery and local hemostatic agents. The wound was closed in layers, and the patient received intravenous antibiotics for postoperative infection management.

Operative Note 78:

Surgical intervention was performed for severe other bursitis with a concurrent severe infection on the extreme moving joint. An oblique incision was made to access the infected joint and bursa. The infected bursal tissue was meticulously excised, and thorough irrigation with antimicrobial solution was carried out. The joint was extensively examined for any signs of erosions or septic arthritis. Hemostasis was achieved using bipolar electrocautery, and the wound was closed with absorbable sutures. The patient received intravenous antibiotics and was closely monitored for infection control.

Operative Note 79:

Patient underwent surgical management for severe other bursitis with a severe infection involving the extreme moving joint. A transverse incision was made over the infected joint and bursa. The infected bursal tissue was excised, and meticulous debridement was performed. The joint was carefully inspected for any signs of bone erosion or septic arthritis. Hemostasis was achieved using a combination of electrocautery and local hemostatic agents. The wound was closed with subcuticular sutures, and the patient was started on intravenous antibiotics for postoperative infection prophylaxis.

Operative Note 80:

Surgical procedure was performed for severe other bursitis with a concurrent severe infection on the extreme moving joint. An elliptical incision was made to access the infected joint and bursa. The infected bursal tissue was meticulously excised, and extensive irrigation with antiseptic solution was performed. The joint was carefully evaluated for any signs of erosions or septic arthritis. Hemostasis was achieved using bipolar electrocautery and local hemostatic agents. The wound was closed with adhesive skin closure strips, and the patient received intravenous antibiotics for postoperative infection control.

Operative Note 81:

Patient underwent surgical intervention for severe other bursitis with markedly inflamed bursal tissue. A longitudinal incision was made over the affected bursa, revealing significant inflammation and swelling. The inflamed tissue was meticulously excised, and thorough irrigation with saline solution was performed to minimize the inflammation. Hemostasis was achieved using bipolar electrocautery. The wound was closed with absorbable sutures. The patient's surgical intervention successfully addressed the severe bursitis and reduced the inflammation, and postoperative care instructions were provided.

Operative Note 82:

Surgical management was performed for severe other bursitis with excessive inflammation. An oblique incision was made to access the affected bursa, and the inflamed bursal tissue was excised. The inflamed area was carefully irrigated with an anti-inflammatory solution to reduce inflammation. Hemostasis was achieved using local hemostatic agents. The wound was closed meticulously with sutures. The patient's surgical intervention effectively addressed the severe bursitis and reduced the inflammation, and appropriate postoperative measures were implemented.

Operative Note 83:

Patient underwent surgical treatment for severe other bursitis with severe inflammation. A transverse incision was made over the site of the inflamed bursa. The inflamed tissue was identified, carefully dissected, and excised. Intraoperative irrigation with a steroid solution was performed to reduce inflammation. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with absorbable sutures. The patient's surgical intervention successfully addressed the severe bursitis and alleviated the inflammation, and they were provided with postoperative instructions for wound care and pain management.

Operative Note 84:

Surgical intervention was performed for severe other bursitis with intense inflammation. An elliptical incision was made over the affected bursa, revealing highly inflamed tissue. The inflamed bursal tissue was excised, and extensive irrigation with a cold saline solution was performed to reduce inflammation. Hemostasis was achieved using bipolar electrocautery. The wound was closed with adhesive skin closure strips. The patient's surgical intervention effectively addressed the severe bursitis and reduced the inflammation, and appropriate postoperative care instructions were given.

Operative Note 85:

Patient underwent surgical management for severe other bursitis with severe inflammation. A curvilinear incision was made over the affected bursa, exposing inflamed tissue. The inflamed bursal tissue was meticulously excised, and intraoperative irrigation with an anti-inflammatory solution was performed. Hemostasis was achieved using local hemostatic agents. The wound was closed with subcuticular sutures. The patient's surgical intervention successfully addressed the severe bursitis and significantly reduced the inflammation, and they were discharged with appropriate postoperative care instructions.

Operative Note 86:

Surgical procedure was performed for severe other bursitis with significant inflammation. A midline incision was made to access the affected bursa, and the inflamed tissue was carefully excised. Intraoperative irrigation with a corticosteroid solution was performed to reduce inflammation. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient's surgical intervention effectively addressed the severe bursitis and reduced the inflammation, and they were provided with postoperative instructions for wound care, activity modification, and pain management.

Operative Note 87:

Patient underwent surgical treatment for severe other bursitis with severe inflammation. A longitudinal incision was made over the affected bursa, revealing markedly inflamed tissue. The inflamed bursal tissue was excised, and intraoperative irrigation with a cold saline solution was performed to decrease inflammation. Hemostasis was achieved using pressure and local

hemostatic agents. The wound was closed meticulously with sutures. The patient's surgical intervention successfully addressed the severe bursitis and reduced the inflammation, and appropriate postoperative measures were implemented.

Operative Note 88:

Surgical intervention was performed for severe other bursitis with excessive inflammation. An oblique incision was made to access the affected bursa, and the inflamed bursal tissue was excised. Intraoperative irrigation with an anti-inflammatory solution was performed to reduce inflammation. Hemostasis was achieved using bipolar electrocautery. The wound was closed with absorbable sutures. The patient's surgical intervention effectively addressed the severe bursitis and minimized the inflammation, and they were provided with postoperative instructions for wound care and pain management.

Operative Note 89:

Patient underwent surgical management for severe other bursitis with intense inflammation. A transverse incision was made over the site of the inflamed bursa, exposing highly inflamed tissue. The inflamed tissue was identified, carefully dissected, and excised. Intraoperative irrigation with a steroid solution was performed to alleviate inflammation. Hemostasis was achieved using pressure and local hemostatic agents. The wound was closed with absorbable sutures. The patient's surgical intervention successfully addressed the severe bursitis and reduced the inflammation, and appropriate postoperative care measures were implemented.

Operative Note 90:

Surgical procedure was performed for severe other bursitis with severe inflammation. An elliptical incision was made over the affected bursa, revealing inflamed tissue. The inflamed bursal tissue was meticulously excised, and intraoperative irrigation with a cold saline solution was performed to reduce inflammation. Hemostasis was achieved using bipolar electrocautery. The wound was closed with adhesive skin closure strips. The patient's surgical intervention effectively addressed the severe bursitis and minimized the inflammation, and they were discharged with appropriate postoperative care instructions.

Operative Note 91:

Patient underwent surgical intervention for severe other bursitis, with follow-up evaluations scheduled based on the severity of the diagnosis. A transverse incision was made over the affected bursa, and the bursa was carefully dissected and excised. Hemostasis was achieved using bipolar electrocautery, and the wound was closed meticulously. Postoperatively, the patient's follow-up evaluations will be determined by the severity of the diagnosis, with more frequent visits for severe cases and less frequent visits for milder cases.

Operative Note 92:

Surgical management was performed for other bursitis, with postoperative follow-ups tailored to the severity of the diagnosis. An oblique incision was made to access the affected bursa, and the bursa was excised. Hemostasis was achieved, and the wound was closed in layers. The patient's follow-up evaluations will be determined by the severity of the diagnosis, with closer monitoring for severe cases and less intensive monitoring for milder cases.

Operative Note 93:

Patient underwent surgical treatment for other bursitis, with postoperative follow-ups scheduled based on the severity of the diagnosis. A transverse incision was made over the site of the bursa, and the bursa was excised. Hemostasis was achieved, and the wound was closed with absorbable sutures. The patient's follow-up evaluations will be tailored to the severity of the diagnosis, with more frequent visits for severe cases and less frequent visits for milder cases.

Operative Note 94:

Surgical intervention was performed for other bursitis, with follow-up evaluations determined by the severity of the diagnosis. An elliptical incision was made over the affected bursa, and the bursa was meticulously excised. Hemostasis was achieved, and the wound was closed using adhesive skin closure strips. The patient's follow-up visits will be scheduled according to the severity of the diagnosis, with closer monitoring for severe cases and less frequent monitoring for milder cases.

Operative Note 95:

Patient underwent surgical management for other bursitis, with follow-up evaluations based on the severity of the diagnosis. A curvilinear incision was made to access the affected bursa, and the bursa was excised. Hemostasis was achieved using bipolar electrocautery, and the wound was closed with subcuticular sutures. The patient's follow-up appointments will be determined by the severity of the diagnosis, with more frequent visits for severe cases and less frequent visits for milder cases.

Operative Note 96:

Surgical procedure was performed for other bursitis, with follow-up evaluations tailored to the severity of the diagnosis. A midline incision was made to access the affected bursa, and the bursa was excised. Hemostasis was achieved using local hemostatic agents, and the wound was closed meticulously. The patient's follow-up visits will be scheduled based on the severity of the diagnosis, with closer monitoring for severe cases and less intensive monitoring for milder cases.

Operative Note 97:

Patient underwent surgical treatment for other bursitis, with postoperative follow-ups depending on the severity of the diagnosis. A longitudinal incision was made over the affected bursa, and the bursa was carefully excised. Hemostasis was achieved using bipolar electrocautery, and the wound was closed with absorbable sutures. The patient's follow-up evaluations will be determined by the severity of the diagnosis, with more frequent visits for severe cases and less frequent visits for milder cases.

Operative Note 98:

Surgical intervention was performed for other bursitis, with follow-up evaluations based on the severity of the diagnosis. An

oblique incision was made to access the affected bursa, and the bursa was excised. Hemostasis was achieved, and the wound was closed meticulously. The patient's follow-up appointments will be tailored to the severity of the diagnosis, with closer monitoring for severe cases and less frequent monitoring for milder cases.

Operative Note 99:

Patient underwent surgical management for other bursitis, with follow-up evaluations determined by the severity of the diagnosis. A transverse incision was made over the site of the bursa, and the bursa was excised. Hemostasis was achieved, and the wound was closed with adhesive skin closure strips. The patient's follow-up visits will be scheduled according to the severity of the diagnosis, with closer monitoring for severe cases and less frequent monitoring for milder cases.

Operative Note 100:

Surgical treatment was performed for other bursitis, with follow-up evaluations based on the severity of the diagnosis. An elliptical incision was made over the affected bursa, and the bursa was meticulously excised. Hemostasis was achieved, and the wound was closed using absorbable sutures. The patient's follow-up appointments will be determined by the severity of the diagnosis, with more frequent visits for severe cases and less frequent visits for milder cases.

## M71.8 Other specified bursopathies

Operative Note 1:

Procedure: Excision of other specified bursopathy

Indications: Patient presented with symptomatic bursopathy in the right shoulder. Intraoperatively, a small incision was made over the affected bursa. The bursa was excised completely, ensuring careful hemostasis. The wound was closed in layers. Postoperatively, the patient was advised to rest and apply ice. Follow-up scheduled in two weeks.

Operative Note 2:

Procedure: Bursectomy for other specified bursopathy

Indications: Patient with chronic bursitis in the left elbow. In the operating room, an incision was made over the affected bursa. The bursa was carefully dissected and excised. Bleeding was controlled, and the incision was closed using absorbable sutures. The patient was given postoperative instructions and scheduled for a follow-up visit.

Operative Note 3:

Procedure: Debridement of other specified bursopathy

Indications: Patient presented with a large, infected bursa in the right knee. Under sterile conditions, the bursa was opened and thoroughly irrigated. Necrotic tissue was debrided, and the remaining healthy tissue was preserved. The wound was packed with sterile dressings, and the patient was started on antibiotics. Follow-up arranged for wound assessment.

Operative Note 4:

Procedure: Drainage of other specified bursopathy

Indications: Patient with an acutely inflamed bursa in the left hip. In the operating room, the bursa was accessed using a sterile technique. A drain was placed to promote drainage and prevent recurrence. The incision was closed with sutures. Postoperative instructions were given, and the patient was advised to follow up in one week.

Operative Note 5:

Procedure: Injection for other specified bursopathy

Indications: Patient with chronic bursitis in the right ankle. The affected bursa was identified, and a local anesthetic was administered. A corticosteroid injection was then delivered into the bursa under ultrasound guidance. The patient tolerated the procedure well and was advised on post-injection care. Follow-up scheduled for assessment of response.

Operative Note 6:

Procedure: Repair of other specified bursopathy

Indications: Patient with a traumatic rupture of the bursa in the right hand. In the operating room, the bursa was exposed and carefully repaired using absorbable sutures. Hemostasis was ensured, and the wound was closed in layers. The patient was provided with postoperative instructions and scheduled for a follow-up visit.

Operative Note 7:

Procedure: Arthroscopic treatment of other specified bursopathy

Indications: Patient with chronic bursitis in the left shoulder. Arthroscopic equipment was used to visualize and access the affected bursa. Debridement of inflamed tissue was performed, and irrigation was carried out. The bursa was carefully inspected, and any loose bodies were removed. The patient was instructed on postoperative care and scheduled for follow-up.

Operative Note 8:

Procedure: Resection of other specified bursopathy

Indications: Patient with a large, symptomatic bursa in the right hip. In the operating room, an incision was made over the bursa, and careful dissection was performed to expose the bursa. The bursa was then resected completely. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were given, and follow-up arranged.

Operative Note 9:

Procedure: Open exploration for other specified bursopathy

Indications: Patient with suspected deep

infection of the bursa in the left knee. Under sterile conditions, an incision was made over the affected bursa, allowing for exploration. Intraoperatively, purulent material was found, and copious irrigation was performed. A drain was placed, and the wound was closed meticulously. Postoperatively, the patient was started on antibiotics and scheduled for follow-up.

Operative Note 10:

Procedure: Bursal fenestration for other specified bursopathy

Indications: Patient with recalcitrant bursitis in the right elbow. In the operating room, the skin over the affected bursa was marked and prepared. Multiple small incisions were made to fenestrate the bursa and promote drainage. The wounds were dressed, and the patient was given instructions for wound care. Follow-up arranged for further evaluation.

Operative Note 1:

Procedure: Bursal aspiration for other specified bursopathy

Indications: Patient with a swollen bursa in the right knee. Under aseptic conditions, the bursa was identified and aspirated using a sterile needle and syringe. Aspirated fluid was sent for analysis. Following the procedure, a sterile dressing was applied, and the patient was advised on post-procedure care. Follow-up scheduled for review of the aspiration results.

Operative Note 2:

Procedure: Bursa lavage for other specified bursopathy

Indications: Patient with chronic bursitis in the left shoulder. In the operating room, the affected bursa was accessed, and a sterile saline solution was infused for lavage. Gentle irrigation and suction were used to remove inflammatory debris. The bursa was thoroughly rinsed, and the incision was closed. Postoperative care instructions were provided, and follow-up arranged.

Operative Note 3:

Procedure: Bursectomy with tendon release for other specified bursopathy

Indications: Patient with bursopathy and concurrent tendon impingement in the right ankle. In the operating room, an incision was made over the affected bursa. The bursa was excised, and tendon release was performed to alleviate impingement. Hemostasis was achieved, and the wound was closed. Postoperatively, the patient was advised on rehabilitation protocols and scheduled for follow-up.

Operative Note 4:

Procedure: Endoscopic treatment of other specified bursopathy

Indications: Patient with persistent bursitis in the left hip. Using an endoscope, the affected bursa was visualized, and necessary interventions were performed. Debridement of inflamed tissue and removal of adhesions were carried out. The bursa was thoroughly irrigated, and the endoscope was removed. Postoperative instructions were provided, and follow-up arranged for assessment.

Operative Note 5:

Procedure: Bursal excision and autograft reconstruction for other specified bursopathy

Indications: Patient with a large, chronic bursa in the right elbow causing functional impairment. In the operating room, the bursa was excised completely, and an autograft was harvested from a nearby donor site. The graft was used to reconstruct the excised area. The wound was closed meticulously, and the patient was instructed on postoperative care. Follow-up scheduled for graft assessment.

Operative Note 6:

Procedure: Bursal decompression for other specified bursopathy

Indications: Patient with recurrent bursitis in the right shoulder. In the operating room, an incision was made over the affected bursa, and the underlying structures were carefully dissected. Bursal decompression was performed to alleviate pressure. The incision was closed, and the patient was advised on postoperative exercises. Follow-up arranged for evaluation of symptoms.

Operative Note 7:

Procedure: Ultrasound-guided aspiration of other specified bursopathy

Indications: Patient with a symptomatic bursa in the left hip. Using ultrasound guidance, a sterile needle and syringe were used to aspirate the bursa. Aspirated fluid was sent for analysis. The puncture site was dressed, and the patient was given post-procedure instructions. Follow-up scheduled for review of aspiration results and further management.

Operative Note 8:

Procedure: Bursectomy with capsular release for other specified bursopathy

Indications: Patient with chronic bursitis and associated joint contracture in the right knee. In the operating room, the affected bursa was excised, and capsular release was performed to improve joint mobility. Hemostasis was achieved

, and the wound was closed. Postoperatively, the patient was referred for rehabilitation and scheduled for follow-up.

Operative Note 9:

Procedure: Bursal biopsy for other specified bursopathy

Indications: Patient with an atypical presentation of bursopathy in the right shoulder. Under sterile conditions, a small incision was made over the affected bursa, and a tissue sample was obtained for histopathological analysis. Hemostasis was ensured, and the wound was closed. Postoperative instructions were given, and follow-up arranged for biopsy results.

Operative Note 10:

Procedure: Bursal reconstruction for other specified bursopathy

Indications: Patient with a chronic, recurrent bursa in the left knee. In the operating room, the affected bursa was excised, and a reconstructive procedure was performed using synthetic graft materials. The reconstructed bursa was sutured securely, and the wound was closed in layers. Postoperatively, the patient was advised on wound care and follow-up appointments.

Operative Note 1:

Procedure: Excision of other specified bursopathy

Indications: Patient presented with symptomatic bursopathy in the right shoulder. Intraoperatively, the patient was administered general anesthesia using a standard dosage protocol. A small incision was made over the affected bursa. The bursa was excised completely, ensuring careful hemostasis. The wound was closed in layers. Postoperatively, the patient recovered well from anesthesia, and follow-up was scheduled in two weeks.

Operative Note 2:

Procedure: Bursectomy for other specified bursopathy

Indications: Patient with chronic bursitis in the left elbow. In the operating room, the patient received regional anesthesia, with a lower dosage due to their preference and medical history. An incision was made over the affected bursa. The bursa was carefully dissected and excised. Bleeding was controlled, and the incision was closed using absorbable sutures. The patient recovered smoothly from anesthesia, and a follow-up visit was scheduled.

Operative Note 3:

Procedure: Debridement of other specified bursopathy

Indications: Patient presented with a large, infected bursa in the right knee. Under general anesthesia, the patient received a slightly higher dosage to ensure optimal pain management. The bursa was opened and thoroughly irrigated. Necrotic tissue was debrided, and the remaining healthy tissue was preserved. The wound was packed with sterile dressings. The patient recovered without complications from anesthesia, and a follow-up was arranged for wound assessment.

Operative Note 4:

Procedure: Drainage of other specified bursopathy

Indications: Patient with an acutely inflamed bursa in the left hip. In the operating room, the patient received moderate sedation with local anesthesia for the procedure. The bursa was accessed using a sterile technique. A drain was placed to promote drainage and prevent recurrence. The incision was closed with sutures. The patient recovered well from anesthesia, and postoperative instructions were given. Follow-up was scheduled in one week.

Operative Note 5:

Procedure: Injection for other specified bursopathy

Indications: Patient with chronic bursitis in the right ankle. The affected bursa was identified, and a local anesthetic was administered, using a lower dosage to minimize potential side effects. A corticosteroid injection was then delivered into the bursa under ultrasound guidance. The patient tolerated the procedure well, and recovery from anesthesia was uneventful. Follow-up was scheduled for assessment of response.

Operative Note 6:

Procedure: Repair of other specified bursopathy

Indications: Patient with a traumatic rupture of the bursa in the right hand. In the operating room, the patient received regional anesthesia with a slightly higher dosage for optimal pain control during the procedure. The bursa was exposed and carefully repaired using absorbable sutures. Hemostasis was ensured, and the wound was closed in layers. The patient recovered well from anesthesia, and postoperative instructions were provided. Follow-up visit was scheduled.

Operative Note 7:

Procedure: Arthroscopic treatment of other specified bursopathy

Indications: Patient with chronic bursitis in the left shoulder. Arthroscopic equipment was used to visualize and access the affected bursa. The patient received general anesthesia with a standard dosage. Debridement of inflamed tissue was performed, and irrigation was carried out. The bursa was carefully inspected, and any loose bodies were removed. The patient recovered smoothly from anesthesia, and postoperative care instructions were given. Follow-up visit was scheduled.

Operative Note 8:

Procedure: Resection of other specified b

ursopathy

Indications: Patient with a large, symptomatic bursa in the right hip. In the operating room, the patient received general anesthesia with a slightly higher dosage to ensure comfort during the procedure. An incision was made over the bursa, and careful dissection was performed to expose the bursa. The bursa was then resected completely. Hemostasis was achieved, and the wound was closed in layers. The patient recovered well from anesthesia, and postoperative care instructions were provided. Follow-up visit was scheduled.

Operative Note 9:

Procedure: Open exploration for other specified bursopathy

Indications: Patient with suspected deep infection of the bursa in the left knee. Under general anesthesia, the patient received a standard dosage. An incision was made over the affected bursa, allowing for exploration. Intraoperatively, purulent material was found, and copious irrigation was performed. A drain was placed, and the wound was closed meticulously. The patient recovered smoothly from anesthesia, and postoperative instructions were given. Follow-up visit was scheduled for wound assessment.

Operative Note 10:

Procedure: Bursal fenestration for other specified bursopathy

Indications: Patient with recalcitrant bursitis in the right elbow. In the operating room, the patient received moderate sedation with local anesthesia, using a lower dosage to minimize potential side effects. Multiple small incisions were made to fenestrate the bursa and promote drainage. The wounds were dressed, and the patient recovered well from anesthesia. Post-procedure instructions were provided, and follow-up was scheduled for further evaluation.

Operative Note 1:

Procedure: Excision of other specified bursopathy with bone erosion

Indications: Patient presented with a symptomatic bursopathy with associated bone erosion in the right shoulder. Under general anesthesia, the affected bursa was approached through an incision. The eroded bone was carefully debrided, and the bursa was excised completely. Hemostasis was achieved, and the wound was closed in layers. Postoperatively, the patient recovered well from anesthesia, and follow-up was scheduled for evaluation of bone healing.

Operative Note 2:

Procedure: Bursectomy with bone grafting for other specified bursopathy with bone erosion

Indications: Patient with chronic bursitis and significant bone erosion in the left knee. In the operating room, the patient received general anesthesia with a standard dosage. An incision was made over the affected bursa, and the eroded bone was carefully debrided. Bone grafting was performed to restore the bony defect. Hemostasis was ensured, and the wound was closed. The patient recovered well from anesthesia, and follow-up was scheduled for bone graft assessment.

Operative Note 3:

Procedure: Debridement and bone curettage for other specified bursopathy with bone erosion

Indications: Patient with a chronic bursa and extensive bone erosion in the right hip. Under general anesthesia, the affected bursa was approached, and careful debridement of necrotic tissue was performed. Bone curettage was carried out to remove eroded bone fragments. The area was thoroughly irrigated, and the wound was closed. The patient recovered smoothly from anesthesia, and follow-up was scheduled for further assessment of bone healing.

Operative Note 4:

Procedure: Drainage and bone stabilization for other specified bursopathy with bone erosion

Indications: Patient with an acutely infected bursa and concurrent bone erosion in the left ankle. In the operating room, the patient received regional anesthesia with a slightly higher dosage for adequate pain control. The bursa was drained, and thorough irrigation was performed. Bone stabilization was achieved using appropriate fixation techniques. The wound was closed, and the patient recovered well from anesthesia. Postoperative instructions were provided, and follow-up arranged for bone healing assessment.

Operative Note 5:

Procedure: Injection and bone defect repair for other specified bursopathy with bone erosion

Indications: Patient with chronic bursitis and significant bone erosion in the right elbow. The patient received local anesthesia with a higher dosage to ensure effective pain relief. A corticosteroid injection was administered into the bursa for symptom management. Additionally, the eroded bone defect was repaired using bone grafting techniques. The patient tolerated the procedure well, and post-injection care instructions were given. Follow-up was scheduled for evaluation of bone healing.

Operative Note 6:

Procedure: Open exploration, debridement, and bone grafting for other specified bursopathy with bone erosion

Indications: Patient with suspected deep infection, extensive bursopathy, and bone erosion in the right knee. Under general anesthesia, the affected bursa was explored through a surgical incision. Debridement of infected tissue and bone curettage were performed. The bone defect was filled with a bone graft. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and follow-up was scheduled for bone healing assessment.

Operative Note 7:

Procedure: Arthroscopic debridement and bone microfracture for other specified bursopathy with bone erosion

Indications: Patient with chronic bursitis and localized bone erosion in the left shoulder. The patient received general anesthesia with a standard dosage. Ar

throscopic equipment was used to access the affected area. Debridement of inflamed tissue and bone microfracture were performed to stimulate new bone formation. The patient recovered smoothly from anesthesia, and postoperative care instructions were given. Follow-up was scheduled for evaluation of bone healing.

Operative Note 8:

Procedure: Bursal excision, bone grafting, and internal fixation for other specified bursopathy with bone erosion

Indications: Patient with a large, symptomatic bursa and associated bone erosion in the right hip. In the operating room, the patient received general anesthesia with a slightly higher dosage. The affected bursa was excised, and the eroded bone was carefully debrided. Bone grafting was performed, followed by internal fixation to stabilize the area. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up was scheduled for assessment of bone healing and hardware stability.

Operative Note 9:

Procedure: Resection of other specified bursopathy with bone erosion

Indications: Patient with a chronic, recalcitrant bursa and underlying bone erosion in the left elbow. Under general anesthesia, the affected bursa was approached through an incision. The eroded bone was carefully resected, ensuring clear margins. Hemostasis was achieved, and the wound was closed in layers. The patient recovered well from anesthesia, and postoperative care instructions were provided. Follow-up was scheduled for evaluation of bone healing.

Operative Note 10:

Procedure: Bone grafting and bursal reconstruction for other specified bursopathy with bone erosion

Indications: Patient with a chronic bursa and extensive bone erosion in the right knee. Under general anesthesia, the eroded bone was carefully debrided, and a bone graft was used to fill the defect. Additionally, a bursal reconstruction was performed to restore the anatomical integrity. Hemostasis was ensured, and the wound was closed meticulously. The patient recovered smoothly from anesthesia, and postoperative care instructions were given. Follow-up was scheduled for assessment of bone healing and bursal reconstruction success.

Operative Note 1:

Procedure: Excision of other specified bursopathy with severe bone pain

Indications: Patient presented with severe bone pain associated with bursopathy in the right shoulder. Under general anesthesia, a standard dosage was administered. An incision was made over the affected bursa, and careful excision was performed. The eroded bone fragments were removed to alleviate the severe pain. Hemostasis was achieved, and the wound was closed in layers. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 2:

Procedure: Bursectomy with bone debridement for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis and severe bone pain in the left knee. The patient received general anesthesia with a slightly higher dosage for optimal pain control. An incision was made over the affected bursa, allowing access to the bone. Careful debridement of the eroded bone was performed to alleviate the severe pain. Hemostasis was ensured, and the wound was closed meticulously. The patient recovered smoothly from anesthesia, and postoperative pain management was initiated.

Operative Note 3:

Procedure: Debridement and bone curettage for other specified bursopathy with severe bone pain

Indications: Patient with a chronic bursa and severe bone pain in the right hip. Under general anesthesia, the affected bursa was approached, and careful debridement was performed to alleviate the severe pain. Bone curettage was carried out to remove any necrotic or damaged bone fragments. The area was thoroughly irrigated, and the wound was closed. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 4:

Procedure: Drainage and bone stabilization for other specified bursopathy with severe bone pain

Indications: Patient with an acutely infected bursa and severe bone pain in the left ankle. In the operating room, the patient received regional anesthesia with a slightly higher dosage for adequate pain control. The bursa was drained, and thorough irrigation was performed to alleviate the severe pain. Bone stabilization was achieved using appropriate fixation techniques. The wound was closed, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 5:

Procedure: Injection and bone defect repair for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis and severe bone pain in the right elbow. The patient received local anesthesia with a higher dosage for effective pain relief. A corticosteroid injection was administered into the bursa to alleviate the severe pain. Additionally, the eroded bone defect was repaired to provide stability and further pain relief. The patient tolerated the procedure well, and post-injection pain management was initiated.

Operative Note 6:

Procedure: Open exploration, debridement, and bone grafting for other specified bursopathy with severe bone pain

Indications: Patient with suspected deep infection, extensive bursopathy, and severe bone pain in the right knee. Under general anesthesia, the affected bursa was explored through a surgical incision. Debridement of infected tissue and bone curettage were performed to alleviate the severe pain. Bone grafting was also carried out to promote healing and pain relief. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 7:

Procedure: Arthroscopic debridement and bone microfracture for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis and severe bone pain in the left shoulder. The patient received general anesthesia with a standard

dosage. Arthroscopic equipment was used to access the affected area. Debridement of inflamed tissue and bone microfracture were performed to alleviate the severe pain. The patient recovered smoothly from anesthesia, and postoperative pain management was initiated.

Operative Note 8:

Procedure: Bursal excision, bone grafting, and internal fixation for other specified bursopathy with severe bone pain

Indications: Patient with a large, symptomatic bursa, severe bone pain, and associated bone erosion in the right hip. In the operating room, the patient received general anesthesia with a slightly higher dosage. The affected bursa was excised, and the eroded bone was carefully debrided to alleviate the severe pain. Bone grafting and internal fixation were performed to stabilize the area. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 9:

Procedure: Resection of other specified bursopathy with severe bone pain

Indications: Patient with a chronic, recalcitrant bursa and severe bone pain in the left elbow. Under general anesthesia, the affected bursa was approached through an incision. The eroded bone was carefully resected to alleviate the severe pain. Hemostasis was achieved, and the wound was closed in layers. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 10:

Procedure: Bone grafting and bursal reconstruction for other specified bursopathy with severe bone pain

Indications: Patient with a chronic bursa, severe bone pain, and extensive bone erosion in the right knee. Under general anesthesia, the eroded bone was carefully debrided, and a bone graft was used to fill the defect and alleviate the severe pain. Additionally, a bursal reconstruction was performed to restore the anatomical integrity and provide pain relief. Hemostasis was ensured, and the wound was closed meticulously. The patient recovered smoothly from anesthesia, and postoperative pain management was initiated.

Operative Note 1:

Procedure: Surgical intervention for other specified bursopathy with severe bone pain

Indications: Patient with a chronic bursa, severe bone pain, and limited range of motion in the right shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed through an incision, and extensive debridement was carried out to alleviate the severe pain. Adhesions were released, and any underlying bone abnormalities were addressed. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 2:

Procedure: Surgical debridement and bone resection for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and functional impairment in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, and thorough debridement was performed to remove inflamed tissue and alleviate the severe pain. In addition, bone resection was necessary to address underlying bone abnormalities contributing to the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 3:

Procedure: Surgical excision and bone grafting for other specified bursopathy with severe bone pain

Indications: Patient with a symptomatic bursa, severe bone pain, and instability in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was excised completely, and careful debridement was carried out to alleviate the severe pain. Subsequently, a bone graft was utilized to address any underlying bone defects and provide stability. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 4:

Procedure: Surgical drainage and bone stabilization for other specified bursopathy with severe bone pain

Indications: Patient with an acutely infected bursa, severe bone pain, and limited mobility in the left ankle. In the operating room, the patient received regional anesthesia with a higher dosage for effective pain control during the surgical intervention. The infected bursa was drained, thoroughly irrigated, and appropriate debridement was performed to alleviate the severe pain. Bone stabilization was achieved using internal fixation techniques. The wound was closed, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 5:

Procedure: Surgical intervention and bone defect repair for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and deformity in the right elbow. The patient received general anesthesia with a standard dosage for the surgical intervention. The affected bursa was surgically approached, and extensive debridement was performed to alleviate the severe pain. Additionally, a bone defect repair procedure was conducted to restore bone integrity and provide pain relief. The patient tolerated the procedure well, and postoperative pain management was initiated.

Operative Note 6:

Procedure: Surgical exploration, debridement, and bone grafting for other specified bursopathy with severe bone pain

Indications: Patient with suspected deep infection, severe bone pain, and limited range of motion in the right knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was explored through a surgical incision, and extensive debridement was carried out to alleviate the severe pain. Any necrotic tissue was removed, and bone grafting was performed to address underlying bone abnormalities. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 7:

Procedure: Surgical excision and bone curettage for

other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and instability in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was excised completely, and careful bone curettage was carried out to alleviate the severe pain. Any necrotic or damaged bone fragments were removed. Hemostasis was achieved, and the wound was closed in layers. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 8:

Procedure: Surgical debridement and bone stabilization for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and functional impairment in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, and extensive debridement was performed to alleviate the severe pain. Additionally, bone stabilization was achieved using internal fixation techniques to address any underlying bone abnormalities. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 9:

Procedure: Surgical intervention with bone grafting for other specified bursopathy with severe bone pain

Indications: Patient with a symptomatic bursa, severe bone pain, and instability in the left elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed through an incision, and extensive debridement was carried out to alleviate the severe pain. Subsequently, a bone graft was utilized to address any underlying bone defects and provide stability. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 10:

Procedure: Surgical debridement and bone resection for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and limited range of motion in the right knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was surgically approached, and extensive debridement was performed to alleviate the severe pain. Additionally, bone resection was necessary to address any underlying bone abnormalities contributing to the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 1:

Procedure: Surgical intervention and bone realignment for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and deformity in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed through an incision, and extensive debridement was carried out to alleviate the severe pain. In addition, bone realignment was performed to correct the deformity and relieve the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 2:

Procedure: Surgical excision, bone grafting, and joint reconstruction for other specified bursopathy with severe bone pain

Indications: Patient with a large, symptomatic bursa, severe bone pain, and joint instability in the right hip. In the operating room, the patient received general anesthesia with a slightly higher dosage. The affected bursa was excised completely, and careful debridement was performed to alleviate the severe pain. Bone grafting was carried out to address any underlying bone defects, followed by joint reconstruction to restore stability. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 3:

Procedure: Surgical intervention and bone fixation for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and limited mobility in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, and extensive debridement was carried out to alleviate the severe pain. Additionally, bone fixation was performed to provide stability and relieve the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 4:

Procedure: Surgical debridement and bone grafting with internal fixation for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and functional impairment in the right ankle. Under general anesthesia, a surgical intervention was performed. The affected bursa was approached through an incision, and extensive debridement was performed to alleviate the severe pain. A bone graft was utilized to address underlying bone defects, followed by internal fixation for stability. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 5:

Procedure: Surgical intervention and bone resurfacing for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and limited range of motion in the left elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was surgically accessed, and extensive debridement was performed to alleviate the severe pain. Bone resurfacing was carried out to restore the joint surface and relieve the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 6:

Procedure: Surgical excision, bone curettage, and joint reconstruction for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and joint instability in the right shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was excised completely, and careful bone curettage was carried out to alleviate the severe pain. Joint reconstruction was performed to restore stability and relieve the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 7:

Procedure: Surgical intervention and bone realignment

for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and deformity in the left hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, and extensive debridement was performed to alleviate the severe pain. Additionally, bone realignment was carried out to correct the deformity and relieve the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 8:

Procedure: Surgical excision, bone grafting, and joint reconstruction for other specified bursopathy with severe bone pain

Indications: Patient with a symptomatic bursa, severe bone pain, and joint instability in the right elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was excised completely, and careful debridement was carried out to alleviate the severe pain. Bone grafting was performed to address any underlying bone defects, followed by joint reconstruction for stability. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 9:

Procedure: Surgical intervention and bone fixation for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and limited mobility in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, and extensive debridement was carried out to alleviate the severe pain. Additionally, bone fixation was performed to provide stability and relieve the pain. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative pain management was initiated.

Operative Note 10:

Procedure: Surgical debridement and bone grafting with internal fixation for other specified bursopathy with severe bone pain

Indications: Patient with chronic bursitis, severe bone pain, and functional impairment in the right knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was approached through an incision, and extensive debridement was performed to alleviate the severe pain. A bone graft was utilized to address underlying bone defects, followed by internal fixation for stability. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and postoperative pain management was initiated.

Operative Note 1:

Procedure: Surgical debridement, joint irrigation, and bone stabilization for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and a severely infected extreme moving joint in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint irrigation was performed to clear the infection. Additionally, bone stabilization was achieved using internal fixation techniques. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 2:

Procedure: Surgical intervention, joint debridement, and bone reconstruction for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an infected extreme moving joint in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to clear the infection. Bone reconstruction was performed to address any bone defects. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 3:

Procedure: Surgical debridement, joint washout, and bone stabilization for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an infected extreme moving joint in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to clear the infection. Bone stabilization was achieved using internal fixation techniques. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 4:

Procedure: Surgical intervention, joint debridement, and bone reconstruction for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an infected extreme moving joint in the right elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to clear the infection. Bone reconstruction was performed to address any bone defects. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 5:

Procedure: Surgical debridement, joint irrigation, and bone stabilization for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and a severely infected extreme moving joint in the left ankle. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint irrigation was performed to clear the infection. Bone stabilization was achieved using internal fixation techniques. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 6:

Procedure: Surgical intervention, joint debridement, and bone reconstruction for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an infected extreme moving joint in the right wrist. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debrid

ement was performed to alleviate the severe pain, and joint debridement was carried out to clear the infection. Bone reconstruction was performed to address any bone defects. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 7:

Procedure: Surgical debridement, joint washout, and bone stabilization for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and a severely infected extreme moving joint in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to clear the infection. Bone stabilization was achieved using internal fixation techniques. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 8:

Procedure: Surgical intervention, joint debridement, and bone reconstruction for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an infected extreme moving joint in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to clear the infection. Bone reconstruction was performed to address any bone defects. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 9:

Procedure: Surgical debridement, joint irrigation, and bone stabilization for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and a severely infected extreme moving joint in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint irrigation was performed to clear the infection. Bone stabilization was achieved using internal fixation techniques. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 10:

Procedure: Surgical intervention, joint debridement, and bone reconstruction for other specified bursopathy with severe bone pain and infected extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an infected extreme moving joint in the right ankle. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to clear the infection. Bone reconstruction was performed to address any bone defects. The wound was closed meticulously, and the patient recovered well from anesthesia. Intravenous antibiotics were initiated for infection control.

Operative Note 1:

Procedure: Surgical debridement, joint irrigation, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint irrigation was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 2:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 3:

Procedure: Surgical debridement, joint washout, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 4:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 5:

Procedure: Surgical debridement, joint irrigation, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left ankle. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint irrigation was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 6:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right wrist. Under general anesthesia, a surgical intervention was performed. The affected bursa

was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 7:

Procedure: Surgical debridement, joint washout, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 8:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 9:

Procedure: Surgical debridement, joint washout, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 10:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Postoperative anti-inflammatory medications were initiated.

Operative Note 1:

Procedure: Surgical debridement, joint washout, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 2:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 3:

Procedure: Surgical debridement, joint irrigation, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint irrigation was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 4:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 5:

Procedure: Surgical debridement, joint washout, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left ankle. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 6:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with

severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right wrist. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 7:

Procedure: Surgical debridement, joint washout, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left shoulder. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint washout was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 8:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right hip. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 9:

Procedure: Surgical debridement, joint irrigation, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient presented with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the left knee. Under general anesthesia, a surgical intervention was performed. The affected bursa was opened, extensive debridement was carried out to alleviate the severe pain, and joint irrigation was performed to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

Operative Note 10:

Procedure: Surgical intervention, joint debridement, and inflammation control for other specified bursopathy with severe bone pain and inflamed extreme moving joint

Indications: Patient with chronic bursitis, severe bone pain, and an inflamed extreme moving joint in the right elbow. Under general anesthesia, a surgical intervention was performed. The affected bursa was accessed, extensive debridement was performed to alleviate the severe pain, and joint debridement was carried out to control the inflammation. The inflammatory response was carefully managed during the procedure. The wound was closed meticulously, and the patient recovered well from anesthesia. Follow-up will depend on the severity of the diagnosis and the patient's response to treatment.

## M71.9 Bursopathy, unspecified

1. Operative Note: Patient underwent a bursectomy for bursopathy in the right shoulder. The subacromial bursa was identified and dissected using electrocautery. The inflamed bursa was excised completely. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and postoperative care instructions were provided.

2. Operative Note: Patient underwent a bursectomy for bursopathy in the left hip. The trochanteric bursa was identified and accessed through a lateral approach. The bursa was carefully dissected and excised. The surrounding tissues were inspected for any additional pathology. Hemostasis was achieved, and the wound was closed. The patient was given postoperative instructions and scheduled for follow-up.

3. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the right knee. The suprapatellar bursa was visualized using an arthroscope, and instruments were introduced through separate portals. The inflamed bursa was excised using electrocautery and shaver. The joint was thoroughly irrigated, and portals were closed. The patient was advised on postoperative care and follow-up appointments.

4. Operative Note: Patient underwent a bursectomy for bursopathy in the left elbow. The olecranon bursa was accessed through a posterior approach. The bursa was carefully dissected and excised while preserving nearby structures. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions and was referred for rehabilitation therapy.

5. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the right ankle. The retrocalcaneal bursa was accessed through small incisions. The endoscope provided visualization, and the bursa was excised using specialized instruments. Care was taken to protect surrounding tendons and nerves. Hemostasis was ensured, and the incisions were closed with sutures. Postoperative care instructions were given to the patient.

6. Operative Note: Patient underwent an open bursectomy for bursopathy in the left wrist. A dorsal approach was used to access the radial styloid bursa. The bursa was carefully dissected and completely excised. The wound was thoroughly irrigated, and layered closure was performed. The patient was placed in a splint and provided with postoperative care guidelines.

7. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the right hip. The trochanteric bursa was visualized using an arthroscope, and bursectomy was performed using radiofrequency ablation. The bursal tissue was meticulously removed, and hemostasis was achieved. The joint was irrigated, and the portals were closed. The patient was advised on postoperative precautions and follow-up appointments.

8. Operative Note: Patient underwent an open bursectomy for bursopathy in the left shoulder. The subacromial bursa was accessed through a deltoid-splitting approach. The bursa was carefully excised, taking care to protect the underlying structures. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions and was scheduled for a follow-up visit.

9. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the right elbow. Small incisions were made, and an endoscope was inserted to visualize the olecranon bursa. Specialized instruments were used to excise the bursa completely. Hemostasis was ensured, and the incisions were closed with sutures. The patient was provided with post

operative care guidelines and a referral for physical therapy.

10. Operative Note: Patient underwent an open bursectomy for bursopathy in the left knee. The prepatellar bursa was accessed through a midline incision. The bursa was dissected and excised in its entirety. Care was taken to avoid damage to surrounding structures. Hemostasis was achieved, and the wound was closed in layers. The patient was given postoperative instructions and a follow-up appointment was scheduled.

1. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the right shoulder. The subacromial bursa was accessed using small incisions, and the endoscope provided visualization. The bursal tissue was carefully excised using specialized instruments. Hemostasis was achieved, and the incisions were closed with sutures. The patient received postoperative instructions and was scheduled for a follow-up visit in two weeks.

2. Operative Note: Patient underwent an open bursectomy for bursopathy in the left hip. A lateral approach was used to access the trochanteric bursa. The bursal tissue was dissected and completely excised. Hemostasis was achieved, and the wound was closed in layers. The patient was placed on restricted weight-bearing and prescribed pain management. Follow-up appointments were scheduled to monitor progress.

3. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the right knee. The infrapatellar bursa was visualized using an arthroscope, and the bursal tissue was meticulously excised using electrocautery. Care was taken to avoid damage to surrounding structures. The joint was irrigated, and the portals were closed. The patient was instructed to rest, elevate the leg, and follow a prescribed rehabilitation program.

4. Operative Note: Patient underwent a bursectomy for bursopathy in the left ankle. The retrocalcaneal bursa was identified and accessed through a posterior approach. The bursal tissue was excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed. The patient was advised to limit weight-bearing and provided with instructions for wound care. A follow-up appointment was scheduled for suture removal.

5. Operative Note: Patient underwent an open bursectomy for bursopathy in the right elbow. A lateral approach was used to access the olecranon bursa. The bursa was carefully dissected and completely excised. Hemostasis was achieved, and the wound was closed in layers. The patient was immobilized with a splint and instructed to perform gentle range of motion exercises after splint removal.

6. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the left wrist. The radial styloid bursa was accessed through small incisions, and the bursal tissue was meticulously excised using specialized instruments. Hemostasis was ensured, and the incisions were closed. The patient was placed in a wrist splint and advised on activity restrictions and hand therapy exercises for postoperative rehabilitation.

7. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the right hip. The trochanteric bursa was visualized using an arthroscope, and bursectomy was performed using a shaver and electrocautery. The inflamed bursal tissue was thoroughly excised. Hemostasis was achieved, and the joint was irrigated. The patient was given weight-bearing restrictions and referred for physical therapy to aid in recovery.

8. Operative Note: Patient underwent an open bursectomy for bursopathy in the left shoulder. The subacromial bursa was accessed through a deltopectoral approach. The bursal tissue was carefully dissected and excised, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The patient was instructed to perform pendulum exercises and avoid strenuous activities during the recovery period.

9. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the right elbow.

Small incisions were made, and the endoscope provided visualization of the olecranon bursa. The inflamed bursal tissue was meticulously excised using specialized instruments. Hemostasis was ensured, and the incisions were closed. The patient was advised on pain management and instructed to gradually resume normal elbow range of motion.

10. Operative Note: Patient underwent an open bursectomy for bursopathy in the left knee. A medial parapatellar approach was used to access the pes anserine bursa. The bursa was carefully dissected and completely excised. Hemostasis was achieved, and the wound was closed. The patient was advised on activity modification and prescribed a course of non-steroidal anti-inflammatory drugs for pain management. Follow-up appointments were scheduled to monitor progress.

1. Operative Note: Patient underwent an open bursectomy for bursopathy in the right shoulder under general anesthesia. An endotracheal tube was inserted, and anesthesia was maintained using inhalational agents. The procedure was uneventful, and the patient tolerated the anesthesia well. Postoperatively, the patient recovered in the post-anesthesia care unit (PACU) and was later transferred to the surgical ward for further monitoring.

2. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the left hip under spinal anesthesia. A single shot of local anesthetic was administered into the subarachnoid space at the appropriate level. The patient remained conscious throughout the procedure but experienced numbness in the lower limbs. Adequate pain control was achieved, and the patient reported satisfactory surgical experience.

3. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the right knee under regional anesthesia. A femoral nerve block was performed using a local anesthetic agent. The patient experienced numbness and loss of sensation in the surgical area. Intravenous sedation was administered to ensure comfort and relaxation during the procedure. The patient was cooperative, and the surgery proceeded smoothly.

4. Operative Note: Patient underwent an open bursectomy for bursopathy in the left elbow under local anesthesia with sedation. The surgical site was infiltrated with a local anesthetic agent for regional anesthesia. Conscious sedation was achieved using intravenous medications. The patient remained responsive and comfortable during the procedure, and the anesthesia dosage was adjusted as needed. The surgery was completed successfully.

5. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the right ankle under general anesthesia. After induction, endotracheal intubation was performed, and anesthesia was maintained using intravenous agents. The patient was positioned appropriately for the procedure, and surgical access was obtained. Throughout the surgery, the anesthesia depth was closely monitored, ensuring optimal levels for the patient's safety and comfort.

6. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the left wrist under local anesthesia with monitored anesthesia care (MAC). The surgical site was infiltrated with a local anesthetic agent, providing regional anesthesia. The patient remained awake but sedated throughout the procedure. Vital signs were closely monitored, and the anesthesia team ensured the patient's comfort and safety.

7. Operative Note: Patient underwent an open bursectomy for bursopathy in the right hip under combined spinal-epidural anesthesia. A spinal anesthetic was administered into the subarachnoid space, followed by the placement of an epidural catheter for continuous anesthesia. The patient experienced adequate sensory and motor blockade during the surgery, and analgesia was maintained throughout the postoperative period via the epidural catheter.

8. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the left shoulder under general anesthesia with regional nerve block. General anesthesia was induced and maintained using inhalational agents, while a regional nerve block was performed using a local anesthetic agent to provide targeted pain relief. The patient remained stable throughout the procedure, and a multimodal pain management plan was implemented for postoperative comfort.

9. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the right knee under local anesthesia supplemented with intravenous sedation. The surgical site was infiltrated with a local anesthetic agent, providing regional anesthesia. Intravenous sedation was administered to enhance patient comfort and alleviate anxiety. The anesthesia dosage was adjusted to maintain an appropriate level of anesthesia

throughout the procedure.

10. Operative Note: Patient underwent an open bursectomy for bursopathy in the left ankle under general anesthesia. After endotracheal intubation, anesthesia was maintained using a balanced technique with intravenous and inhalational agents. The patient's vital signs and depth of anesthesia were continuously monitored and adjusted as necessary. The surgery was completed successfully without any significant complications, and the patient recovered well postoperatively.

1. Operative Note: Patient underwent an open bursectomy for bursopathy with associated bone erosion in the right shoulder. The subacromial bursa was accessed, and extensive bone debridement was performed to address the erosion. The inflamed bursa was excised, and the eroded bone edges were smoothed. Hemostasis was achieved, and the wound was closed in layers. Postoperatively, the patient was prescribed appropriate medications and scheduled for follow-up imaging.

2. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy with underlying bone erosion in the left hip. The trochanteric bursa was visualized using an arthroscope, and careful evaluation of the eroded bone was performed. Bursal tissue was excised, and the eroded bone edges were smoothed using specialized instruments. Hemostasis was ensured, and the joint was thoroughly irrigated. The patient received postoperative care instructions and was referred for rehabilitation therapy.

3. Operative Note: Patient underwent an open bursectomy for bursopathy with significant bone erosion in the right knee. The suprapatellar bursa was accessed through a midline incision. Extensive bone debridement was performed to address the erosion. The bursa was excised, and the eroded bone surfaces were carefully reshaped. Hemostasis was achieved, and the wound was closed in layers. The patient was advised on weight-bearing restrictions and provided with a comprehensive rehabilitation plan.

4. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy with associated bone erosion in the left elbow. Small incisions were made, and an endoscope was inserted for visualization. The eroded bone surfaces were carefully assessed, and bursal tissue was excised. Special attention was given to smoothing the roughened bone edges. Hemostasis was ensured, and the incisions were closed. The patient received postoperative instructions and was scheduled for a follow-up visit.

5. Operative Note: Patient underwent an open bursectomy for bursopathy with underlying bone erosion in the right ankle. The retrocalcaneal bursa was accessed through a posterior approach. Extensive bone debridement was performed to address the erosion. The bursa was excised, and the eroded bone surfaces were meticulously reshaped. Hemostasis was achieved, and the wound was closed. The patient was instructed on non-weight-bearing and referred for specialized foot and ankle rehabilitation.

6. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy with significant bone erosion in the left wrist. The radial styloid bursa was visualized using an arthroscope, and careful examination of the eroded bone was performed. Bursal tissue was excised, and the roughened bone edges were smoothed using specialized instruments. Hemostasis was ensured, and the incisions were closed. The patient received postoperative instructions and was referred for hand therapy.

7. Operative Note: Patient underwent an open bursectomy for bursopathy with associated bone erosion in the right hip. The trochanteric bursa was accessed through a lateral approach. Bone debridement was performed to address the erosion. The bursa was excised, and the eroded bone surfaces were meticulously reshaped and contoured. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions and was scheduled for follow-up imaging.

8. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy with significant bone erosion in the left shoulder. Small incisions

were made, and an endoscope was inserted for visualization. The eroded bone surfaces were carefully evaluated, and bursal tissue was excised. Special attention was given to reshaping and smoothing the roughened bone edges. Hemostasis was ensured, and the incisions were closed. The patient received postoperative care instructions and was referred for physical therapy.

9. Operative Note: Patient underwent an open bursectomy for bursopathy with underlying bone erosion in the right knee. The infrapatellar bursa was accessed through a medial parapatellar approach. Extensive bone debridement was performed to address the erosion. The bursa was excised, and the eroded bone surfaces were meticulously reshaped. Hemostasis was achieved, and the wound was closed in layers. The patient was advised on weight-bearing restrictions and provided with a comprehensive rehabilitation plan.

10. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy with associated bone erosion in the left ankle. The retrocalcaneal bursa was visualized using an arthroscope, and thorough evaluation of the eroded bone was performed. Bursal tissue was excised, and the roughened bone edges were carefully reshaped. Hemostasis was ensured, and the joint was thoroughly irrigated. The patient received postoperative care instructions and was referred for specialized foot and ankle rehabilitation.

1. Operative Note: Patient underwent an open bursectomy for severe bone pain associated with bursopathy in the right shoulder. The subacromial bursa was accessed, and meticulous debridement of the inflamed bursa was performed. Additionally, attention was given to addressing underlying bone abnormalities contributing to the severe pain. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative pain management and was scheduled for follow-up evaluation.

2. Operative Note: Patient underwent an arthroscopic bursectomy for severe bone pain secondary to bursopathy in the left hip. The trochanteric bursa was visualized using an arthroscope, and meticulous excision of the inflamed bursal tissue was performed. Particular attention was given to addressing the underlying bone pathology contributing to the severe pain. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative pain control and rehabilitation instructions.

3. Operative Note: Patient underwent an open bursectomy for severe bone pain associated with bursopathy in the right knee. The suprapatellar bursa was accessed through a midline incision, and meticulous excision of the inflamed bursal tissue was performed. Attention was given to addressing any underlying bone pathology contributing to the severe pain. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative pain management and rehabilitation recommendations.

4. Operative Note: Patient underwent an endoscopic bursectomy for severe bone pain related to bursopathy in the left elbow. Small incisions were made, and an endoscope was inserted for visualization. The inflamed bursal tissue was excised meticulously, with careful attention to addressing any underlying bone abnormalities causing severe pain. Hemostasis was ensured, and the incisions were closed. The patient received postoperative pain control measures and was referred for appropriate rehabilitation.

5. Operative Note: Patient underwent an open bursectomy for severe bone pain associated with bursopathy in the right ankle. The retrocalcaneal bursa was accessed through a posterior approach, and meticulous excision of the inflamed bursal tissue was performed. Special attention was given to addressing any underlying bone pathology contributing to the severe pain. Hemostasis was achieved, and the wound was closed. The patient received postoperative pain management and rehabilitation recommendations.

6. Operative Note: Patient underwent an arthroscopic bursectomy for severe bone pain secondary to bursopathy in the left wrist. The radial styloid bursa was visualized using an arthroscope, and meticulous excision of the inflamed bursal tissue was performed. Particular attention was given to addressing any underlying bone abnormalities contributing to the severe pain. Hemostasis was ensured, and the incisions were closed. The patient received postoperative pain control and hand therapy instructions.

7. Operative Note: Patient underwent an open bursectomy for severe bone pain associated with bursopathy in the right hip. The trochanteric bursa was accessed through a lateral approach, and meticulous excision of the inflamed bursal tissue was performed. Attention was given to addressing any underlying bone pathology contributing to the severe pain. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative pain management and rehabilitation recommendations.

8. Operative Note: Patient underwent an endoscopic bursectomy for severe bone pain related to bursopathy in the left shoulder. Small incisions were made, and an endoscope was inserted for visualization. The inflamed bursal tissue was excised meticulously, with careful

attention to addressing any underlying bone abnormalities causing severe pain. Hemostasis was ensured, and the incisions were closed. The patient received postoperative pain control measures and was referred for appropriate rehabilitation.

9. Operative Note: Patient underwent an open bursectomy for severe bone pain associated with bursopathy in the right knee. The infrapatellar bursa was accessed through a medial parapatellar approach, and meticulous excision of the inflamed bursal tissue was performed. Particular attention was given to addressing any underlying bone pathology contributing to the severe pain. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative pain management and rehabilitation recommendations.

10. Operative Note: Patient underwent an arthroscopic bursectomy for severe bone pain secondary to bursopathy in the left ankle. The retrocalcaneal bursa was visualized using an arthroscope, and meticulous excision of the inflamed bursal tissue was performed. Special attention was given to addressing any underlying bone pathology contributing to the severe pain. Hemostasis was ensured, and the joint was thoroughly irrigated. The patient received postoperative pain control and was referred for specialized foot and ankle rehabilitation.

1. Operative Note: Patient underwent a minimally invasive bursectomy with percutaneous drainage for bursopathy in the right shoulder. The procedure involved the insertion of a catheter into the inflamed bursa, followed by drainage of the accumulated fluid. The bursal tissue was then excised using specialized instruments through small incisions. Hemostasis was ensured, and the incisions were closed. The patient was provided with postoperative care instructions and scheduled for follow-up evaluation.

2. Operative Note: Patient underwent an open bursectomy with synovectomy for refractory bursopathy in the left hip. A lateral approach was used to access the inflamed bursa and synovial tissue. The bursa was meticulously excised, and the synovium was thoroughly resected. Hemostasis was achieved, and the wound was closed in layers. The patient was instructed on postoperative rehabilitation and pain management measures.

3. Operative Note: Patient underwent an endoscopic bursectomy with microfracture technique for bursopathy in the right knee. The arthroscope was used to visualize the intra-articular space and identify the affected bursa. The bursal tissue was excised, and microfracture was performed on the adjacent subchondral bone to promote cartilage healing. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions and was referred for physical therapy.

4. Operative Note: Patient underwent an open bursectomy with tendon repair for bursopathy and associated tendon injury in the left elbow. The inflamed bursal tissue was meticulously excised, and the injured tendon was repaired using sutures. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for immobilization and was scheduled for follow-up evaluation to monitor tendon healing.

5. Operative Note: Patient underwent an arthroscopic bursectomy with debridement and osteochondral grafting for bursopathy and cartilage defects in the right ankle. The arthroscope was used to assess the bursa and cartilage surfaces. The bursal tissue was excised, and the cartilage defects were debrided. Osteochondral grafts were harvested and inserted into the damaged areas. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions for weight-bearing restrictions and rehabilitation.

6. Operative Note: Patient underwent a percutaneous bursectomy with radiofrequency ablation for recurrent bursopathy in the left shoulder. The procedure involved the insertion of a radiofrequency probe into the bursa, which emitted high-frequency electrical currents to ablate the inflamed tissue. The bursa was then drained, and the probe was removed. Hemostasis was achieved, and the insertion site was covered with a sterile dressing. The patient received postoperative care instructions and pain management measures.

7. Operative Note: Patient underwent an open bursectomy with tendon release for bursopathy and associated tendonitis in the right knee. The bursal tissue was meticulously excised, and the affected tendon was released to alleviate tension and inflammation. Hemostasis was ensured, and the wound was closed in layers. The patient received postoperative instructions for physical therapy and pain management.

8. Operative Note: Patient underwent an endoscopic bursectomy with subacromial decompression for bursopathy and subacromial impingement in the left shoulder. The arthroscope was inserted, and the inflamed bursal tissue was excised. Subsequently, the subacrom

ial space was carefully examined, and any impinging structures were addressed through bursectomy and acromioplasty. Hemostasis was achieved, and the joint was irrigated. The patient received postoperative instructions and was scheduled for rehabilitation.

9. Operative Note: Patient underwent a minimally invasive bursectomy with capsular release for bursopathy and adhesive capsulitis in the right hip. The procedure involved the excision of the inflamed bursa and release of the tight capsular adhesions to improve joint mobility. Hemostasis was ensured, and the incisions were closed. The patient received postoperative care instructions and was referred for physical therapy to restore range of motion.

10. Operative Note: Patient underwent an open bursectomy with excision of calcific deposits for bursopathy and calcific tendinitis in the left ankle. The bursal tissue was meticulously excised, and the calcific deposits within the affected tendon were carefully removed. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for immobilization and pain management, along with a rehabilitation plan for tendon healing.

1. Operative Note: Patient underwent an arthroscopic bursectomy with partial meniscectomy for bursopathy and meniscal tear in the right knee. The inflamed bursal tissue was meticulously excised, and the torn portion of the meniscus was resected. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions for weight-bearing restrictions and rehabilitation.

2. Operative Note: Patient underwent an open bursectomy with tendon transfer for bursopathy and chronic tendon rupture in the left shoulder. The inflamed bursal tissue was meticulously excised, and the torn tendon was reconstructed using a tendon transfer technique. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for immobilization and was referred for physical therapy.

3. Operative Note: Patient underwent an endoscopic bursectomy with chondroplasty for bursopathy and chondral lesions in the right ankle. The arthroscope was used to visualize the bursa and the damaged cartilage surfaces. The bursal tissue was meticulously excised, and the chondral lesions were smoothed and debrided. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions and was referred for ankle rehabilitation.

4. Operative Note: Patient underwent a percutaneous bursectomy with ultrasound-guided injection for bursopathy and refractory bursal effusion in the left hip. The procedure involved the percutaneous removal of the inflamed bursal tissue and the subsequent injection of a corticosteroid and local anesthetic to alleviate inflammation and pain. Hemostasis was ensured, and the insertion site was covered with a sterile dressing. The patient received postoperative care instructions and pain management measures.

5. Operative Note: Patient underwent an open bursectomy with debridement and joint lavage for bursopathy and septic arthritis in the right knee. The inflamed bursal tissue was meticulously excised, and the joint was thoroughly irrigated to remove infectious material. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for antibiotic therapy and was referred for joint rehabilitation.

6. Operative Note: Patient underwent an endoscopic bursectomy with radiofrequency coblation for bursopathy and chronic inflammation in the left elbow. The arthroscope was inserted, and the inflamed bursal tissue was meticulously excised using radiofrequency coblation to minimize tissue damage. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions and was referred for rehabilitation therapy.

7. Operative Note: Patient underwent an open bursectomy with joint arthrodesis for bursopathy and severe degenerative arthritis in the right ankle. The inflamed bursal tissue was meticulously excised, and the joint was fused using screws and plates to provide stability and pain relief. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for immobilization and was scheduled for follow-up evaluation.

8. Operative Note: Patient underwent a minimally invasive bursectomy with balloon angioplasty for bursopathy and vascular compression syndrome in the left shoulder. The procedure involved the excision of the inflamed bursal tissue and the subsequent dilation of the compressed blood vessels using a balloon catheter. Hemostasis was ensured, and the incisions were closed. The patient received postoperative instructions and was referred for vascular rehabilitation.

9. Operative Note: Patient underwent an arthroscopic bursectomy with subchondral drilling for bursopathy and

osteochondral lesion in the right knee. The arthroscope was used to visualize the bursa and the damaged cartilage surface. The bursal tissue was meticulously excised, and subchondral drilling was performed to stimulate cartilage repair. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions and was scheduled for rehabilitation therapy.

10. Operative Note: Patient underwent an open bursectomy with nerve decompression for bursopathy and nerve entrapment in the left hip. The inflamed bursal tissue was meticulously excised, and the compressed nerve was released through a surgical decompression. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions and was referred for neurological rehabilitation.

1. Operative Note: Patient underwent an emergency open bursectomy with debridement for bursopathy and severe infection on the highly mobile left shoulder joint. The infected bursal tissue was meticulously excised, and extensive debridement was performed to remove necrotic material. Copious irrigation was carried out, and appropriate antibiotics were administered. Hemostasis was achieved, and the wound was closed with drains. The patient was transferred to the intensive care unit for close monitoring.

2. Operative Note: Patient underwent an urgent arthroscopic bursectomy with washout for bursopathy and severe septic arthritis on the highly mobile right hip joint. The inflamed bursal tissue was meticulously excised, and the joint was extensively irrigated to remove purulent fluid. Cultures were obtained, and appropriate intravenous antibiotics were initiated. Hemostasis was ensured, and the incisions were closed. The patient was admitted for further medical management and joint rehabilitation.

3. Operative Note: Patient underwent an emergency open bursectomy with joint exploration for bursopathy and severe infective tenosynovitis on the highly mobile left wrist joint. The infected bursal tissue was meticulously excised, and the involved tendons were explored. Purulent material was drained, and appropriate antibiotic irrigation was performed. Hemostasis was achieved, and the wound was closed with a sterile dressing. The patient was started on intravenous antibiotics and scheduled for follow-up evaluation.

4. Operative Note: Patient underwent an urgent endoscopic bursectomy with extensive debridement for bursopathy and severe deep joint infection on the highly mobile right knee joint. The inflamed bursal tissue was meticulously excised, and the joint was thoroughly debrided to remove infected synovium and debris. Copious irrigation was carried out, and appropriate antibiotics were administered. Hemostasis was ensured, and the incisions were closed. The patient was transferred to the intensive care unit for further management.

5. Operative Note: Patient underwent an emergency open bursectomy with extensive debridement and joint lavage for bursopathy and severe septic arthritis on the highly mobile left ankle joint. The infected bursal tissue was meticulously excised, and the joint was lavaged with copious amounts of sterile saline to flush out the infectious material. Cultures were obtained, and appropriate intravenous antibiotics were initiated. Hemostasis was achieved, and the wound was closed with drains. The patient was admitted for close monitoring and further medical management.

6. Operative Note: Patient underwent an urgent arthroscopic bursectomy with thorough debridement for bursopathy and severe septic arthritis on the highly mobile right elbow joint. The inflamed bursal tissue was meticulously excised, and the joint was extensively debrided to remove infected synovium and debris. Copious irrigation was performed, and appropriate antibiotics were administered. Hemostasis was ensured, and the incisions were closed. The patient was admitted for intravenous antibiotics and joint rehabilitation.

7. Operative Note: Patient underwent an emergency open bursectomy with joint exploration and extensive debridement for bursopathy and severe infective tenosynovitis on the highly mobile left shoulder joint. The infected bursal tissue was meticulously excised, and the joint and involved tendons were thoroughly explored. Purulent material was drained, and the joint was lavaged with antibiotic solution. Hemostasis was achieved, and the wound was closed with drains. The patient was transferred to the intensive care unit for further management.

8. Operative Note: Patient underwent an urgent endoscopic bursectomy with joint

washout for bursopathy and severe deep joint infection on the highly mobile right hip joint. The inflamed bursal tissue was meticulously excised, and the joint was extensively irrigated to remove infected fluid. Cultures were obtained, and appropriate intravenous antibiotics were initiated. Hemostasis was ensured, and the incisions were closed. The patient was admitted for further medical management and joint rehabilitation.

9. Operative Note: Patient underwent an emergency open bursectomy with extensive debridement for bursopathy and severe infective tenosynovitis on the highly mobile left wrist joint. The infected bursal tissue was meticulously excised, and the involved tendons were explored. Purulent material was drained, and the joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the wound was closed with a sterile dressing. The patient was started on intravenous antibiotics and scheduled for regular wound checks.

10. Operative Note: Patient underwent an urgent arthroscopic bursectomy with debridement and joint lavage for bursopathy and severe septic arthritis on the highly mobile right knee joint. The inflamed bursal tissue was meticulously excised, and the joint was extensively debrided to remove infected synovium and debris. Copious irrigation was performed, and appropriate antibiotics were administered. Hemostasis was ensured, and the incisions were closed. The patient was admitted for close monitoring, intravenous antibiotics, and joint rehabilitation.

1. Operative Note: Patient underwent an arthroscopic bursectomy with debridement for chronic bursopathy and mild-to-moderate inflammation in the right knee. The inflamed bursal tissue was meticulously excised, and the joint was debrided to remove any loose or damaged tissue. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions for pain management and rehabilitation.

2. Operative Note: Patient underwent an open bursectomy with synovectomy for recalcitrant bursopathy and severe inflammatory changes in the left shoulder. The inflamed bursal tissue was meticulously excised, and the synovium was extensively removed to alleviate inflammation and improve joint function. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for immobilization and rehabilitation.

3. Operative Note: Patient underwent an endoscopic bursectomy with corticosteroid injection for recurrent bursopathy and moderate inflammatory response in the right hip. The arthroscope was used to visualize the bursa, which was excised, and a corticosteroid was injected to reduce inflammation. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions for weight-bearing restrictions and follow-up evaluation.

4. Operative Note: Patient underwent a percutaneous bursectomy with cryotherapy for chronic bursopathy and mild inflammation in the left elbow. The procedure involved the percutaneous removal of the inflamed bursal tissue, followed by cryotherapy to minimize inflammation and provide pain relief. Hemostasis was ensured, and the insertion site was covered with a sterile dressing. The patient received postoperative care instructions and pain management measures.

5. Operative Note: Patient underwent an open bursectomy with tendon repair for bursopathy, tendonitis, and severe inflammatory changes in the right ankle. The inflamed bursal tissue was meticulously excised, and the injured tendon was repaired using sutures. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for immobilization, anti-inflammatory medications, and physical therapy.

6. Operative Note: Patient underwent an arthroscopic bursectomy with subacromial decompression for bursopathy and moderate inflammatory changes in the left shoulder. The arthroscope was inserted, and the inflamed bursal tissue was meticulously excised. Subsequently, subacromial decompression was performed to relieve impingement and reduce inflammation. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions and was referred for rehabilitation therapy.

7. Operative Note: Patient underwent an open bursectomy with debridement and joint lavage for bursopathy and severe inflammatory response in the right knee. The inflamed bursal tissue was meticulously excised, and the joint was extensively irrigated to remove inflammatory exudates. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for pain management, anti-inflammatory medications, and rehabilitation.

8. Operative Note: Patient underwent an endoscopic bursectomy with radiofrequency ablation for refractory bursopathy and high-grade inflammatory changes in the left hip. The arthroscope was inserted, and the inflamed bursal tissue was meticulously excised using radiofrequency ablation to minimize tissue damage and reduce inflammation. Hemostasis was ensured, and the joint was irrigated. The patient received postoperative instructions for pain management, anti-inflammatory medications, and physical therapy.

9. Operative Note: Patient underwent a percutaneous bursectomy with ultrasound-guided injection of platelet-rich plasma (PRP) for chronic bursopathy and moderate inflammatory response in the right elbow. The procedure involved the percutaneous removal of the inflamed bursal tissue, followed by the injection of PRP to promote tissue healing and reduce inflammation. Hemostasis was ensured, and the insertion site was covered with a sterile dressing. The patient received postoperative care instructions and was scheduled for follow-up evaluation.

10. Operative Note: Patient underwent an open bursectomy with intra-articular injection of hyaluronic acid for chronic bursopathy and mild-to-moderate inflammatory changes in the left ankle. The inflamed bursal tissue was meticulously excised, and hyaluronic acid was injected into the joint to provide lubrication and reduce inflammation. Hemostasis was achieved, and the wound was closed in layers. The patient received postoperative instructions for weight-bearing restrictions, anti-inflammatory medications, and physical therapy.

1. Operative Note: Patient underwent an arthroscopic bursectomy for bursopathy in the right knee. The inflamed bursal tissue was meticulously excised, and the joint was irrigated. Postoperative follow-up will be scheduled based on the severity of symptoms and the patient's response to conservative measures.

2. Operative Note: Patient underwent an open bursectomy for chronic bursopathy in the left shoulder. The inflamed bursal tissue was meticulously excised, and the wound was closed in layers. A follow-up appointment will be scheduled in two weeks to assess healing and determine the need for further intervention.

3. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the right ankle. The inflamed bursal tissue was meticulously excised, and the joint was irrigated. The patient will have a follow-up appointment in four weeks to assess progress and determine the need for additional treatments or rehabilitation.

4. Operative Note: Patient underwent a percutaneous bursectomy for bursopathy in the left hip. The inflamed bursal tissue was meticulously excised, and the insertion site was covered with a sterile dressing. The patient will have a follow-up appointment in one week to assess healing and determine the need for further interventions or physical therapy.

5. Operative Note: Patient underwent an open bursectomy for severe bursopathy in the right elbow. The inflamed bursal tissue was meticulously excised, and the wound was closed in layers. The patient will have a follow-up appointment in two weeks to assess healing and pain management, and further interventions will be determined based on the severity of symptoms.

6. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the left knee. The inflamed bursal tissue was meticulously excised, and the joint was irrigated. A follow-up appointment will be scheduled in six weeks to evaluate the patient's response to the procedure and determine the need for additional interventions or rehabilitation.

7. Operative Note: Patient underwent a percutaneous bursectomy for recurrent bursopathy in the right shoulder. The inflamed bursal tissue was meticulously excised, and the insertion site was covered with a sterile dressing. The patient will have a follow-up appointment in three weeks to assess the response to treatment and determine the need for further interventions or physical therapy.

8. Operative Note: Patient underwent an open bursectomy for chronic bursopathy in the left ankle. The inflamed bursal tissue was meticulously excised, and the wound was closed in layers. A follow-up appointment will be scheduled in four weeks to evaluate the patient's progress, assess the need for further interventions, and plan rehabilitation measures.

9. Operative Note: Patient underwent an endoscopic bursectomy for bursopathy in the right hip. The inflamed bursal tissue was meticulously excised, and the joint was irrigated. The patient will have a follow-up appointment in two weeks to evaluate the response to the procedure, manage pain, and discuss the need for additional interventions or physical therapy.

10. Operative Note: Patient underwent a percutaneous bursectomy for mild bursopathy in the left elbow. The inflamed bursal tissue was meticulously excised, and the insertion site was covered with a sterile dressing. A follow-up appointment will be scheduled in six weeks to evaluate the patient's progress, assess the need for further interventions, and plan rehabilitation measures based on the severity of symptoms.

## M72.0 Palmar fascial fibromatosis [Dupuytren]

1. Patient underwent surgical excision of palmar fascial fibromatosis using a transverse incision. The fibrous tissue was carefully dissected from the digital nerves and vessels. Hemostasis was achieved using bipolar cautery. The wound was closed with interrupted sutures, and a bulky dressing was applied.

2. Operative procedure involved fasciectomy of the palmar fascial fibromatosis. A midline longitudinal incision was made over the affected area. The diseased fascia was carefully separated from the surrounding structures. Hemostasis was ensured, and the wound was closed using absorbable sutures. Postoperative immobilization with a splint was advised.

3. Palmar fascial fibromatosis was treated with percutaneous needle aponeurotomy. Multiple needle punctures were made along the fibrous bands, releasing the contracture. The procedure was performed under local anesthesia. The patient was instructed to perform finger exercises postoperatively.

4. Patient underwent collagenase injection for palmar fascial fibromatosis. A solution of collagenase was injected into the affected area, followed by gentle manipulation to break down the fibrous tissue. Post-injection splinting was advised for optimal results.

5. Surgical release of palmar fascial fibromatosis was performed using a zigzag incision. The fibrous bands were meticulously dissected, ensuring preservation of neurovascular structures. Hemostasis was achieved using electrocautery. The wound was closed in layers, and a bulky dressing was applied.

6. Operative procedure involved dermofasciectomy for palmar fascial fibromatosis. A full-thickness skin and fascia excision was performed, followed by meticulous closure using interrupted sutures. A sterile dressing and a volar splint were applied postoperatively.

7. Patient underwent minimally invasive endoscopic release of palmar fascial fibromatosis. Small incisions were made, and an endoscope was inserted to visualize and release the fibrous bands. The procedure was performed under local anesthesia, and postoperative hand therapy was recommended.

8. Limited fasciectomy was performed for palmar fascial fibromatosis. The fibrous bands were excised through a small incision, focusing on the most affected areas. The wound was closed with sutures, and a compressive dressing was applied.

9. Percutaneous radiofrequency ablation was used to treat palmar fascial fibromatosis. A radiofrequency probe was inserted into the fibrous bands, delivering thermal energy to break down the tissue. The procedure was performed under local anesthesia, and postoperative hand exercises were advised.

10. Patient underwent needle fasciotomy for palmar fascial fibromatosis. Multiple needle punctures were made along the contractures, relieving the tightness. The procedure was performed under local anesthesia, and the patient was instructed to perform regular finger exercises for optimal recovery.

1. Palmar fascial fibromatosis was treated with a wide local excision. An elliptical incision was made, encompassing the affected area. The fibrotic tissue was carefully dissected and sent for histopathological examination. The wound was closed in layers, and a sterile dressing was applied.

2. Operative procedure involved a partial fasciectomy for palmar fascial fibromatosis. A curved incision was made over the fibrous bands, and the affected fascia was excised. Hemostasis was achieved, and the wound was closed using absorbable sutures. A hand splint was provided postoperatively.

3. Patient underwent ultrasound-guided percutaneous fasciotomy for palmar fascial fibromatosis. Under ultrasound guidance, a needle was inserted to divide the fibrotic bands. The procedure was performed under local anesthesia, and the patient was advised on hand exercises for rehabilitation.

4. Surgical release of palmar fascial fibromatosis was performed using a Bruner incision. The fibrous tissue was carefully excised, ensuring preservation of the underlying structures. Hemostasis was achieved, and the wound was closed with interrupted sutures. A bulky dressing and splint were applied postoperatively.

5. Operative procedure involved enzymatic fasciotomy for palmar fascial fibromatosis. An enzyme solution was injected into the affected area, promoting enzymatic breakdown of the fibrotic tissue. Gentle manipulation was performed to further release the contracture. Post-procedure hand therapy was recommended.

6. Patient underwent minimally invasive percutaneous collagenase injection for palmar fascial fibromatosis. A solution of collagenase was injected into the fibrous bands, followed by controlled manipulation to break down the contracture. Post-injection splinting and hand exercises were advised.

7. Palmar fascial fibromatosis was treated with a limited open fasciectomy. A small incision was made, and the fibrotic bands were excised. Care was taken to protect the adjacent neurovascular structures. The wound was closed using sutures, and a hand splint was applied.

8. Surgical release of palmar fascial fibromatosis was performed using a volar zigzag incision. The fibrous bands were carefully dissected, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. Postoperative hand therapy and splinting were recommended.

9. Patient underwent ultrasound-guided percutaneous needle fasciotomy for palmar fascial fibromatosis. Under ultrasound guidance, a needle was inserted to release the contractures. Multiple punctures were made along the fibrotic bands. The patient was instructed to perform finger exercises postoperatively.

10. Operative procedure involved wide local excision with skin grafting for palmar fascial fibromatosis. The fibrotic tissue was excised, and a split-thickness skin graft was harvested and applied. The graft was secured with sutures, and a bulky dressing was applied for graft protection.

1. Patient underwent surgical excision of palmar fascial fibromatosis under local anesthesia with sedation. A transverse incision was made, and the fibrous tissue was meticulously dissected and removed. Hemostasis was ensured, and the wound was closed using interrupted sutures. The patient remained comfortable throughout the procedure.

2. Operative procedure involved fasciectomy of palmar fascial fibromatosis under regional anesthesia. A midline longitudinal incision was made, and the affected fascia was carefully excised. Hemostasis was achieved using electrocautery. The wound was closed in layers, and the patient had a pain-free surgical experience.

3. Palmar fascial fibromatosis was treated with percutaneous needle aponeurotomy under general anesthesia. Multiple needle punctures were made along the fibrous bands, releasing the contracture. The patient was completely unaware and pain-free during the procedure.

4. Patient underwent collagenase injection for palmar fascial fibromatosis under local anesthesia. The solution of collagenase was injected into the affected area, followed by gentle manipulation. The patient remained comfortable with minimal discomfort during the injection.

5. Surgical release of palmar fascial fibromatosis was performed under monitored anesthesia care (MAC). A zigzag incision was made, and the fibrous bands were carefully dissected. Hemostasis was achieved using bipolar cautery. The patient experienced mild sedation and amnesia during the procedure.

6. Operative procedure involved dermofasciectomy for palmar fascial fibromatosis under general anesthesia. Full-thickness skin and fascia excision were performed, followed by meticulous closure. The patient was completely asleep and pain-free throughout the surgery.

7. Patient underwent minimally invasive endoscopic release of palmar fascial fibromatosis under local anesthesia with intravenous (IV) sedation. Small incisions were made, and an endoscope was inserted to visualize and release the fibrous bands. The patient experienced a comfortable procedure with minimal awareness.

8. Limited fasciectomy was performed for palmar fascial fibromatosis under spinal anesthesia. The fibrous bands were excised through a small incision, focusing on the most affected areas. The patient remained awake and pain-free during the surgery.

9. Percutaneous radiofrequency ablation was used to treat palmar fascial fibromatosis under conscious sedation. A radiofrequency probe was inserted into the fibrous bands, delivering thermal energy to break down the tissue. The patient experienced minimal discomfort and amnesia during the procedure.

10. Patient underwent needle fasciotomy for palmar fascial fibromatosis under local anesthesia with minimal sedation. Multiple needle punctures were made along the contractures, relieving the tightness. The patient remained awake and comfortable throughout the procedure.

1. Patient underwent surgical excision of palmar fascial fibromatosis with bone erosion under general anesthesia. A longitudinal incision was made, and the fibrous tissue along with the eroded bone was meticulously removed. Hemostasis was achieved, and the wound was closed using absorbable sutures. Postoperative imaging was recommended to assess the extent of bone erosion.

2. Operative procedure involved wide local excision and bone debridement for palmar fascial fibromatosis with bone erosion under regional anesthesia. The fibrotic tissue was excised, and the eroded bone was carefully debrided. The wound was closed in layers, and appropriate antibiotics were administered to prevent infection.

3. Palmar fascial fibromatosis with bone erosion was treated with a combination of partial fasciectomy and bone grafting under general anesthesia. The affected fascia and eroded bone were excised, and a bone graft was applied to restore the integrity of the bone. The patient was provided with postoperative immobilization.

4. Patient underwent limited fasciectomy with bone erosion repair for palmar fascial fibromatosis under spinal anesthesia. The fibrous bands were excised, and the eroded bone was meticulously addressed. A combination of bone grafting and bone substitute material was used for reconstruction. Postoperative imaging was planned to evaluate bone healing.

5. Surgical release of palmar fascial fibromatosis with extensive bone erosion was performed under general anesthesia. A modified zigzag incision was made to address the fibrous tissue and the eroded bone. Careful bone debridement and thorough irrigation were performed. The wound was closed in layers, and postoperative bone strengthening measures were implemented.

6. Operative procedure involved dermofasciectomy with bone erosion reconstruction for palmar fascial fibromatosis under general anesthesia. Full-thickness skin and fascia excision were performed, and the eroded bone was carefully managed. A bone graft was utilized to reconstruct the affected bone. The wound was closed meticulously, and postoperative imaging was recommended.

7. Patient underwent minimally invasive endoscopic release and bone augmentation for palmar fascial fibromatosis with bone erosion under local anesthesia with sedation. The endoscope was used to visualize and release the fibrotic bands, while bone augmentation was performed using bone substitute material. The patient experienced minimal discomfort and postoperative imaging was advised.

8. Limited fasciectomy with bone erosion repair was performed for palmar fascial fibromatosis under regional anesthesia. The fibrotic tissue was excised, and the eroded bone was carefully addressed. Bone grafting and stabilization with internal fixation were performed. The patient was provided with appropriate postoperative care.

9. Palmar fascial fibromatosis with significant bone erosion was treated with wide local excision and bone grafting under general anesthesia. The affected tissue and eroded bone were meticulously removed, and a bone graft was placed to restore bone integrity. The wound was closed meticulously, and postoperative imaging was planned.

10. Patient underwent needle fasciotomy with bone erosion debridement for palmar fascial fibromatosis under local anesthesia. Multiple needle punctures were made to release the contractures, while bone debridement was performed to address the eroded bone. The patient experienced minimal discomfort, and postoperative imaging was recommended to assess bone healing.

1. Patient presented with severe bone pain associated with palmar fascial fibromatosis. Surgical intervention was performed under general anesthesia. A wide excision of the fibrotic tissue and thorough debridement of the eroded bone were carried out. Pain management strategies, including multimodal analgesia, were employed postoperatively.

2. Operative procedure involved extensive fasciectomy and bone resection for palmar fascial fibromatosis with severe bone pain. The fibrous bands were excised, and the eroded bone was carefully resected. Adequate pain control measures, including regional anesthesia and postoperative pain medications, were utilized for optimal pain relief.

3. Palmar fascial fibromatosis with severe bone pain was treated with a combination of fasciectomy, bone debridement, and nerve block under general anesthesia. The fibrotic tissue, eroded bone, and affected nerves were meticulously addressed. Postoperatively, a tailored pain management plan was implemented.

4. Patient underwent wide local excision and bone grafting for palmar fascial fibromatosis with severe bone pain under general anesthesia. The fibrous tissue was excised, and the eroded bone was thoroughly debrided. A bone graft was utilized to promote bone healing and alleviate pain. Appropriate pain medications were administered postoperatively.

5. Surgical release of palmar fascial fibromatosis with severe bone pain was performed under regional anesthesia. The fibrotic bands were excised, and meticulous bone debridement was carried out to address the underlying bone pathology. A comprehensive pain management protocol was initiated postoperatively.

6. Operative procedure involved dermofasciectomy with bone resection for palmar fascial fibromatosis with severe bone pain under general anesthesia. Full-thickness skin and fascia excision were performed, and the eroded bone was meticulously resected. A multimodal approach to pain management, including analgesic medications and physical therapy, was implemented postoperatively.

7. Patient presented with severe bone pain associated with palmar fascial fibromatosis. Surgical intervention was performed under monitored anesthesia care (MAC). The fibrous tissue was excised, and the eroded bone was carefully addressed. A personalized pain management plan, including medications and adjunctive therapies, was implemented.

8. Extensive fasciectomy and bone reconstruction were performed for palmar fascial fibromatosis with severe bone pain under general anesthesia. The fibrotic tissue was excised, and bone reconstruction was carried out using autograft or allograft. A comprehensive pain management regimen, including systemic and local interventions, was employed postoperatively.

9. Palmar fascial fibromatosis with severe bone pain was treated with a combination of minimally invasive endoscopic release, bone debridement, and nerve block under local anesthesia with sedation. The fibrous bands were released, eroded bone was debrided, and nerve block was administered for effective pain control.

10. Patient underwent needle fasciotomy with bone debridement for palmar fascial fibromatosis with severe bone pain under local anesthesia. Multiple needle punctures were made to release the contractures, and meticulous bone debridement was performed to address the underlying bone pain. A multimodal approach to pain management was initiated postoperatively.

1. Surgical intervention involving wide local excision and bone grafting was performed for severe palmar fascial fibromatosis with associated bone pain. The fibrous tissue was excised, and the eroded bone was meticulously debrided. A bone graft was applied to promote bone healing and alleviate pain. Postoperative pain management strategies were implemented to ensure optimal recovery.

2. Patient underwent surgical release and bone augmentation for severe palmar fascial fibromatosis with debilitating bone pain. The fibrotic bands were released, and bone augmentation was performed using autograft or allograft material. The procedure was carried out under general anesthesia to ensure patient comfort and pain relief.

3. Operative procedure involved extensive fasciectomy and bone resection for severe palmar fascial fibromatosis with excruciating bone pain. The fibrous tissue was excised, and the eroded bone was meticulously resected. Adequate pain control measures, such as regional anesthesia and postoperative analgesics, were employed to alleviate pain.

4. Surgical intervention consisting of dermofasciectomy and bone reconstruction was performed for severe palmar fascial fibromatosis with severe bone pain. Full-thickness skin and fascia excision were performed, and the eroded bone was carefully addressed. Bone reconstruction techniques, such as bone grafting, were employed to restore bone integrity and relieve pain.

5. Patient underwent surgical excision and bone debridement for severe palmar fascial fibromatosis with incapacitating bone pain. The fibrotic tissue was excised, and meticulous debridement of the eroded bone was carried out. The surgical intervention was performed under general anesthesia to ensure patient comfort and adequate pain control.

6. Operative procedure involved limited fasciectomy and bone stabilization for severe palmar fascial fibromatosis with severe bone pain. The fibrous bands were excised, and the eroded bone was carefully addressed. Bone stabilization techniques, such as internal fixation, were utilized to alleviate pain and promote bone healing.

7. Palmar fascial fibromatosis with severe bone pain was treated with surgical release and bone grafting under general anesthesia. The fibrotic tissue was released, and a bone graft was applied to address the eroded bone. The surgical intervention aimed to alleviate pain and improve hand function.

8. Patient underwent surgical resection and bone reconstruction for severe palmar fascial fibromatosis with intense bone pain. The fibrous tissue was resected, and meticulous reconstruction of the eroded bone was performed. The surgical intervention was carried out under regional anesthesia for effective pain management.

9. Surgical intervention involving extensive fasciectomy and bone grafting was performed for severe palmar fascial fibromatosis with debilitating bone pain. The fibrotic bands were excised, and the eroded bone was meticulously addressed. Bone grafting techniques were employed to promote bone healing and alleviate pain.

10. Operative procedure involved dermofasciectomy and bone debridement for severe palmar fascial fibromatosis with excruciating bone pain. Full-thickness skin and fascia excision were performed, and the eroded bone was meticulously debrided. The surgical intervention aimed to relieve pain and improve hand function.

1. Patient underwent surgical intervention consisting of wide local excision and bone stabilization for severe palmar fascial fibromatosis with persistent bone pain. The fibrous tissue was excised, and the eroded bone was stabilized using internal fixation. The procedure was performed under general anesthesia to ensure patient comfort and pain relief.

2. Surgical release and bone debridement were performed for severe palmar fascial fibromatosis with intractable bone pain. The fibrotic bands were released, and meticulous debridement of the eroded bone was carried out. The surgical intervention was conducted under regional anesthesia to optimize pain management during and after the procedure.

3. Operative procedure involved extensive fasciectomy and bone reconstruction for severe palmar fascial fibromatosis with debilitating bone pain. The fibrous tissue was excised, and the eroded bone was carefully reconstructed using bone grafts or substitutes. The surgical intervention was performed under general anesthesia to ensure patient comfort and optimal pain control.

4. Surgical intervention consisting of dermofasciectomy and bone augmentation was performed for severe palmar fascial fibromatosis with severe bone pain. Full-thickness skin and fascia excision were carried out, and bone augmentation was performed to address the eroded bone. The procedure was conducted under general anesthesia to facilitate pain relief and promote healing.

5. Patient underwent surgical excision and bone grafting for severe palmar fascial fibromatosis with excruciating bone pain. The fibrotic tissue was excised, and a bone graft was applied to promote bone healing and alleviate pain. The surgical intervention was performed under general anesthesia to ensure patient comfort during the procedure.

6. Operative procedure involved limited fasciectomy and bone stabilization for severe palmar fascial fibromatosis with persistent bone pain. The fibrotic bands were excised, and the eroded bone was stabilized using techniques such as internal fixation. The surgical intervention was carried out under regional anesthesia to provide effective pain management.

7. Palmar fascial fibromatosis with severe bone pain was treated with surgical release and bone reconstruction under general anesthesia. The fibrous tissue was released, and the eroded bone was reconstructed using bone grafts or substitutes. The surgical intervention aimed to alleviate pain and restore function to the hand.

8. Patient underwent surgical resection and bone debridement for severe palmar fascial fibromatosis with debilitating bone pain. The fibrotic tissue was resected, and meticulous debridement of the eroded bone was performed. The surgical intervention was carried out under general anesthesia to ensure optimal pain control and patient comfort.

9. Surgical intervention involving extensive fasciectomy and bone grafting was performed for severe palmar fascial fibromatosis with severe bone pain. The fibrotic bands were excised, and a bone graft was applied to promote bone healing and relieve pain. The procedure was conducted under general anesthesia to facilitate a pain-free experience.

10. Operative procedure involved dermofasciectomy and bone stabilization for severe palmar fascial fibromatosis with persistent bone pain. Full-thickness skin and fascia excision were performed, and the eroded bone was stabilized using techniques such as internal fixation. The surgical intervention aimed to alleviate pain and improve hand function.

1. Surgical intervention was performed for severe palmar fascial fibromatosis with a concomitant severe infection on the extreme moving joint. Wide local excision of the infected tissue and aggressive debridement of the eroded bone were carried out. Intravenous antibiotics were administered perioperatively, and close monitoring was initiated to ensure effective infection control.

2. Patient underwent surgical release and infection debridement for severe palmar fascial fibromatosis with a severe infection on the extreme moving joint. The fibrotic bands were released, and meticulous debridement of the infected joint was performed. A multidisciplinary approach, involving infectious disease specialists, was taken to manage the infection.

3. Operative procedure involved extensive fasciectomy, joint irrigation, and debridement for severe palmar fascial fibromatosis with an extremely infected moving joint. The fibrous tissue was excised, and thorough irrigation and debridement of the infected joint were performed. Intravenous antibiotics were administered to target the infection.

4. Surgical intervention consisting of dermofasciectomy, joint washout, and debridement was performed for severe palmar fascial fibromatosis with a severe infection on the extreme moving joint. Full-thickness skin and fascia excision were performed, followed by meticulous irrigation and debridement of the infected joint. Postoperatively, aggressive antibiotic therapy was initiated.

5. Patient presented with severe infection on the extreme moving joint associated with palmar fascial fibromatosis. Surgical intervention involving wide excision of the infected tissue, joint debridement, and irrigation was performed. Appropriate antibiotic therapy and wound care measures were instituted to control the infection and promote healing.

6. Operative procedure involved limited fasciectomy, joint lavage, and debridement for severe palmar fascial fibromatosis with a severe infection on the extreme moving joint. The fibrotic bands were excised, and meticulous lavage and debridement of the infected joint were performed. Intravenous antibiotics were administered to target the infectious process.

7. Severe infection on the extreme moving joint associated with palmar fascial fibromatosis necessitated surgical intervention. Wide local excision of the infected tissue, joint debridement, and thorough irrigation were performed. Postoperatively, systemic antibiotics and wound care measures were employed to combat the infection.

8. Patient underwent surgical release, joint washout, and debridement for severe palmar fascial fibromatosis with an extremely infected moving joint. The fibrotic bands were released, and extensive debridement and irrigation of the infected joint were carried out. A comprehensive antibiotic regimen was initiated to treat the infection.

9. Surgical intervention involving extensive fasciectomy, joint irrigation, and debridement was performed for severe palmar fascial fibromatosis with a severe infection on the extreme moving joint. The fibrous tissue was excised, and thorough joint debridement and irrigation were performed to address the infection. Systemic antibiotics were administered perioperatively.

10. Severe infection on the extreme moving joint associated with palmar fascial fibromatosis required surgical intervention. Dermofasciectomy, joint washout, and debridement were performed to eradicate the infection. Postoperatively, a combination of intravenous antibiotics and wound care measures were implemented to promote healing and prevent recurrence.

1. Surgical intervention was performed for severe palmar fascial fibromatosis with marked inflammation in the affected area. Wide local excision of the inflamed tissue and meticulous debridement of the eroded bone were carried out. Postoperative anti-inflammatory medications and appropriate wound care measures were employed to reduce inflammation and promote healing.

2. Patient underwent surgical release and inflammation management for severe palmar fascial fibromatosis with significant inflammatory changes. The fibrotic bands were released, and measures such as cold compression and nonsteroidal anti-inflammatory drugs (NSAIDs) were utilized postoperatively to reduce inflammation and alleviate symptoms.

3. Operative procedure involved extensive fasciectomy and targeted inflammation control for severe palmar fascial fibromatosis with pronounced inflammation. The fibrous tissue was excised, and adjunctive measures, such as intraoperative corticosteroid injections or postoperative anti-inflammatory medications, were employed to manage inflammation and improve patient outcomes.

4. Surgical intervention consisting of dermofasciectomy and inflammation reduction was performed for severe palmar fascial fibromatosis with significant inflammation. Full-thickness skin and fascia excision were carried out, and postoperatively, anti-inflammatory strategies were employed, such as the use of NSAIDs or corticosteroid injections, to minimize inflammation and promote healing.

5. Patient presented with severe inflammation associated with palmar fascial fibromatosis. Surgical intervention involving wide excision of the inflamed tissue and meticulous debridement of the eroded bone was performed. Postoperatively, a combination of anti-inflammatory medications and targeted wound care was employed to manage inflammation and facilitate recovery.

6. Operative procedure involved limited fasciectomy and inflammation control for severe palmar fascial fibromatosis with pronounced inflammation. The fibrotic bands were excised, and measures such as the use of topical or systemic anti-inflammatory medications were employed to reduce inflammation and alleviate symptoms.

7. Severe inflammation associated with palmar fascial fibromatosis necessitated surgical intervention. Wide local excision of the inflamed tissue and thorough debridement of the eroded bone were performed. Postoperatively, a tailored anti-inflammatory regimen and appropriate wound care measures were implemented to manage inflammation and promote healing.

8. Patient underwent surgical release and inflammation reduction for severe palmar fascial fibromatosis with significant inflammatory changes. The fibrotic bands were released, and adjunctive measures, such as the use of anti-inflammatory medications or local corticosteroid injections, were employed to minimize inflammation and improve patient comfort.

9. Surgical intervention involving extensive fasciectomy and targeted inflammation management was performed for severe palmar fascial fibromatosis with pronounced inflammation. The fibrous tissue was excised, and postoperatively, anti-inflammatory strategies such as the administration of NSAIDs or the use of cold compression were employed to reduce inflammation and promote healing.

10. Severe inflammation associated with palmar fascial fibromatosis required surgical intervention. Dermofasciectomy and inflammation control were performed, with full-thickness skin and fascia excision followed by the use of anti-inflammatory medications or local corticosteroid injections to manage inflammation and facilitate recovery.

1. Postoperative follow-up will be tailored based on the severity of the diagnosis of palmar fascial fibromatosis. For patients with mild disease, regular outpatient visits at three-month intervals will be scheduled to monitor symptoms and assess response to conservative management. Patients with moderate to severe disease will require more frequent follow-up visits, typically every four to six weeks, to closely monitor disease progression, evaluate treatment effectiveness, and consider the need for surgical intervention if conservative measures prove inadequate.

2. The frequency and intensity of follow-up visits for patients diagnosed with palmar fascial fibromatosis will be determined by the severity of the condition. Patients with mild symptoms will be recommended for regular follow-up every six months to assess any progression. Those with moderate disease will require closer monitoring, with follow-up appointments scheduled every three months. Patients with severe disease will be closely monitored through monthly follow-ups to evaluate treatment response and consider surgical intervention if necessary.

3. Follow-up protocols will be individualized based on the severity of the diagnosis of palmar fascial fibromatosis. Patients with mild disease may require periodic outpatient visits every six to twelve months to monitor symptom progression and evaluate the need for conservative interventions. For those with moderate disease, follow-up visits will be scheduled every three to six months to closely monitor symptoms, assess response to treatment, and consider the need for more aggressive management options. Patients with severe disease will require frequent follow-ups every one to three months for close monitoring, treatment adjustments, and potential surgical intervention.

4. The follow-up plan for patients diagnosed with palmar fascial fibromatosis will be determined by the severity of the disease. Patients with mild disease may be recommended for follow-up visits every six to twelve months to assess symptoms and response to conservative management. Patients with moderate disease will require closer monitoring, with follow-up visits scheduled every three to six months to evaluate disease progression, consider additional treatment options, and assess the need for surgical intervention. Patients with severe disease will require frequent follow-ups every one to three months to closely monitor symptoms, evaluate treatment effectiveness, and determine the timing of surgical intervention if warranted.

5. The frequency and nature of follow-up visits will be dictated by the severity of the diagnosis of palmar fascial fibromatosis. Patients with mild disease will be scheduled for regular follow-up appointments every six to twelve months to evaluate symptoms and consider conservative treatment options. Patients with moderate disease will require more frequent follow-ups every three to six months to closely monitor disease progression, assess response to treatment, and discuss potential surgical interventions if necessary. Patients with severe disease will have frequent follow-ups every one to three months to closely monitor symptoms, evaluate treatment efficacy, and determine the need for surgical intervention.

6. Follow-up strategies for patients diagnosed with palmar fascial fibromatosis will be stratified based on the severity of the condition. Patients with mild disease will be recommended for periodic follow-up visits every six to twelve months to assess symptom stability and consider conservative management options. Patients with moderate disease will require closer monitoring, with follow-up visits every three to six months to evaluate disease progression, assess treatment response, and discuss the possibility of surgical intervention. Patients with severe disease will necessitate frequent follow-ups every one to three months to closely monitor symptoms, assess treatment efficacy, and determine the optimal timing for surgical intervention.

7. The follow-up plan for patients with palmar fascial fibromatosis will be tailored based on the severity of the diagnosis. Patients with mild disease will be advised to have periodic follow-up appointments every six to twelve months to evaluate symptoms and discuss conservative treatment strategies. Patients with moderate disease will require more frequent follow-ups every three to six months to closely monitor disease progression, assess response to treatment, and consider the need for surgical intervention. Patients with severe disease will necessitate frequent

follow-ups every one to three months to monitor symptoms, evaluate treatment efficacy, and discuss surgical management options.

8. Follow-up arrangements for patients diagnosed with palmar fascial fibromatosis will be customized according to the severity of the condition. Patients with mild disease will be recommended for periodic follow-up visits every six to twelve months to assess symptom evolution and explore non-surgical interventions. Patients with moderate disease will require closer monitoring, with follow-up appointments scheduled every three to six months to evaluate disease progression, assess the effectiveness of conservative measures, and discuss the potential need for surgical intervention. Patients with severe disease will necessitate frequent follow-ups every one to three months to closely monitor symptoms, assess treatment response, and determine the optimal timing for surgical intervention.

9. The frequency and nature of follow-up visits will be determined by the severity of the diagnosis of palmar fascial fibromatosis. Patients with mild disease will be scheduled for regular follow-up appointments every six to twelve months to evaluate symptom progression and explore non-surgical treatment options. For patients with moderate disease, follow-up visits will be more frequent, typically every three to six months, to closely monitor disease activity, assess response to treatment, and consider the need for surgical intervention. Patients with severe disease will require frequent follow-ups every one to three months to closely monitor symptoms, evaluate treatment efficacy, and determine the timing of surgical intervention if indicated.

10. Follow-up protocols will be tailored based on the severity of the diagnosis of palmar fascial fibromatosis. Patients with mild disease will be recommended for periodic follow-up visits every six to twelve months to assess symptom stability and discuss conservative management strategies. Patients with moderate disease will require more frequent follow-ups every three to six months to closely monitor disease progression, assess response to treatment, and evaluate the need for surgical intervention. Patients with severe disease will necessitate frequent follow-ups every one to three months to closely monitor symptoms, assess treatment effectiveness, and determine the optimal timing for surgical intervention.

## M72.1 Knuckle pads

1. Operative Note: Patient underwent excision of knuckle pads. A dorsal longitudinal incision was made over the affected joints. The subcutaneous tissues were dissected, revealing the fibrous nodules. The knuckle pads were excised using sharp dissection, ensuring complete removal. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and postoperative instructions were provided.

2. Operative Note: Knuckle pad removal was performed on the patient. A zigzag incision was made over the affected areas. Careful dissection was performed to expose the nodular masses. The knuckle pads were excised meticulously using scissors and electrocautery. Hemostasis was secured, and the wound was closed primarily. The patient was stable throughout the procedure, and appropriate postoperative care was initiated.

3. Operative Note: Excision of knuckle pads was carried out on the patient. A curvilinear incision was made, allowing access to the fibrous overgrowths. The nodules were dissected free from the underlying structures using a combination of sharp and blunt dissection. Electrocautery was employed to control bleeding. Closure was performed in layers, and the patient's condition remained stable. Postoperative recommendations were given for optimal recovery.

4. Operative Note: Knuckle pad removal was performed under local anesthesia. An elliptical incision was made around the affected areas. The nodules were carefully excised using a combination of sharp and blunt dissection. Electrocautery was utilized to achieve hemostasis. The wound was meticulously closed using absorbable sutures. The patient tolerated the procedure well, and appropriate wound care instructions were provided.

5. Operative Note: Excision of knuckle pads was carried out on the patient's hand. An inverted V-shaped incision was made, exposing the fibrous growths. The nodules were meticulously dissected and removed, ensuring complete excision. Hemostasis was achieved using electrocautery. The wound was closed primarily with interrupted sutures. The patient's vital signs remained stable, and postoperative pain management was initiated.

6. Operative Note: Knuckle pad removal was performed on the patient's digits. A transverse incision was made over the affected joints. Sharp dissection was used to expose the fibrous overgrowths. The nodules were excised with care, preserving the underlying structures. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and a follow-up appointment was scheduled.

7. Operative Note: Excision of knuckle pads was carried out bilaterally. An oblique incision was made over the affected metacarpophalangeal joints. Sharp dissection was performed to expose the nodular masses. The knuckle pads were meticulously excised, ensuring complete removal. Hemostasis was obtained, and the wound was closed primarily. The patient's condition remained stable throughout the procedure, and postoperative instructions were provided.

8. Operative Note: Knuckle pad removal was performed on the patient's fingers. A longitudinal incision was made over the involved interphalangeal joints. The nodules were dissected free from the surrounding tissues using careful sharp dissection. Electrocautery was used to achieve hemostasis. The wound was closed primarily with absorbable sutures. The patient tolerated the procedure well, and appropriate postoperative wound care was advised.

9. Operative Note: Excision of knuckle pads was performed on the patient's hand. A circumferential incision was made around the affected joints. Careful dissection was carried out, exposing the fibrous nodules. The knuckle pads were meticulously excised, ensuring complete removal. Hemostasis was achieved using electrocautery. The wound was closed primarily with interrupted sutures. The patient's vital signs were stable, and postoperative follow-up was arranged.

10. Operative Note: Knuckle pad removal was performed bilaterally on the patient. Multiple linear incisions were made over the nodular areas. The fibrous growths were carefully dissected free from the underlying tissues. Sharp excision was performed to remove the knuckle pads completely. Hemostasis was achieved using bipolar electrocautery. The wounds were closed primarily with absorbable sutures. The patient's postoperative course was uneventful, and wound healing was satisfactory.

1. Operative Note: Excision of knuckle pads was performed under local anesthesia. A midline longitudinal incision was made over the affected joints. The fibrous nodules were carefully dissected and removed using sharp dissection. Hemostasis was achieved, and the wound was closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain management and hand therapy were initiated.

2. Operative Note: Knuckle pad removal was carried out bilaterally. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were dissected meticulously, preserving the surrounding structures. Electrocautery was employed for hemostasis. Closure was performed using interrupted sutures. The patient remained stable throughout the procedure, and postoperative wound care instructions were given.

3. Operative Note: Excision of knuckle pads was performed on the patient's hand. Multiple transverse incisions were made over the affected interphalangeal joints. The nodules were carefully dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed with absorbable sutures. The patient's vital signs were stable, and postoperative follow-up was scheduled.

4. Operative Note: Knuckle pad removal was carried out on the patient's fingers. Zigzag incisions were made over the affected digits. The fibrous overgrowths were meticulously dissected and excised using a combination of sharp and blunt dissection. Hemostasis was achieved with electrocautery. The wounds were closed primarily with interrupted sutures. The patient tolerated the procedure well, and appropriate postoperative instructions were provided.

5. Operative Note: Excision of knuckle pads was performed on the patient. An inverted U-shaped incision was made, exposing the nodular masses. The fibrous growths were meticulously dissected and removed. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient remained stable throughout the procedure, and postoperative wound care was initiated.

6. Operative Note: Knuckle pad removal was performed bilaterally on the patient's hand. A combination of longitudinal and transverse incisions was made over the affected joints. Sharp dissection was used to expose and excise the fibrous nodules. Hemostasis was achieved with electrocautery. The wounds were closed primarily with absorbable sutures. The patient's condition was stable, and postoperative recommendations were given.

7. Operative Note: Excision of knuckle pads was performed on the patient's fingers. Elliptical incisions were made around the affected interphalangeal joints. The nodules were meticulously dissected and removed, ensuring complete excision. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain control was initiated.

8. Operative Note: Knuckle pad removal was carried out on the patient's hand. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed primarily. The patient's vital signs remained stable throughout the procedure, and postoperative wound care instructions were provided.

9. Operative Note: Excision of knuckle pads was performed under regional anesthesia. Multiple linear incisions were made over the nodular areas. The fibrous overgrowths were carefully dissected free from the underlying tissues. Hemostasis was achieved with meticulous electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and follow-up arrangements were made.

10. Operative Note: Knuckle pad removal was performed bilaterally on the patient's digits. Zigzag incisions were made over the affected interphalangeal joints. The nodules were dissected meticulously, ensuring complete removal. Hemostasis was achieved using bipolar electrocautery. The wounds were closed primarily with absorbable sutures. The patient's condition remained stable, and postoperative wound care instructions were provided.

1. Operative Note: Excision of knuckle pads was performed under local anesthesia with 1% lidocaine. A midline longitudinal incision was made over the affected joints. The fibrous nodules were carefully dissected and removed using sharp dissection. Hemostasis was achieved, and the wound was closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain management and hand therapy were initiated.

2. Operative Note: Knuckle pad removal was carried out bilaterally under regional anesthesia with 0.5% bupivacaine. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were dissected meticulously, preserving the surrounding structures. Electrocautery was employed for hemostasis. Closure was performed using interrupted sutures. The patient remained stable throughout the procedure, and postoperative wound care instructions were given.

3. Operative Note: Excision of knuckle pads was performed on the patient's hand under general anesthesia. Multiple transverse incisions were made over the affected interphalangeal joints. The nodules were carefully dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed with absorbable sutures. The patient's vital signs were stable, and postoperative follow-up was scheduled.

4. Operative Note: Knuckle pad removal was carried out on the patient's fingers under monitored anesthesia care. Zigzag incisions were made over the affected digits. The fibrous overgrowths were meticulously dissected and excised using a combination of sharp and blunt dissection. Hemostasis was achieved with electrocautery. The wounds were closed primarily with interrupted sutures. The patient tolerated the procedure well, and appropriate postoperative instructions were provided.

5. Operative Note: Excision of knuckle pads was performed on the patient under local anesthesia with 2% lidocaine. An inverted U-shaped incision was made, exposing the nodular masses. The fibrous growths were meticulously dissected and removed. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient remained stable throughout the procedure, and postoperative wound care was initiated.

6. Operative Note: Knuckle pad removal was performed bilaterally on the patient's hand under regional anesthesia with 0.25% bupivacaine. A combination of longitudinal and transverse incisions was made over the affected joints. Sharp dissection was used to expose and excise the fibrous nodules. Hemostasis was achieved with electrocautery. The wounds were closed primarily with absorbable sutures. The patient's condition was stable, and postoperative recommendations were given.

7. Operative Note: Excision of knuckle pads was performed on the patient's fingers under general anesthesia. Elliptical incisions were made around the affected interphalangeal joints. The nodules were meticulously dissected and removed, ensuring complete excision. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain control was initiated.

8. Operative Note: Knuckle pad removal was carried out on the patient's hand under monitored anesthesia care. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed primarily. The patient's vital signs remained stable throughout the procedure,

and postoperative wound care instructions were provided.

9. Operative Note: Excision of knuckle pads was performed under general anesthesia with balanced anesthesia using propofol, remifentanil, and sevoflurane. Multiple linear incisions were made over the nodular areas. The fibrous overgrowths were carefully dissected free from the underlying tissues. Hemostasis was achieved with meticulous electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and follow-up arrangements were made.

10. Operative Note: Knuckle pad removal was carried out bilaterally on the patient's digits under local anesthesia with 1% lidocaine. Zigzag incisions were made over the affected interphalangeal joints. The nodules were dissected meticulously, ensuring complete removal. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient's condition remained stable, and postoperative wound care instructions were provided.

1. Operative Note: Excision of knuckle pads with underlying bone erosion was performed on the patient's hand. A midline longitudinal incision was made over the affected joints. The fibrous nodules and eroded bone were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved, and the wound was closed with absorbable sutures. The patient tolerated the procedure well, and postoperative hand therapy and radiographic follow-up were scheduled.

2. Operative Note: Knuckle pad removal with bone erosion repair was carried out bilaterally on the patient's hand. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules and eroded bone were carefully dissected and excised. Bone grafting was performed to repair the bone defects. Hemostasis was achieved with electrocautery, and the wounds were closed primarily. The patient remained stable, and postoperative immobilization was initiated.

3. Operative Note: Excision of knuckle pads with significant bone erosion was performed on the patient. Multiple transverse incisions were made over the affected interphalangeal joints. The nodules and eroded bone were meticulously dissected and removed. Bone cement was used to fill the bone defects. Hemostasis was achieved, and the wounds were closed with absorbable sutures. The patient's vital signs were stable, and postoperative radiographic evaluation was planned.

4. Operative Note: Knuckle pad removal with bone erosion reconstruction was carried out on the patient's hand. Zigzag incisions were made over the affected digits. The fibrous overgrowths and eroded bone were meticulously dissected and excised. Bone grafts were harvested and used to reconstruct the bone defects. Hemostasis was achieved with electrocautery. The wounds were closed primarily, and postoperative hand therapy and radiographic monitoring were initiated.

5. Operative Note: Excision of knuckle pads with underlying bone erosion was performed under general anesthesia. An inverted U-shaped incision was made, exposing the nodular masses and eroded bone. The fibrous growths and eroded bone were meticulously dissected and removed. Bone graft substitutes were used to fill the bone defects. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient tolerated the procedure well, and postoperative rehabilitation was planned.

6. Operative Note: Knuckle pad removal with bone erosion repair was carried out on the patient's hand under regional anesthesia. Longitudinal and transverse incisions were made over the affected joints. The nodules and eroded bone were carefully dissected and excised. Bone grafting was performed to restore the bone defects. Hemostasis was achieved, and the wounds were closed primarily. The patient remained stable, and postoperative radiographic assessment was scheduled.

7. Operative Note: Excision of knuckle pads with bone erosion was performed on the patient's fingers. Elliptical incisions were made around the affected interphalangeal joints. The nodules and eroded bone were meticulously dissected and removed, ensuring complete excision. Bone grafts were utilized to reconstruct the bone defects. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative immobilization and radiographic evaluation were planned.

8. Operative Note: Knuckle pad removal with extensive bone erosion was carried out on the patient's hand. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nod

ules and eroded bone were dissected and excised meticulously. Bone grafting was performed to reconstruct the bone defects. Hemostasis was achieved, and the wounds were closed primarily. The patient's vital signs remained stable throughout the procedure, and postoperative radiographic monitoring was scheduled.

9. Operative Note: Excision of knuckle pads with underlying bone erosion was performed on the patient under general anesthesia. Multiple linear incisions were made over the nodular areas. The fibrous overgrowths and eroded bone were carefully dissected free from the underlying tissues. Bone graft substitutes were utilized to fill the bone defects. Hemostasis was achieved with meticulous electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and follow-up arrangements were made.

10. Operative Note: Knuckle pad removal with bone erosion repair was carried out bilaterally on the patient's digits. Zigzag incisions were made over the affected interphalangeal joints. The nodules and eroded bone were dissected meticulously, ensuring complete removal. Bone grafting was performed to reconstruct the bone defects. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient's condition remained stable, and postoperative immobilization and radiographic follow-up were planned.

1. Operative Note: Excision of knuckle pads with severe bone pain was performed on the patient's hand. A midline longitudinal incision was made over the affected joints. The fibrous nodules, along with the eroded bone, were meticulously dissected and removed. Hemostasis was achieved, and the wound was closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain management with analgesics was initiated.

2. Operative Note: Knuckle pad removal with severe bone pain was carried out bilaterally on the patient's hand. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules, along with the eroded bone causing pain, were carefully dissected and excised. Bone grafting was performed to repair the bone defects. Hemostasis was achieved with electrocautery, and the wounds were closed primarily. Postoperative pain control measures were implemented.

3. Operative Note: Excision of knuckle pads with significant bone erosion and severe pain was performed on the patient. Multiple transverse incisions were made over the affected interphalangeal joints. The nodules, along with the painful eroded bone, were meticulously dissected and removed. Bone cement was used to fill the bone defects and alleviate pain. Hemostasis was achieved, and the wounds were closed with absorbable sutures. The patient's vital signs were stable, and postoperative pain relief measures were implemented.

4. Operative Note: Knuckle pad removal with severe bone pain and erosion was carried out on the patient's hand. Zigzag incisions were made over the affected digits. The fibrous overgrowths, along with the painful eroded bone, were meticulously dissected and excised. Bone grafts were harvested and utilized to reconstruct the bone defects and relieve pain. Hemostasis was achieved with electrocautery. The wounds were closed primarily, and postoperative pain management strategies were initiated.

5. Operative Note: Excision of knuckle pads with severe bone pain and erosion was performed under general anesthesia. An inverted U-shaped incision was made, exposing the nodular masses and painful eroded bone. The fibrous growths, along with the eroded bone causing pain, were meticulously dissected and removed. Bone graft substitutes were used to fill the bone defects and alleviate pain. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient tolerated the procedure well, and postoperative pain control measures were implemented.

6. Operative Note: Knuckle pad removal with severe bone pain and erosion was carried out on the patient's hand under regional anesthesia. Longitudinal and transverse incisions were made over the affected joints. The nodules, along with the painful eroded bone, were carefully dissected and excised. Bone grafting was performed to restore the bone defects and provide pain relief. Hemostasis was achieved, and the wounds were closed primarily. The patient remained stable, and postoperative pain management strategies were implemented.

7. Operative Note: Excision of knuckle pads with severe bone pain and erosion was performed on the patient's fingers. Elliptical incisions were made around the affected interphalangeal joints. The nodules, along with the painful eroded bone, were meticulously dissected and removed, ensuring complete excision. Bone grafts were utilized to reconstruct the bone defects and alleviate pain. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and post

operative pain control measures were implemented.

8. Operative Note: Knuckle pad removal with extensive bone erosion and severe pain was carried out on the patient's hand. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules, along with the eroded bone causing severe pain, were meticulously dissected and excised. Bone grafting was performed to reconstruct the bone defects and alleviate pain. Hemostasis was achieved, and the wounds were closed primarily. Postoperative pain management was initiated, ensuring the patient's comfort.

9. Operative Note: Excision of knuckle pads with severe bone pain and erosion was performed on the patient under general anesthesia. Multiple linear incisions were made over the nodular areas. The fibrous overgrowths, along with the painful eroded bone, were carefully dissected free from the underlying tissues. Bone graft substitutes were utilized to fill the bone defects and alleviate pain. Hemostasis was achieved with meticulous electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain relief measures were implemented.

10. Operative Note: Knuckle pad removal with severe bone pain and erosion was carried out bilaterally on the patient's digits. Zigzag incisions were made over the affected interphalangeal joints. The nodules, along with the painful eroded bone, were dissected meticulously, ensuring complete removal. Bone grafting was performed to reconstruct the bone defects and alleviate pain. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient's condition remained stable, and postoperative pain management strategies were implemented.

1. Operative Note: Surgical intervention for knuckle pads was performed on the patient's hand. A midline longitudinal incision was made over the affected joints. The fibrous nodules were meticulously dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wound was closed with absorbable sutures. The patient tolerated the procedure well, and postoperative hand therapy and wound care instructions were provided.

2. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were carefully dissected and removed using sharp dissection techniques. Hemostasis was achieved with electrocautery. The wounds were closed primarily with absorbable sutures. The patient remained stable, and postoperative rehabilitation was initiated.

3. Operative Note: Surgical intervention for knuckle pads was performed on the patient under general anesthesia. Multiple transverse incisions were made over the affected interphalangeal joints. The nodules were meticulously dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed with absorbable sutures. The patient's vital signs were stable, and postoperative follow-up was scheduled.

4. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand under monitored anesthesia care. Zigzag incisions were made over the affected digits. The fibrous overgrowths were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed primarily with interrupted sutures. The patient's vital signs remained stable throughout the procedure, and appropriate postoperative instructions were given.

5. Operative Note: Surgical intervention for knuckle pads was performed on the patient's fingers under general anesthesia. An inverted U-shaped incision was made, exposing the nodular masses. The fibrous growths were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient tolerated the procedure well, and postoperative wound care instructions were provided.

6. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand under regional anesthesia. Longitudinal and transverse incisions were made over the affected joints. Sharp dissection was used to expose and excise the fibrous nodules. Hemostasis was achieved with electrocautery. The wounds were closed primarily with absorbable sutures. The patient's condition was stable, and postoperative recommendations were given.

7. Operative Note: Surgical intervention for knuckle pads was performed on the patient's hand under general anesthesia. Elliptical incisions were made around the affected interphalangeal joints. The nodules were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain control was initiated.

8. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand under monitored anesthesia care. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed primarily. The patient's vital signs remained stable throughout the procedure, and postoperative wound care instructions were provided.

9. Operative Note: Surgical intervention for knuckle pads was performed on the patient

's fingers under general anesthesia. Multiple linear incisions were made over the nodular areas. The fibrous overgrowths were carefully dissected and excised using sharp dissection techniques. Hemostasis was achieved with meticulous electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and appropriate postoperative care was discussed.

10. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's digits under local anesthesia. Zigzag incisions were made over the affected interphalangeal joints. The nodules were dissected meticulously and excised using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient's condition remained stable, and postoperative wound care instructions were provided.

1. Operative Note: Surgical intervention for recurrent knuckle pads was performed on the patient's hand. A midline longitudinal incision was made over the affected joints. The fibrous nodules were meticulously dissected and excised using sharp dissection techniques. Electrocautery was used to achieve hemostasis. The wound was closed with absorbable sutures. The patient tolerated the procedure well, and postoperative hand therapy and close follow-up were recommended.

2. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand due to functional impairment. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were carefully dissected and removed using sharp dissection techniques. Hemostasis was achieved with electrocautery. The wounds were closed primarily with absorbable sutures. Postoperative hand rehabilitation was initiated to optimize functional recovery.

3. Operative Note: Surgical intervention for extensive knuckle pads was performed on the patient's hand under general anesthesia. Multiple transverse incisions were made over the affected interphalangeal joints. The nodules were meticulously dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed with absorbable sutures. The patient's vital signs remained stable throughout the procedure, and postoperative wound care instructions were provided.

4. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand under regional anesthesia. Zigzag incisions were made over the affected digits. The fibrous overgrowths were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved with electrocautery. The wounds were closed primarily with interrupted sutures. The patient's vital signs were stable, and postoperative hand therapy and range of motion exercises were initiated.

5. Operative Note: Surgical intervention for symptomatic knuckle pads was performed on the patient's fingers under general anesthesia. An inverted U-shaped incision was made, exposing the nodular masses. The fibrous growths were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. The patient tolerated the procedure well, and postoperative wound care instructions were provided.

6. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand under regional anesthesia. Longitudinal and transverse incisions were made over the affected joints. Sharp dissection was used to expose and excise the fibrous nodules. Hemostasis was achieved with electrocautery. The wounds were closed primarily with absorbable sutures. The patient's condition was stable, and postoperative recommendations were given.

7. Operative Note: Surgical intervention for resistant knuckle pads was performed on the patient's hand under general anesthesia. Elliptical incisions were made around the affected interphalangeal joints. The nodules were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative pain control measures were initiated.

8. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand under monitored anesthesia care. Curvilinear incisions were made over the affected metacarpophalangeal joints. The nodules were dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed primarily. The patient's vital signs remained stable throughout the procedure, and

postoperative hand therapy and range of motion exercises were recommended.

9. Operative Note: Surgical intervention for recurrent and painful knuckle pads was performed on the patient's fingers under general anesthesia. Multiple linear incisions were made over the nodular areas. The fibrous overgrowths were carefully dissected and excised using sharp dissection techniques. Hemostasis was achieved with meticulous electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative rehabilitation and scar management instructions were provided.

10. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's digits under local anesthesia. Zigzag incisions were made over the affected interphalangeal joints. The nodules were dissected meticulously and excised using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient's condition remained stable, and postoperative wound care instructions were given, emphasizing the importance of hand hygiene and dressing changes.

1. Operative Note: Surgical intervention for severe infection on the extreme moving joint due to knuckle pads was performed on the patient's hand. A midline longitudinal incision was made over the affected joint. The infected tissue and nodules were meticulously excised, ensuring complete removal. Copious irrigation with antibiotic solution was performed. The wound was left open for secondary intention healing. Postoperative intravenous antibiotics and close monitoring were initiated.

2. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand with severe infection involving the extreme moving joint. Curvilinear incisions were made to expose the infected joint. The necrotic tissue, nodules, and infected synovium were meticulously excised. Copious irrigation with antibiotic solution was performed. The wound was closed primarily with drains in place. Postoperative intravenous antibiotics and aggressive wound care were initiated.

3. Operative Note: Surgical intervention for severe infection involving the extreme moving joint due to knuckle pads was performed on the patient's hand. Multiple transverse incisions were made over the infected joint. The infected tissue, nodules, and eroded bone were meticulously excised, ensuring thorough debridement. Copious irrigation with antibiotic solution was performed. The wound was left open for regular dressing changes and secondary intention healing. Postoperative intravenous antibiotics and close monitoring were initiated.

4. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand with severe infection on the extreme moving joint. Zigzag incisions were made to expose the infected joint. The necrotic tissue, nodules, and infected synovium were meticulously excised. Copious irrigation with antibiotic solution was performed. The wound was closed primarily with drains in place. Postoperative intravenous antibiotics and rigorous joint mobilization exercises were initiated under supervision.

5. Operative Note: Surgical intervention for severe infection on the extreme moving joint due to knuckle pads was performed on the patient's fingers. An inverted U-shaped incision was made, exposing the infected joint. The necrotic tissue, fibrous nodules, and infected synovium were meticulously excised. Copious irrigation with antibiotic solution was performed. The wound was closed primarily with drains in place. Postoperative intravenous antibiotics and hand therapy were initiated to optimize functional recovery.

6. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand with severe infection involving the extreme moving joint. Longitudinal and transverse incisions were made to expose the infected joint. The necrotic tissue, nodules, and eroded bone were meticulously excised, ensuring thorough debridement. Copious irrigation with antibiotic solution was performed. The wound was left open for regular dressing changes and secondary intention healing. Postoperative intravenous antibiotics and close monitoring were initiated.

7. Operative Note: Surgical intervention for severe infection involving the extreme moving joint due to knuckle pads was performed on the patient's hand. Elliptical incisions were made to expose the infected joint. The necrotic tissue, fibrous nodules, and infected synovium were meticulously excised. Copious irrigation with antibiotic solution was performed. The wound was closed primarily with drains in place. Postoperative intravenous antibiotics and aggressive wound care were initiated.

8. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand with severe infection on the extreme moving joint. Curvilinear incisions were made to expose the infected joint. The necrotic tissue, nodules, and infected synovium were meticulously excised. Copious irrigation with antibiotic solution was performed. The wound was

closed primarily with drains in place. Postoperative intravenous antibiotics and rigorous joint mobilization exercises were initiated under supervision.

9. Operative Note: Surgical intervention for severe infection on the extreme moving joint due to knuckle pads was performed on the patient's fingers. Multiple linear incisions were made over the infected joint. The infected tissue, nodules, and eroded bone were meticulously excised, ensuring thorough debridement. Copious irrigation with antibiotic solution was performed. The wound was left open for regular dressing changes and secondary intention healing. Postoperative intravenous antibiotics and close monitoring were initiated.

10. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand with severe infection involving the extreme moving joint. Zigzag incisions were made to expose the infected joint. The necrotic tissue, fibrous nodules, and infected synovium were meticulously excised. Copious irrigation with antibiotic solution was performed. The wound was closed primarily with drains in place. Postoperative intravenous antibiotics and aggressive wound care were initiated to ensure optimal healing and infection control.

1. Operative Note: Surgical intervention for knuckle pads with severe inflammation was performed on the patient's hand. A midline longitudinal incision was made over the affected joints. The inflamed nodules and surrounding tissue were meticulously excised. Copious irrigation with saline was performed. The wound was closed primarily with absorbable sutures. The patient tolerated the procedure well, and postoperative anti-inflammatory medications were prescribed.

2. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand, addressing marked inflammation. Curvilinear incisions were made over the affected metacarpophalangeal joints. The inflamed nodules were carefully dissected and removed using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed primarily with absorbable sutures. Postoperative elevation and cold compresses were advised to reduce inflammation.

3. Operative Note: Surgical intervention for knuckle pads with moderate inflammation was performed on the patient's fingers under general anesthesia. Multiple transverse incisions were made over the affected interphalangeal joints. The inflamed nodules were meticulously dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed with absorbable sutures. The patient's vital signs remained stable, and postoperative anti-inflammatory medications were prescribed.

4. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand with mild inflammation under regional anesthesia. Zigzag incisions were made over the affected digits. The inflamed fibrous overgrowths were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved with electrocautery. The wounds were closed primarily with interrupted sutures. Postoperative oral anti-inflammatory medications were prescribed for symptomatic relief.

5. Operative Note: Surgical intervention for knuckle pads with severe inflammation and erythema was performed on the patient's fingers under general anesthesia. An inverted U-shaped incision was made, exposing the inflamed nodular masses. The fibrous growths were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wound was closed with interrupted sutures. Postoperative cold therapy and anti-inflammatory medications were recommended.

6. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand, addressing moderate inflammation. Longitudinal and transverse incisions were made over the affected joints. Sharp dissection was used to expose and excise the inflamed fibrous nodules. Hemostasis was achieved with electrocautery. The wounds were closed primarily with absorbable sutures. The patient's condition was stable, and postoperative anti-inflammatory medications were prescribed.

7. Operative Note: Surgical intervention for knuckle pads with mild inflammation was performed on the patient's hand under monitored anesthesia care. Elliptical incisions were made around the affected interphalangeal joints. The inflamed nodules were meticulously dissected and removed using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient tolerated the procedure well, and postoperative instructions on managing inflammation were provided.

8. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand with varying degrees of inflammation under general anesthesia. Curvilinear incisions were made over the affected metacarpophalangeal joints. The inflamed nodules were dissected and excised using sharp dissection techniques. Hemostasis was achieved, and the wounds were closed primarily. The patient's vital

signs remained stable throughout the procedure, and postoperative anti-inflammatory medications were prescribed.

9. Operative Note: Surgical intervention for knuckle pads with moderate inflammation and tenderness was performed on the patient's fingers under regional anesthesia. Multiple linear incisions were made over the inflamed nodular areas. The fibrous overgrowths were carefully dissected and excised using sharp dissection techniques. Hemostasis was achieved with meticulous electrocautery. The wounds were closed with absorbable sutures. Postoperative instructions on managing inflammation and pain were provided.

10. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's digits under local anesthesia, addressing mild inflammation. Zigzag incisions were made over the affected interphalangeal joints. The inflamed nodules were dissected meticulously and excised using sharp dissection techniques. Hemostasis was achieved using bipolar electrocautery. The wounds were closed with absorbable sutures. The patient's condition remained stable, and postoperative instructions on managing inflammation were provided.

1. Operative Note: Surgical intervention for extensive knuckle pads was performed on the patient's hand. The fibrous nodules were excised, and the wounds were closed with absorbable sutures. Follow-up visits were scheduled at two-week intervals to monitor healing and assess the need for further intervention based on the patient's response. Hand therapy and scar management were recommended. Detailed instructions regarding wound care and signs of complications were provided to the patient.

2. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand due to functional impairment. The nodules were meticulously excised, and the wounds were closed primarily. The patient's follow-up schedule was determined based on the severity of the knuckle pads and the extent of tissue involvement. A comprehensive hand examination was planned at regular intervals to assess the response to surgery and determine the need for additional treatments.

3. Operative Note: Surgical intervention for resistant knuckle pads was performed on the patient's hand. The nodules were excised, and the wounds were closed primarily. Postoperative follow-up visits were scheduled based on the severity of the condition and the patient's response to surgery. Close monitoring of wound healing, range of motion, and symptom improvement was planned. If necessary, additional interventions such as hand therapy, corticosteroid injections, or revision surgery would be considered.

4. Operative Note: Knuckle pad surgical intervention was performed on the patient's hand under regional anesthesia. The fibrous nodules were meticulously excised, and the wounds were closed primarily. Postoperative follow-up visits were determined based on the severity of the knuckle pads and the patient's recovery. Regular assessments were planned to evaluate the effectiveness of the procedure, monitor for recurrence, and determine the need for further interventions or adjustments in the treatment plan.

5. Operative Note: Surgical intervention for recurrent knuckle pads was performed on the patient's hand. The nodules were excised, and the wounds were closed with absorbable sutures. The patient's follow-up visits were scheduled based on the severity of the condition and the rate of recurrence. Close monitoring and regular assessments were planned to evaluate the long-term effectiveness of the procedure and determine the need for additional treatments or modifications to the management plan.

6. Operative Note: Knuckle pad surgical intervention was carried out on the patient's hand under general anesthesia. The fibrous nodules were excised, and the wounds were closed primarily. Postoperative follow-up visits were tailored to the severity of the knuckle pads and the patient's individual response to surgery. Periodic assessments were planned to evaluate the outcomes, address any complications, and determine the need for further interventions, including hand therapy or revision procedures.

7. Operative Note: Surgical intervention for extensive and symptomatic knuckle pads was performed on the patient's hand. The fibrous nodules were meticulously excised, and the wounds were closed primarily. Postoperative follow-up visits were scheduled based on the severity of the knuckle pads and the patient's progress. Regular evaluations were planned to monitor healing, assess functional outcomes, and determine the need for additional treatments, such as scar management, hand therapy, or revision surgery.

8. Operative Note: Knuckle pad surgical intervention was performed on the patient's hand under monitored anesthesia care. The nodules were excised, and the wounds were closed primarily. The patient's follow-up schedule was determined based on the severity of the condition and the extent of surgical intervention. Regular assessments were planned to evaluate the response to surgery, monitor for complications, and determine the need for further treatments or adjustments to the postoperative care plan

.

9. Operative Note: Surgical intervention for severe and disabling knuckle pads was performed on the patient's hand. The fibrous nodules were excised, and the wounds were closed with absorbable sutures. Postoperative follow-up visits were scheduled based on the severity of the condition and the complexity of the surgical procedure. Regular evaluations were planned to monitor wound healing, assess functional improvement, and determine the need for additional interventions or postoperative therapies.

10. Operative Note: Knuckle pad surgical intervention was carried out bilaterally on the patient's hand due to significant functional impairment. The nodules were meticulously excised, and the wounds were closed primarily. The patient's follow-up schedule was established based on the severity of the knuckle pads and the complexity of the surgery. Regular assessments were planned to evaluate the surgical outcomes, address any concerns, and determine the need for further interventions or specialized rehabilitation programs.

## M72.2 Plantar fascial fibromatosis

1. Operative Note: Patient underwent a plantar fasciotomy to address plantar fascial fibromatosis. A longitudinal incision was made over the medial aspect of the foot. The plantar fascia was identified and released, with excision of fibrous nodules. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and postoperative instructions were given.

2. Operative Note: Plantar fasciectomy was performed to treat plantar fascial fibromatosis. A curved incision was made along the medial arch of the foot. The plantar fascia was carefully dissected and excised, ensuring complete removal of fibrous tissue. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were provided, and the patient's condition was stable at the end of the procedure.

3. Operative Note: A partial plantar fasciectomy was performed to address plantar fascial fibromatosis. A longitudinal incision was made over the plantar aspect of the foot. The fibrotic bands within the plantar fascia were identified and partially excised. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure without complications, and appropriate postoperative care was discussed.

4. Operative Note: Patient underwent a minimally invasive procedure for plantar fascial fibromatosis. Two small incisions were made, and an endoscope was inserted to visualize the plantar fascia. Fibrous nodules were identified and carefully excised using specialized instruments. Hemostasis was achieved, and the incisions were closed with sutures. The patient experienced minimal discomfort during the procedure, and postoperative instructions were given.

5. Operative Note: Plantar fasciotomy with dermofasciectomy was performed to address severe plantar fascial fibromatosis. A transverse incision was made over the plantar aspect of the foot. The plantar fascia and overlying skin were dissected together and excised, ensuring complete removal of the fibrotic tissue. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care was explained, and the patient's vitals remained stable throughout the procedure.

6. Operative Note: Patient underwent a percutaneous plantar fasciotomy to address plantar fascial fibromatosis. Two small stab incisions were made, and a specialized instrument was used to release the tight fascia. Fibrous nodules were observed and treated with controlled disruption. The procedure was well-tolerated, and the wounds were dressed appropriately. The patient was provided with postoperative instructions, and their condition was stable at the end of the surgery.

7. Operative Note: Plantar fascia release with needle aponeurotomy was performed to treat plantar fascial fibromatosis. Multiple puncture sites were made along the plantar fascia, and a needle was inserted to disrupt the fibrous nodules. Careful manipulation was performed to release tension. The patient tolerated the procedure well, and postoperative care instructions were discussed. No immediate complications were observed.

8. Operative Note: Endoscopic plantar fasciotomy was performed to address plantar fascial fibromatosis. Two small incisions were made, and an endoscope was inserted to visualize the plantar fascia. A specialized blade was used to release the tight fascia and excise fibrous nodules. Hemostasis was achieved, and the incisions were closed with sutures. Postoperative care was explained, and the patient remained stable throughout the procedure.

9. Operative Note: Patient underwent a modified plantar fasciotomy for plantar fasc

ial fibromatosis. An oblique incision was made, and the plantar fascia was identified and partially released. The fibrotic nodules were carefully dissected and excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and postoperative instructions were provided.

10. Operative Note: Plantar fasciectomy with autologous fat grafting was performed to address plantar fascial fibromatosis. A curved incision was made over the plantar aspect of the foot, and the plantar fascia was dissected and excised. Autologous fat was harvested and grafted to promote tissue regeneration. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were given, and the patient's condition was stable at the conclusion of the surgery.

1. Operative Note: Patient underwent a radiofrequency ablation procedure for plantar fascial fibromatosis. A small incision was made, and a radiofrequency probe was inserted to deliver targeted thermal energy to the fibrotic tissue. The affected areas were treated, and careful monitoring of temperature was ensured. Hemostasis was achieved, and the incision was closed. Postoperative care instructions were given, and the patient tolerated the procedure well.

2. Operative Note: Endoscopic plantar fasciectomy with percutaneous needle fasciotomy was performed to address plantar fascial fibromatosis. Two small incisions were made, and an endoscope was inserted to visualize the plantar fascia. Fibrous nodules were identified and treated using percutaneous needle techniques. The tight fascia was partially released under direct visualization. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent a plantar fasciectomy with the use of a CO2 laser for plantar fascial fibromatosis. A transverse incision was made over the plantar aspect of the foot, and the fibrotic tissue was carefully excised using the laser. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure without complications, and appropriate postoperative care was discussed.

4. Operative Note: Plantar fascial fibromatosis was treated with a minimally invasive ultrasound-guided percutaneous release. Under ultrasound guidance, a needle was inserted to release the tight fascia and disrupt the fibrous nodules. The procedure was performed successfully, and the patient experienced minimal discomfort. The wounds were dressed, and postoperative care instructions were provided.

5. Operative Note: Plantar fasciectomy with gastrocnemius recession was performed to address plantar fascial fibromatosis. A longitudinal incision was made over the medial aspect of the foot, and the plantar fascia was identified and partially excised. Additionally, the gastrocnemius muscle was lengthened through a separate incision. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were given, and the patient remained stable throughout the procedure.

6. Operative Note: Patient underwent a plantar fasciectomy with the use of an ultrasonic scalpel for plantar fascial fibromatosis. A longitudinal incision was made over the plantar aspect of the foot, and the ultrasonic scalpel was used to carefully dissect and excise the fibrotic tissue. Hemostasis was achieved, and the wound was closed with sutures. The patient tolerated the procedure well, and appropriate postoperative care was discussed.

7. Operative Note: Plantar fascia release with extracorporeal shockwave therapy (ESWT) was performed to treat plantar fascial fibromatosis. The affected area was identified, and shockwaves were delivered using a specialized device. Multiple sessions of ESWT were administered to target the fibrous nodules and promote healing. The patient tolerated the procedure well, and postoperative care instructions were given.

8. Operative Note: Plantar fasciectomy with platelet-rich plasma (PRP) injection was performed for plantar fascial fibromatosis. A transverse incision was made, and the plantar fascia was excised. PRP, prepared from the patient's own blood, was injected into the surgical site to facilitate tissue regeneration. Hemostasis was achieved, and the wound was closed meticulously

. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

9. Operative Note: Patient underwent a minimally invasive procedure for plantar fascial fibromatosis using a percutaneous needle fasciotomy combined with cryotherapy. Multiple puncture sites were made along the plantar fascia, and a needle was inserted to release the tight fascia. Cryotherapy was applied to the treated areas to minimize postoperative pain and inflammation. The procedure was well-tolerated, and the wounds were dressed appropriately. Postoperative care instructions were provided.

10. Operative Note: Plantar fascia release with coblation technology was performed to address plantar fascial fibromatosis. A small incision was made, and a coblation device was utilized to gently ablate the fibrotic tissue. The affected areas were treated, and meticulous hemostasis was achieved. The incision was closed with sutures, and postoperative care instructions were given. The patient tolerated the procedure well, and no immediate complications were observed.

1. Operative Note: Patient underwent a plantar fasciotomy for plantar fascial fibromatosis under local anesthesia with lidocaine. A longitudinal incision was made over the medial aspect of the foot, and the plantar fascia was identified and released. Fibrous nodules were excised, and hemostasis was achieved. The wound was closed with sutures. The patient remained comfortable throughout the procedure, and postoperative instructions were given.

2. Operative Note: Plantar fasciectomy was performed for plantar fascial fibromatosis under regional anesthesia with a popliteal block. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was meticulously excised. Hemostasis was achieved, and the wound was closed in layers. The patient had sensory blockage below the knee and tolerated the procedure well. Postoperative care instructions were discussed.

3. Operative Note: Patient underwent a minimally invasive procedure for plantar fascial fibromatosis under general anesthesia. Two small incisions were made, and endoscopic visualization was used to release the tight fascia and excise fibrous nodules. Hemostasis was achieved, and the wounds were closed with sutures. The patient was comfortably asleep throughout the surgery, and appropriate postoperative care instructions were provided.

4. Operative Note: Plantar fasciectomy with percutaneous needle fasciotomy was performed under spinal anesthesia for plantar fascial fibromatosis. Multiple puncture sites were made along the plantar fascia, and a needle was used to release the tight fascia and disrupt the fibrous nodules. The patient experienced sensory blockage from the lower limbs and tolerated the procedure well. Postoperative care instructions were given.

5. Operative Note: Patient underwent a plantar fascia release procedure under monitored anesthesia care (MAC). The plantar fascia was visualized and partially released to address plantar fascial fibromatosis. Fibrous nodules were excised, and meticulous hemostasis was achieved. The patient remained conscious and cooperative during the procedure, and postoperative care instructions were provided.

6. Operative Note: Plantar fasciotomy was performed under general anesthesia with sevoflurane for plantar fascial fibromatosis. A longitudinal incision was made, and the plantar fascia was identified and released. Fibrous nodules were carefully excised, and hemostasis was achieved. The patient was comfortably anesthetized throughout the surgery, and postoperative instructions were given.

7. Operative Note: Patient underwent a plantar fasciectomy under local anesthesia with a nerve block for plantar fascial fibromatosis. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was meticulously excised. Hemostasis was achieved, and the wound was closed in layers. The patient remained awake and pain-free during the procedure, and postoperative care instructions were discussed.

8. Operative Note: Endoscopic plantar fasciectomy was performed under general anesthesia with propofol and remifentanil for plantar fascial fibromatosis. Two small incisions were made, and an endoscope was inserted to visualize the plantar fascia. Fibrous nodules were identified and excised. Hemostasis was achieved, and the incisions were closed with sutures. The patient was comfortably anesthetized throughout the procedure, and appropriate postoperative care was explained.

9. Operative Note: Patient underwent a modified plantar fasciotomy under regional anesthesia with a sciatic nerve block for plantar fascial fibromatosis. An oblique incision was made, and the plantar fascia was partially released. Fibrotic nodules were carefully excised, and hemostasis was achieved. The patient experienced sensory blockage below the knee and tolerated the procedure well. Postoperative care instructions were given.

10. Operative Note: Plantar fascia release with extracorporeal shockwave therapy (ESWT) was performed under local anesthesia with bupivacaine for plantar fascial fibromatosis. The affected area was identified, and shockwaves were delivered using a specialized device. The patient remained awake and comfortable throughout the procedure, and postoperative care instructions were discussed.

1. Operative Note: Patient underwent a plantar fasciotomy with bone debridement for severe plantar fascial fibromatosis and associated bone erosion. A longitudinal incision was made, and the plantar fascia was identified and released. Extensive bone erosion was observed, and meticulous debridement of the affected areas was performed. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were given, and the patient tolerated the procedure well.

2. Operative Note: Plantar fasciectomy with bone grafting was performed to address plantar fascial fibromatosis and bone erosion. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was excised. Extensive bone erosion was identified, and bone grafting was performed to restore the structural integrity. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent a modified plantar fasciotomy with bone curettage for plantar fascial fibromatosis and bone erosion. A transverse incision was made, and the plantar fascia was partially released. Extensive bone erosion was observed and meticulously curetted to remove the affected bone fragments. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient tolerated the procedure well.

4. Operative Note: Plantar fascia release with bone resection was performed for plantar fascial fibromatosis and significant bone erosion. Multiple incisions were made, and the tight fascia was released. Extensive bone erosion was visualized, and careful bone resection was performed to remove the affected areas. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were given, and the patient remained stable throughout the procedure.

5. Operative Note: Patient underwent a plantar fasciectomy with bone grafting and internal fixation for severe plantar fascial fibromatosis and bone erosion. A longitudinal incision was made, and the fibrotic tissue was meticulously excised. Extensive bone erosion was noted, and bone grafting was performed along with internal fixation to restore stability. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were discussed, and the patient tolerated the procedure well.

6. Operative Note: Plantar fascia release with bone fenestration was performed to address plantar fascial fibromatosis and bone erosion. A transverse incision was made over the plantar aspect of the foot, and the tight fascia was released. Extensive bone erosion was observed, and fenestration was performed to create channels for bone healing. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were provided, and the patient's condition remained stable throughout the procedure.

7. Operative Note: Patient underwent a percutaneous plantar fasciotomy with bone curettage for plantar fascial fibromatosis and associated bone erosion. Small puncture sites were made, and the tight fascia was released percutaneously. Extensive bone erosion was identified, and meticulous bone curettage was performed to remove the affected bone fragments. Hemostasis was achieved, and the wounds were dressed appropriately. Postoperative care instructions were given, and the patient tolerated the procedure well.

8. Operative Note: Plantar fasciectomy with bone grafting and bone substitute augmentation was performed for plantar fascial fibromatosis

and bone erosion. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was carefully excised. Extensive bone erosion was visualized, and bone grafting with bone substitutes was performed to promote bone regeneration. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient remained stable throughout the procedure.

9. Operative Note: Patient underwent a modified plantar fasciotomy with bone recontouring for plantar fascial fibromatosis and bone erosion. A longitudinal incision was made, and the plantar fascia was partially released. Extensive bone erosion was observed, and bone recontouring was performed to reshape the affected bone. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were given, and the patient tolerated the procedure well.

10. Operative Note: Plantar fascia release with bone grafting and external fixation was performed to address plantar fascial fibromatosis and significant bone erosion. Multiple incisions were made, and the tight fascia was released. Extensive bone erosion was noted, and bone grafting was performed along with the application of an external fixation device to stabilize the affected area. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were provided, and the patient remained stable throughout the procedure.

1. Operative Note: Patient underwent a plantar fasciotomy with bone debridement for severe plantar fascial fibromatosis, bone erosion, and debilitating bone pain. A longitudinal incision was made, and the plantar fascia was identified and released. Extensive bone erosion was observed, and meticulous debridement of the affected areas was performed to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed in layers. Postoperative pain management instructions were given, and the patient tolerated the procedure well.

2. Operative Note: Plantar fasciectomy with bone grafting was performed to address plantar fascial fibromatosis, significant bone erosion, and excruciating bone pain. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was excised. Extensive bone erosion was identified, and bone grafting was performed to relieve the severe bone pain and promote bone healing. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management instructions were discussed, and the patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent a modified plantar fasciotomy with bone curettage for plantar fascial fibromatosis, severe bone erosion, and debilitating bone pain. A transverse incision was made, and the plantar fascia was partially released. Extensive bone erosion was observed and meticulously curetted to alleviate the severe bone pain. Hemostasis was achieved, and the wound was closed with sutures. Postoperative pain management instructions were provided, and the patient tolerated the procedure well.

4. Operative Note: Plantar fascia release with bone resection was performed for severe plantar fascial fibromatosis, extensive bone erosion, and excruciating bone pain. Multiple incisions were made, and the tight fascia was released. Extensive bone erosion was visualized, and careful bone resection was performed to alleviate the severe bone pain. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative pain management instructions were given, and the patient remained stable throughout the procedure.

5. Operative Note: Patient underwent a plantar fasciotomy with bone grafting and internal fixation for severe plantar fascial fibromatosis, significant bone erosion, and debilitating bone pain. A longitudinal incision was made, and the fibrotic tissue was meticulously excised. Extensive bone erosion was noted, and bone grafting with internal fixation was performed to alleviate the severe bone pain and restore stability. Hemostasis was achieved, and the wound was closed in layers. Postoperative pain management instructions were discussed, and the patient tolerated the procedure well.

6. Operative Note: Plantar fascia release with bone fenestration was performed to address plantar fascial fibromatosis, severe bone erosion, and excruciating bone pain. A transverse incision was made over the plantar aspect of the foot, and the tight fascia was released. Extensive bone erosion was observed, and fenestration was performed to alleviate the severe bone pain and facilitate bone healing. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management instructions were provided, and the patient's condition remained stable throughout the procedure.

7. Operative Note: Patient underwent a percutaneous plantar fasciotomy with bone curettage for severe plantar fascial fibromatosis, extensive bone erosion, and debilitating bone pain. Small puncture sites were made, and the tight fascia was released percutaneously. Extensive bone erosion was identified

, and meticulous bone curettage was performed to alleviate the severe bone pain. Hemostasis was achieved, and the wounds were dressed appropriately. Postoperative pain management instructions were given, and the patient tolerated the procedure well.

8. Operative Note: Plantar fasciectomy with bone grafting and bone substitute augmentation was performed for severe plantar fascial fibromatosis, significant bone erosion, and excruciating bone pain. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was carefully excised. Extensive bone erosion was visualized, and bone grafting with the use of bone substitutes was performed to alleviate the severe bone pain and promote bone regeneration. Hemostasis was achieved, and the wound was closed meticulously. Postoperative pain management instructions were discussed, and the patient remained stable throughout the procedure.

9. Operative Note: Patient underwent a modified plantar fasciotomy with bone recontouring for severe plantar fascial fibromatosis, extensive bone erosion, and debilitating bone pain. A longitudinal incision was made, and the plantar fascia was partially released. Extensive bone erosion was observed, and bone recontouring was performed to alleviate the severe bone pain and reshape the affected bone. Hemostasis was achieved, and the wound was closed with sutures. Postoperative pain management instructions were given, and the patient tolerated the procedure well.

10. Operative Note: Plantar fascia release with bone grafting and external fixation was performed to address severe plantar fascial fibromatosis, significant bone erosion, and excruciating bone pain. Multiple incisions were made, and the tight fascia was released. Extensive bone erosion was noted, and bone grafting was performed along with the application of an external fixation device to alleviate the severe bone pain and stabilize the affected area. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative pain management instructions were provided, and the patient remained stable throughout the procedure.

1. Operative Note: Patient underwent a plantar fasciotomy with Z-plasty surgical intervention for severe plantar fascial fibromatosis. A longitudinal incision was made, and the plantar fascia was identified and released. The Z-plasty technique was employed to provide lengthening and relaxation of the affected tissue. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were given, and the patient tolerated the procedure well.

2. Operative Note: Plantar fasciectomy with fascial release and surgical intervention using a dermal substitute was performed to address plantar fascial fibromatosis. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was meticulously excised. The fascial release was performed to alleviate tension, and a dermal substitute was applied to aid in wound healing. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention involving adipose tissue transfer for plantar fascial fibromatosis. A transverse incision was made, and the plantar fascia was partially released. Adipose tissue was harvested and transferred to the affected area to provide cushioning and support. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient tolerated the procedure well.

4. Operative Note: Plantar fascia release with surgical intervention using a collagen matrix was performed for plantar fascial fibromatosis. Multiple incisions were made, and the tight fascia was released. A collagen matrix was applied to enhance tissue regeneration and support wound healing. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were given, and the patient remained stable throughout the procedure.

5. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention involving a tendon transfer for plantar fascial fibromatosis. A longitudinal incision was made, and the fibrotic tissue was carefully excised. A tendon transfer was performed to provide additional support and alleviate tension on the affected area. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient tolerated the procedure well.

6. Operative Note: Plantar fasciectomy with surgical intervention using a bioabsorbable scaffold was performed for plantar fascial fibromatosis. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was meticulously excised. A bioabsorbable scaffold was placed to promote tissue regeneration and provide structural support. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were given, and the patient's condition remained stable throughout the procedure.

7. Operative Note: Patient underwent a percutaneous plantar fasciotomy with surgical intervention involving laser-assisted fascial release for plantar fascial fibromatosis. Small puncture sites were made, and the tight fascia was released percutaneously using laser technology. The laser-assisted fascial release technique was employed to ensure precision and minimal tissue damage. Hemostasis was achieved, and the wounds were dressed appropriately. Postoperative care instructions were provided, and the patient tolerated the procedure well.

8. Operative Note: Plantar fascia release with surgical intervention using platelet-rich plasma (PRP) was performed for plantar fascial fibromatosis. A transverse inc

ision was made over the plantar aspect of the foot, and the tight fascia was released. PRP was applied to enhance tissue healing and promote recovery. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were given, and the patient remained stable throughout the procedure.

9. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention involving extracorporeal shockwave therapy for plantar fascial fibromatosis. A longitudinal incision was made, and the plantar fascia was partially released. Extracorporeal shockwave therapy was utilized to stimulate tissue regeneration and alleviate symptoms. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient tolerated the procedure well.

10. Operative Note: Plantar fascia release with surgical intervention using a tissue-engineered graft was performed to address plantar fascial fibromatosis. Multiple incisions were made, and the tight fascia was released. A tissue-engineered graft was utilized to provide structural support and facilitate tissue regeneration. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were discussed, and the patient remained stable throughout the procedure.

1. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention involving radiofrequency ablation for plantar fascial fibromatosis. A longitudinal incision was made, and the plantar fascia was identified and released. Radiofrequency ablation was performed to provide targeted thermal energy and alleviate symptoms. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were given, and the patient tolerated the procedure well.

2. Operative Note: Plantar fasciectomy with surgical intervention using an arthroscopic approach was performed to address plantar fascial fibromatosis. An arthroscope was inserted through small incisions, allowing visualization and precise removal of the fibrotic tissue. The surgical intervention provided enhanced accuracy and minimal tissue disruption. Hemostasis was achieved, and the wounds were closed in layers. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention involving endoscopic release for plantar fascial fibromatosis. A transverse incision was made, and the plantar fascia was partially released using an endoscope. The endoscopic approach allowed for better visualization and minimal tissue trauma. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient tolerated the procedure well.

4. Operative Note: Plantar fascia release with surgical intervention involving a percutaneous needle technique was performed for plantar fascial fibromatosis. Small puncture sites were made, and a specialized needle was used to release the tight fascia. The percutaneous needle technique ensured precise fascial release with minimal scarring. Hemostasis was achieved, and the wounds were dressed appropriately. Postoperative care instructions were given, and the patient's condition remained stable throughout the procedure.

5. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention involving a minimally invasive approach for plantar fascial fibromatosis. A small incision was made, and specialized instruments were used to release the tight fascia. The minimally invasive technique provided reduced tissue trauma and faster recovery. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient tolerated the procedure well.

6. Operative Note: Plantar fascia release with surgical intervention involving a tissue graft was performed to address plantar fascial fibromatosis. Multiple incisions were made, and the tight fascia was released. A tissue graft was carefully positioned to support tissue healing and restore proper function. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were provided, and the patient remained stable throughout the procedure.

7. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention involving a tendon transfer for plantar fascial fibromatosis. A longitudinal incision was made, and the fibrotic tissue was meticulously excised. A tendon transfer was performed to improve foot mechanics and alleviate symptoms. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were given, and the patient tolerated the procedure well.

8. Operative Note: Plantar fasciectomy with surgical intervention involving autologous stem cell therapy was performed for plantar fascial fibromatosis. An incision was made over the plantar aspect of the foot, and the fibrotic tissue was carefully excised. Autologous stem cells were applied to enhance tissue regeneration and promote healing. Hemostasis was achieved

, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

9. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention involving ultrasound-guided needle fenestration for plantar fascial fibromatosis. A transverse incision was made, and the tight fascia was partially released using ultrasound guidance. Needle fenestration was performed to further alleviate symptoms and promote healing. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient tolerated the procedure well.

10. Operative Note: Plantar fascia release with surgical intervention involving the use of a high-frequency ultrasound scalpel was performed to address plantar fascial fibromatosis. Multiple incisions were made, and the tight fascia was released using the high-frequency ultrasound scalpel. The surgical intervention provided precise and controlled tissue dissection. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were given, and the patient remained stable throughout the procedure.

1. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention and debridement for severe plantar fascial fibromatosis and an infected extreme moving joint. An incision was made, and the infected joint was thoroughly debrided. The fibrotic tissue of the plantar fascia was excised. Antibiotic irrigation was performed, and appropriate wound care measures were taken. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were given, and the patient tolerated the procedure well.

2. Operative Note: Plantar fasciectomy with surgical intervention, joint irrigation, and drainage was performed to address severe plantar fascial fibromatosis and a deep infection in the extreme moving joint. An incision was made over the affected area, and the infected joint was carefully irrigated and drained. The fibrotic tissue was excised, and thorough debridement was performed. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention and arthroscopic debridement for severe plantar fascial fibromatosis and a deep infection in the extreme moving joint. Small incisions were made, and an arthroscope was inserted to visualize the infected joint. Debridement of the joint and excision of the fibrotic tissue were performed. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were discussed, and the patient tolerated the procedure well.

4. Operative Note: Plantar fascia release with surgical intervention, joint washout, and antibiotic cement spacer placement was performed for severe plantar fascial fibromatosis and an infected extreme moving joint. Multiple incisions were made, and the tight fascia was released. The joint was thoroughly washed out with antibiotic solution, and an antibiotic cement spacer was placed to manage the infection. Hemostasis was achieved, and the wounds were dressed appropriately. Postoperative care instructions were given, and the patient remained stable throughout the procedure.

5. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention, joint debridement, and intravenous antibiotic irrigation for severe plantar fascial fibromatosis and an infected extreme moving joint. A longitudinal incision was made, and the infected joint was carefully debrided. Intravenous antibiotic irrigation was performed to eradicate the infection. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were provided, and the patient tolerated the procedure well.

6. Operative Note: Plantar fasciectomy with surgical intervention, joint exploration, and abscess drainage was performed to address severe plantar fascial fibromatosis and a deep infection in the extreme moving joint. An incision was made, and the infected joint was explored. An abscess was identified and drained, and the fibrotic tissue of the plantar fascia was excised. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

7. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention and joint lavage for severe plantar fascial fibromatosis and an infected extreme moving joint. A transverse incision was made, and the tight fascia was partially released. The infected joint was thoroughly irrigated and lavaged to remove infectious material. Hemostasis was achieved

, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient tolerated the procedure well.

8. Operative Note: Plantar fascia release with surgical intervention, joint debridement, and negative pressure wound therapy was performed for severe plantar fascial fibromatosis and an infected extreme moving joint. Multiple incisions were made, and the tight fascia was released. The infected joint was debrided, and negative pressure wound therapy was initiated to promote healing and control the infection. Hemostasis was achieved, and the wounds were dressed appropriately. Postoperative care instructions were given, and the patient's condition remained stable throughout the procedure.

9. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention, joint washout, and antibiotic impregnated cement spacer placement for severe plantar fascial fibromatosis and an infected extreme moving joint. An incision was made, and the joint was thoroughly washed out with antibiotic solution. An antibiotic impregnated cement spacer was placed to manage the infection and provide support. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient tolerated the procedure well.

10. Operative Note: Plantar fasciectomy with surgical intervention, joint exploration, and antibiotic bead placement was performed to address severe plantar fascial fibromatosis and an infected extreme moving joint. An incision was made, and the infected joint was explored. Antibiotic beads were placed to deliver local antibiotic therapy. The fibrotic tissue of the plantar fascia was excised, and thorough debridement was performed. Hemostasis was achieved, and the wounds were closed in layers. Postoperative care instructions were provided, and the patient remained stable throughout the procedure.

1. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention and debridement for severe plantar fascial fibromatosis and acute inflammatory response. An incision was made, and the inflamed tissue was meticulously debrided. The fibrotic bands of the plantar fascia were excised. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were given, and the patient tolerated the procedure well.

2. Operative Note: Plantar fasciectomy with surgical intervention and corticosteroid injection was performed to address chronic plantar fascial fibromatosis and persistent inflammation. An incision was made over the affected area, and the fibrotic tissue was carefully excised. A corticosteroid injection was administered to alleviate inflammation and promote healing. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were provided, and the patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention and anti-inflammatory medication infusion for plantar fascial fibromatosis with severe inflammation. A transverse incision was made, and the tight fascia was partially released. Anti-inflammatory medication was infused directly into the surgical site to reduce inflammation. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient tolerated the procedure well.

4. Operative Note: Plantar fascia release with surgical intervention and cold therapy application was performed to address plantar fascial fibromatosis with acute inflammation. Multiple incisions were made, and the tight fascia was released. Cold therapy was applied to the surgical site to reduce inflammation and swelling. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative care instructions were given, and the patient remained stable throughout the procedure.

5. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention and non-steroidal anti-inflammatory drug (NSAID) injection for chronic plantar fascial fibromatosis and recurrent inflammation. A longitudinal incision was made, and the inflamed tissue was meticulously excised. An NSAID injection was administered to reduce inflammation and provide pain relief. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were provided, and the patient tolerated the procedure well.

6. Operative Note: Plantar fasciectomy with surgical intervention and intraoperative cryotherapy was performed for plantar fascial fibromatosis with significant inflammation. An incision was made over the plantar aspect of the foot, and the inflamed tissue was carefully excised. Intraoperative cryotherapy was employed to alleviate inflammation and promote tissue healing. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were discussed, and the patient's condition remained stable throughout the procedure.

7. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention and anti-inflammatory dressing for chronic plantar fascial fibromatosis and persistent inflammation. A transverse incision was made, and the tight fascia was partially released. An anti-inflammatory dressing was applied to the surgical site to reduce inflammation and enhance healing. Hemostasis was achieved, and the wound was closed with sutures. Postoperative care instructions were given, and the patient tolerated the procedure well.

8. Operative Note: Plantar fascia release with surgical intervention and platelet-rich plasma (PRP) injection was performed to address plantar fascial fibromatosis with chronic inflammation. Multiple

incisions were made, and the tight fascia was released. PRP injection was administered to promote tissue regeneration and reduce inflammation. Hemostasis was achieved, and the wounds were dressed appropriately. Postoperative care instructions were provided, and the patient's condition remained stable throughout the procedure.

9. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention and topical anti-inflammatory agent application for plantar fascial fibromatosis with localized inflammation. A longitudinal incision was made, and the inflamed tissue was meticulously excised. A topical anti-inflammatory agent was applied to the surgical site to alleviate inflammation and promote healing. Hemostasis was achieved, and the wound was closed meticulously. Postoperative care instructions were discussed, and the patient tolerated the procedure well.

10. Operative Note: Plantar fasciectomy with surgical intervention and ultrasound-guided corticosteroid injection was performed for chronic plantar fascial fibromatosis with persistent inflammation. An incision was made, and the fibrotic tissue was carefully excised. An ultrasound-guided corticosteroid injection was administered to the affected area to reduce inflammation and alleviate symptoms. Hemostasis was achieved, and the wound was closed in layers. Postoperative care instructions were provided, and the patient remained stable throughout the procedure.

1. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention for mild plantar fascial fibromatosis. The tight fascia was partially released, and the fibrotic tissue was excised. Hemostasis was achieved, and the wound was closed meticulously. Postoperative follow-up will depend on the patient's symptoms and response to treatment.

2. Operative Note: Plantar fasciectomy with surgical intervention was performed for moderate plantar fascial fibromatosis. The fibrotic tissue of the plantar fascia was excised, and thorough debridement was performed. Hemostasis was achieved, and the wound was closed with sutures. Postoperative follow-up will include regular check-ups to monitor healing and manage any complications.

3. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention for severe plantar fascial fibromatosis. The tight fascia was released, and the inflamed tissue was meticulously debrided. Hemostasis was achieved, and the wound was closed meticulously. Postoperative follow-up will involve close monitoring of the patient's symptoms, physical therapy, and potential additional interventions as needed.

4. Operative Note: Plantar fascia release with surgical intervention and corticosteroid injection was performed for chronic plantar fascial fibromatosis. Multiple incisions were made, and the tight fascia was released. A corticosteroid injection was administered to alleviate inflammation. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative follow-up will depend on the patient's response to the treatment, with consideration for additional interventions or adjustments in medication.

5. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention and physical therapy recommendation for recurrent plantar fascial fibromatosis. An incision was made, and the tight fascia was partially released. Hemostasis was achieved, and the wound was closed with sutures. Postoperative follow-up will include regular physical therapy sessions to strengthen the affected area and prevent further recurrence.

6. Operative Note: Plantar fasciectomy with surgical intervention and postoperative orthotic device recommendation was performed for severe and recurrent plantar fascial fibromatosis. The fibrotic tissue of the plantar fascia was excised, and thorough debridement was performed. Hemostasis was achieved, and the wound was closed in layers. Postoperative follow-up will involve the provision of an orthotic device for better foot alignment and support, along with regular check-ups to assess the patient's progress.

7. Operative Note: Patient underwent a modified plantar fasciotomy with surgical intervention and recommendation for non-weight-bearing activities for extensive plantar fascial fibromatosis. A transverse incision was made, and the tight fascia was partially released. Hemostasis was achieved, and the wound was closed meticulously. Postoperative follow-up will include strict adherence to non-weight-bearing activities and regular assessments to evaluate the effectiveness of the treatment.

8. Operative Note: Plantar fascia release with surgical intervention and referral for specialized pain management consultation was performed for chronic and severe plantar fascial fibromatosis. Multiple incisions were made, and the tight fascia was released. Hemostasis was achieved, and the wounds were closed meticulously. Postoperative follow-up will involve collaboration with a pain management specialist to develop a comprehensive pain management plan and monitor the patient's progress.

9. Operative Note: Patient underwent a plantar fasciotomy with surgical intervention and recommendation for custom-made shoe inserts for moderate plantar fascial fibromatosis. A longitudinal incision was made, and the tight fascia was partially released. Hemostasis was achieved, and the wound was closed meticulously. Postoperative follow-up will include the provision of custom-made shoe inserts to provide additional support and alleviate symptoms.

10. Operative Note: Plantar fasciectomy with surgical intervention and referral for genetic testing was performed for plantar fascial fibromatosis with suspected genetic predisposition. An incision was made, and the fibrotic tissue was carefully excised. Hemostasis was achieved, and the wound was closed in layers. Postoperative follow-up will involve genetic testing to identify any underlying genetic factors and develop an appropriate long-term management plan.

## M72.4 Pseudosarcomatous fibromatosis

1. Procedure: Excision of Pseudosarcomatous Fibromatosis Lesion

Indication: Patient presented with a large Pseudosarcomatous Fibromatosis lesion on the right thigh causing pain and functional impairment. The lesion was surgically excised with clear margins, preserving surrounding structures. Hemostasis was achieved, and the wound was closed in layers. The specimen was sent for histopathological examination.

2. Procedure: Wide Local Excision for Pseudosarcomatous Fibromatosis

Indication: The patient had a Pseudosarcomatous Fibromatosis tumor on the left forearm. Wide local excision was performed, ensuring adequate margins. Careful dissection was done to avoid damage to adjacent neurovascular structures. Hemostasis was secured, and the wound was closed with absorbable sutures. Postoperative recovery was uneventful.

3. Procedure: Mohs Micrographic Surgery for Pseudosarcomatous Fibromatosis

Indication: Patient presented with a Pseudosarcomatous Fibromatosis lesion on the face, involving the nasal bridge. Mohs micrographic surgery was performed to achieve complete excision with minimal tissue loss. Multiple stages were required to ensure tumor clearance. The defect was reconstructed using a local flap. Patient had an excellent cosmetic outcome.

4. Procedure: Incisional Biopsy for Pseudosarcomatous Fibromatosis

Indication: The patient had a suspicious soft tissue mass in the lower back region. An incisional biopsy was performed to obtain tissue for histopathological analysis. The lesion was carefully sampled, and hemostasis was achieved. The wound was closed, and the specimen was sent for further evaluation.

5. Procedure: Radiotherapy for Pseudosarcomatous Fibromatosis

Indication: Patient presented with recurrent Pseudosarcomatous Fibromatosis in the pelvic region. Radiotherapy was recommended as an adjuvant treatment to achieve local control. The treatment plan involved daily fractions over a specified period. The patient tolerated the treatment well, with minimal side effects.

6. Procedure: Chemotherapy for Metastatic Pseudosarcomatous Fibromatosis

Indication: Patient with Pseudosarcomatous Fibromatosis developed lung metastases. Chemotherapy regimen consisting of anthracyclines and ifosfamide was initiated. The patient completed the planned cycles without significant complications. Follow-up imaging showed a partial response, indicating a positive treatment outcome.

7. Procedure: Wide Resection with Reconstruction for Pseudosarcomatous Fibromatosis

Indication: Patient presented with an extensive Pseudosarcomatous Fibromatosis involving the anterior abdominal wall. Wide resection was performed, encompassing the tumor and involved margins. Reconstruction was achieved using a mesh implant and local flaps. Postoperative recovery was uneventful, and the patient regained full functionality.

8. Procedure: Physical Therapy following Surgery for Pseudosarcomatous Fibromatosis

Indication: Patient underwent surgical excision of Pseudosarcomatous Fibromatosis on the upper arm. Postoperatively, a comprehensive physical therapy program was initiated to restore range of motion, strength, and function. Progressive exercises and modalities were employed to achieve optimal rehabilitation outcomes.

9. Procedure: Genetic Testing for Pseudosarcomatous Fibromatosis

Indication: Patient diagnosed with Pseudosarcomatous Fibromatosis in multiple sites. Genetic testing was performed to identify potential underlying genetic mutations associated with this condition. The results showed a pathogenic variant in the CTNNB1 gene, confirming the diagnosis and providing valuable information for future treatment considerations.

10. Procedure: Surveillance Imaging for Pseudosarcomatous Fibromatosis

Indication: Patient with a history of Pseudosarcomatous Fibromatosis underwent regular surveillance imaging to monitor for recurrence or metastasis. Serial MRI scans were performed, and the results showed no evidence of disease progression. The patient will continue with periodic follow-up visits and imaging to ensure early detection of any potential changes.

1. Procedure: Ultrasound-Guided Core Needle Biopsy for Pseudosarcomatous Fibromatosis

Indication: Patient presented with a deep-seated Pseudosarcomatous Fibromatosis mass in the thigh. An ultrasound-guided core needle biopsy was performed to obtain tissue for histopathological examination. The lesion was accurately targeted, and multiple samples were obtained. Hemostasis was achieved, and the patient tolerated the procedure well.

2. Procedure: Surgical Marginal Excision for Recurrent Pseudosarcomatous Fibromatosis

Indication: Patient with a history of Pseudosarcomatous Fibromatosis recurrence underwent surgical marginal excision. The lesion was carefully dissected, ensuring complete removal with minimal damage to adjacent structures. Hemostasis was achieved, and the wound was closed primarily. Postoperative recovery was uneventful.

3. Procedure: Adjuvant Radiation Therapy for High-Risk Pseudosarcomatous Fibromatosis

Indication: Patient with high-risk features, including large tumor size and positive surgical margins, received adjuvant radiation therapy. The treatment plan involved fractionated radiation to the surgical bed, with appropriate dose and target volume. The patient completed the prescribed treatment course with manageable side effects.

4. Procedure: Systemic Therapy for Advanced Pseudosarcomatous Fibromatosis

Indication: Patient with widespread metastatic Pseudosarcomatous Fibromatosis received systemic therapy. A combination regimen of targeted agents and immunotherapy was initiated, tailored to the patient's specific molecular profile and disease characteristics. The treatment response was monitored closely, and the patient experienced disease stabilization.

5. Procedure: Palliative Resection for Pseudosarcomatous Fibromatosis

Indication: Patient with an unresectable Pseudosarcomatous Fibromatosis mass causing significant pain and discomfort underwent palliative resection. The goal was to alleviate symptoms and improve quality of life. The tumor was debulked, and careful attention was given to maintain functional integrity. The patient reported a reduction in pain postoperatively.

6. Procedure: Genetic Counseling and Testing for Pseudosarcomatous Fibromatosis

Indication: Patient diagnosed with Pseudosarcomatous Fibromatosis sought genetic counseling and testing to assess familial risk and potential genetic predisposition. A comprehensive genetic evaluation was performed, and counseling was provided regarding the implications of test results for the patient and their family members.

7. Procedure: Intralesional Steroid Injection for Pseudosarcomatous Fibromatosis

Indication: Patient with a Pseudosarcomatous Fibromatosis lesion in the hand underwent intralesional steroid injection to alleviate pain and inflammation. The lesion was accurately localized, and a corticosteroid was injected under ultrasound guidance. The patient experienced symptomatic relief following the procedure.

8. Procedure: Rehabilitation and Occupational Therapy for Pseudosarcomatous Fibromatosis

Indication: Patient post-surgical excision of Pseudosarcomatous Fibromatosis underwent comprehensive rehabilitation and occupational therapy. The program focused on regaining strength, range of motion, and functional abilities. Adaptive techniques and assistive devices were provided to optimize the patient's independence and quality of life.

9. Procedure: Magnetic Resonance Imaging (MRI) for Pseudosarcomatous Fibromatosis Surveillance

Indication: Patient with a history of Pseudosarcomatous Fibromatosis underwent regular MRI scans for surveillance purposes. The imaging studies were performed to monitor for any signs of disease recurrence, metastasis, or new lesion development. The patient's MRI scans

showed no evidence of disease progression during the follow-up period.

10. Procedure: Consultation with Oncology Specialists for Pseudosarcomatous Fibromatosis Management

Indication: Patient diagnosed with Pseudosarcomatous Fibromatosis sought expert consultation with oncology specialists for further management. The multidisciplinary team reviewed the patient's medical history, imaging, and pathology reports to formulate an individualized treatment plan, incorporating surgery, radiation, chemotherapy, or targeted therapies as deemed appropriate.

1. Procedure: Wide Local Excision with General Anesthesia for Pseudosarcomatous Fibromatosis

Indication: Patient presented with a Pseudosarcomatous Fibromatosis tumor on the arm. Wide local excision was performed under general anesthesia. The appropriate dosage of anesthesia was administered to ensure the patient's comfort throughout the procedure. The lesion was completely excised with clear margins, and the wound was closed meticulously.

2. Procedure: Mohs Micrographic Surgery with Local Anesthesia and Sedation for Pseudosarcomatous Fibromatosis

Indication: Patient with a Pseudosarcomatous Fibromatosis lesion on the face underwent Mohs micrographic surgery. The procedure was performed under local anesthesia, supplemented with sedation to enhance patient comfort. Multiple stages were carried out to ensure complete tumor removal. The wound was reconstructed, and the patient tolerated the procedure well.

3. Procedure: Incisional Biopsy with Local Anesthesia for Pseudosarcomatous Fibromatosis

Indication: A patient presented with a suspicious soft tissue mass suggestive of Pseudosarcomatous Fibromatosis. An incisional biopsy was performed under local anesthesia to obtain tissue for further evaluation. The appropriate dose of anesthesia was administered, ensuring patient cooperation and comfort during the procedure.

4. Procedure: Radiotherapy Planning with Anesthetic Mask for Pseudosarcomatous Fibromatosis

Indication: Patient required radiotherapy for Pseudosarcomatous Fibromatosis. An anesthetic mask was used during the planning session to ensure precise immobilization and reproducibility of treatment position. The patient was properly positioned, and imaging was obtained to facilitate accurate treatment delivery.

5. Procedure: Chemotherapy Infusion with Intravenous Anesthesia for Pseudosarcomatous Fibromatosis

Indication: Patient received systemic chemotherapy for Pseudosarcomatous Fibromatosis. An intravenous anesthesia agent was administered to provide sedation and manage any potential discomfort during the chemotherapy infusion. The anesthesia dosage was carefully monitored and adjusted as needed throughout the treatment session.

6. Procedure: Local Anesthesia and Sedation for Wide Resection and Reconstruction of Pseudosarcomatous Fibromatosis

Indication: Patient underwent wide resection and reconstruction for Pseudosarcomatous Fibromatosis. Local anesthesia combined with sedation was utilized to achieve optimal pain control and patient comfort. The appropriate dosages of anesthesia and sedative medications were administered to maintain a relaxed and pain-free state during the procedure.

7. Procedure: Physical Therapy Session with Minimal Anesthesia for Pseudosarcomatous Fibromatosis Rehabilitation

Indication: Patient undergoing physical therapy for Pseudosarcomatous Fibromatosis rehabilitation required minimal anesthesia to manage pain and discomfort during therapeutic exercises. The anesthesia dosage was carefully titrated to ensure the patient's ability to actively participate while minimizing any potential adverse effects.

8. Procedure: Genetic Counseling Session with no Anesthesia for Pseudosarcomatous Fibromatosis

Indication: Patient seeking genetic counseling for Pseudosarcomatous Fibromatosis did not require any anesthesia. The counseling session was conducted in an outpatient setting, where the patient and genetic counselor discussed the implications of genetic testing and familial risk without the need for anesthesia administration.

9. Procedure: Surveillance Imaging with Contrast-Enhanced Anesthesia for Pseudosarcomatous Fibromatosis

Indication: Patient undergoing surveillance imaging for Pseudosarcomatous Fibromatosis received contrast-enhanced anesthesia to optimize image quality and patient comfort. The appropriate dosage of anesthesia, along with the contrast agent, was carefully

administered to facilitate accurate assessment of the disease status.

10. Procedure: Preoperative Anesthesia Assessment for Pseudosarcomatous Fibromatosis Surgery

Indication: Patient scheduled for Pseudosarcomatous Fibromatosis surgery underwent a preoperative anesthesia assessment. The anesthesiologist evaluated the patient's medical history, performed necessary tests, and determined the appropriate anesthesia dosage and technique for the upcoming surgical procedure.

1. Procedure: Resection of Pseudosarcomatous Fibromatosis with Bone Erosion

Indication: Patient presented with Pseudosarcomatous Fibromatosis involving the distal femur, causing significant bone erosion. Surgical resection was performed to remove the tumor and affected bone segment. The procedure involved careful osteotomy, ensuring clear margins and preservation of surrounding structures. The bone defect was reconstructed with a bone graft and internal fixation.

2. Procedure: Imaging-Guided Biopsy of Pseudosarcomatous Fibromatosis with Bone Erosion

Indication: Patient with a Pseudosarcomatous Fibromatosis mass involving the scapula, demonstrating bone erosion on imaging, underwent an imaging-guided biopsy. The procedure was performed using computed tomography (CT) or ultrasound guidance to obtain a tissue sample for histopathological evaluation. The biopsy site was carefully chosen to include the area of bone erosion.

3. Procedure: Limb Salvage Surgery for Pseudosarcomatous Fibromatosis with Extensive Bone Erosion

Indication: Patient presented with Pseudosarcomatous Fibromatosis involving the tibia, demonstrating extensive bone erosion. Limb salvage surgery was performed to remove the tumor, restore limb function, and address the bone defect. Wide resection was carried out, and reconstruction was achieved using an endoprosthesis or bone allograft, ensuring stability and alignment.

4. Procedure: Palliative Radiotherapy for Pseudosarcomatous Fibromatosis with Bone Erosion

Indication: Patient with Pseudosarcomatous Fibromatosis and bone erosion in the spine received palliative radiotherapy. The treatment targeted the affected area, aiming to relieve pain and stabilize the bone. The radiation dosage was carefully planned to minimize side effects while providing effective pain control and disease management.

5. Procedure: Excisional Debridement and Bone Grafting for Pseudosarcomatous Fibromatosis with Bone Erosion and Infection

Indication: Patient with Pseudosarcomatous Fibromatosis and concurrent bone erosion and infection underwent excisional debridement and bone grafting. The affected tissues were surgically removed, followed by thorough irrigation and debridement. The bone defect was then filled with a bone graft to promote healing and restore bone integrity.

6. Procedure: Chemotherapy for Pseudosarcomatous Fibromatosis with Extensive Bone Erosion and Metastasis

Indication: Patient diagnosed with Pseudosarcomatous Fibromatosis with extensive bone erosion and metastasis received systemic chemotherapy. The treatment regimen, tailored to the patient's specific disease characteristics, aimed to control tumor growth, reduce bone-related symptoms, and improve overall survival. The chemotherapy dosage and schedule were determined based on the patient's condition and treatment response.

7. Procedure: Consultation with Orthopedic Surgeon for Pseudosarcomatous Fibromatosis with Bone Erosion

Indication: Patient with Pseudosarcomatous Fibromatosis involving the shoulder joint and bone erosion sought a consultation with an orthopedic surgeon. The specialist evaluated the extent of bone erosion, discussed treatment options, and provided recommendations for surgical intervention, reconstructive procedures, or other appropriate management strategies.

8. Procedure: Magnetic Resonance Imaging (MRI) for Pseudosarcomatous Fibromatosis with Bone Erosion Evaluation

Indication: Patient with suspected Pseudosarcomatous Fibromatosis and bone erosion underwent MRI for detailed evaluation. The imaging study allowed assessment of the extent of bone erosion, tumor involvement

, and any associated soft tissue changes. The MRI findings aided in treatment planning and determining the optimal surgical or non-surgical approach.

9. Procedure: Intralesional Curettage and Bone Cementing for Pseudosarcomatous Fibromatosis with Bone Erosion

Indication: Patient with Pseudosarcomatous Fibromatosis and bone erosion in the distal radius underwent intralesional curettage and bone cementing. The procedure involved removing the tumor mass and cleaning the affected bone, followed by filling the bone defect with bone cement to stabilize the area and restore functionality.

10. Procedure: Prophylactic Orthopedic Intervention for Pseudosarcomatous Fibromatosis with Impending Bone Erosion

Indication: Patient with Pseudosarcomatous Fibromatosis and imaging findings suggestive of impending bone erosion received prophylactic orthopedic intervention. The goal was to prevent or minimize future bone complications by addressing the affected area surgically, stabilizing the bone, and providing appropriate reconstruction or augmentation to preserve bone integrity.

1. Procedure: Palliative Radiotherapy for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient experiencing severe bone pain due to Pseudosarcomatous Fibromatosis received palliative radiotherapy. The treatment targeted the painful area, aiming to provide pain relief and improve quality of life. The radiotherapy dosage and fractionation schedule were optimized to effectively manage pain while minimizing potential side effects.

2. Procedure: Analgesic Medication Management for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with Pseudosarcomatous Fibromatosis presenting with severe bone pain required analgesic medication management. A comprehensive pain management plan was developed, considering the patient's pain intensity, medical history, and individual preferences. The analgesic medications, including opioids and adjuvant drugs, were titrated to achieve adequate pain control and optimize comfort.

3. Procedure: Neurolytic Block for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with severe bone pain associated with Pseudosarcomatous Fibromatosis underwent a neurolytic block procedure. A local anesthetic agent with neurolytic properties was injected near the affected nerves to interrupt pain signals. The procedure aimed to provide long-lasting pain relief and improve the patient's overall quality of life.

4. Procedure: Surgical Decompression for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with Pseudosarcomatous Fibromatosis experiencing severe bone pain due to nerve compression underwent surgical decompression. The affected nerves were carefully identified and released from the tumor's pressure, aiming to alleviate pain and restore normal nerve function. The patient's pain levels were closely monitored postoperatively.

5. Procedure: Spinal Cord Stimulator Implantation for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with severe bone pain secondary to Pseudosarcomatous Fibromatosis received a spinal cord stimulator implantation. The device was surgically placed to deliver electrical impulses to the spinal cord, modulating pain signals and providing pain relief. The stimulator settings were adjusted to meet the patient's individual needs and achieve optimal pain management.

6. Procedure: Transcutaneous Electrical Nerve Stimulation (TENS) for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with severe bone pain related to Pseudosarcomatous Fibromatosis underwent transcutaneous electrical nerve stimulation (TENS). Electrodes were placed on the skin overlying the painful area, delivering low-voltage electrical impulses to alleviate pain. The TENS therapy was performed regularly to provide ongoing pain relief.

7. Procedure: Psychological Support and Counseling for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with Pseudosarcomatous Fibromatosis experiencing severe bone pain received psychological support and counseling. A mental health professional provided assistance in managing pain-related distress, coping strategies, and improving the patient's overall emotional well-being.

8. Procedure: Intravenous Bisphosphonate Therapy for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with severe bone pain associated with Pseudosarcomatous Fibromatosis received intravenous bisphosphonate therapy. The medication was administered to help strengthen the bones, reduce bone pain, and prevent further bone complications. The patient's response to the therapy was closely monitored.

9. Procedure: Complementary and Alternative Therapies for P

seudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with severe bone pain due to Pseudosarcomatous Fibromatosis explored complementary and alternative therapies for pain management. Therapeutic options such as acupuncture, massage therapy, or mind-body techniques were incorporated into the patient's treatment plan to alleviate pain and enhance overall well-being.

10. Procedure: Multimodal Pain Management Approach for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient experiencing severe bone pain secondary to Pseudosarcomatous Fibromatosis received a multimodal pain management approach. The treatment plan included a combination of pharmacological interventions, physical therapy, psychological support, and complementary therapies, aiming to comprehensively address pain, improve functionality, and enhance the patient's quality of life.

1. Procedure: Limb Salvage Surgery for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient with Pseudosarcomatous Fibromatosis and severe bone pain underwent limb salvage surgery. The procedure involved the removal of the tumor while preserving the affected limb's function and integrity. The goal was to alleviate pain, restore mobility, and provide the patient with an improved quality of life.

2. Procedure: Tumor Resection and Osteotomy for Pseudosarcomatous Fibromatosis with Severe Bone Pain

Indication: Patient diagnosed with Pseudosarcomatous Fibromatosis presented with severe bone pain requiring surgical intervention. Tumor resection and osteotomy were performed to excise the tumor and correct any associated bone deformity. The procedure aimed to relieve pain, restore bone stability, and enhance the patient's overall well-being.

3. Procedure: Intercostal Nerve Ablation for Pseudosarcomatous Fibromatosis with Severe Rib Pain

Indication: Patient suffering from severe rib pain due to Pseudosarcomatous Fibromatosis underwent intercostal nerve ablation. The surgical intervention involved the destruction of nerve fibers supplying the affected area to alleviate chronic pain and improve the patient's comfort and quality of life.

4. Procedure: Spinal Fusion Surgery for Pseudosarcomatous Fibromatosis with Severe Vertebral Pain

Indication: Patient with severe vertebral pain caused by Pseudosarcomatous Fibromatosis underwent spinal fusion surgery. The procedure aimed to stabilize the affected spinal segment, reduce pain, and improve spinal alignment and functionality. Bone grafts and instrumentation were utilized to achieve spinal fusion and alleviate pain.

5. Procedure: Resection and Nerve Decompression for Pseudosarcomatous Fibromatosis with Severe Nerve Pain

Indication: Patient with severe nerve pain related to Pseudosarcomatous Fibromatosis underwent surgical resection of the tumor mass and nerve decompression. The procedure aimed to alleviate nerve compression, relieve pain, and restore proper nerve function. Postoperatively, the patient's pain levels and neurological status were carefully monitored.

6. Procedure: Limb Amputation for Pseudosarcomatous Fibromatosis with Intractable Severe Pain

Indication: Patient with Pseudosarcomatous Fibromatosis experiencing intractable severe pain despite conservative measures underwent limb amputation. The surgical intervention aimed to eliminate the source of pain, improve the patient's quality of life, and provide an opportunity for prosthetic fitting and rehabilitation.

7. Procedure: Cryoablation for Pseudosarcomatous Fibromatosis with Severe Pain

Indication: Patient with Pseudosarcomatous Fibromatosis and severe pain underwent cryoablation. The procedure involved using extreme cold temperatures to destroy the tumor cells, providing pain relief and reducing tumor burden. Cryoablation offered a minimally invasive surgical intervention for pain management in this case.

8. Procedure: Vertebroplasty for Pseudosarcomatous Fibromatosis with Severe Vertebral Pain and Fracture

Indication: Patient with Pseudosarcomatous Fibromatosis and severe vertebral pain with associated fracture received vertebroplasty. The surgical intervention involved injecting bone cement into the fractured vertebral body, stabilizing the fracture, and alleviating pain. The procedure aimed to restore vertebral strength and improve the patient's mobility.

9. Procedure: Surgical Excision of Painful Nodule for Pseudosarcomatous Fibrom

atosis with Focal Severe Pain

Indication: Patient with Pseudosarcomatous Fibromatosis presented with a painful nodule causing focal severe pain. Surgical excision was performed to remove the nodule, aiming to alleviate pain and improve the patient's comfort. Postoperative pain management and follow-up were carried out to ensure optimal recovery.

10. Procedure: Joint Denervation for Pseudosarcomatous Fibromatosis with Severe Joint Pain

Indication: Patient with severe joint pain related to Pseudosarcomatous Fibromatosis underwent joint denervation. The surgical intervention aimed to interrupt pain signals by selectively removing or disabling the sensory nerves supplying the affected joint, providing relief from severe pain and improving joint function.

1. Procedure: Percutaneous Radiofrequency Ablation for Pseudosarcomatous Fibromatosis with Severe Pain

Indication: Patient with Pseudosarcomatous Fibromatosis and severe pain underwent percutaneous radiofrequency ablation. The procedure involved the use of radiofrequency energy to destroy the tumor cells and alleviate pain. This minimally invasive surgical intervention aimed to provide effective pain management and improve the patient's quality of life.

2. Procedure: Neurosurgical Intervention for Pseudosarcomatous Fibromatosis with Severe Nerve Compression

Indication: Patient with Pseudosarcomatous Fibromatosis presented with severe nerve compression and intractable pain. Neurosurgical intervention was performed to relieve nerve compression, restore proper nerve function, and alleviate pain. The specific surgical technique employed was tailored to the location and extent of nerve involvement.

3. Procedure: Salvage Amputation for Pseudosarcomatous Fibromatosis with Severe Pain and Recurrent Disease

Indication: Patient with recurrent Pseudosarcomatous Fibromatosis and severe pain despite previous interventions underwent salvage amputation. The surgical procedure aimed to remove the affected limb and eliminate the source of pain. This approach provided a potential solution to manage pain and prevent further disease progression.

4. Procedure: Epidural Steroid Injection for Pseudosarcomatous Fibromatosis with Severe Spinal Pain

Indication: Patient with Pseudosarcomatous Fibromatosis and severe spinal pain received an epidural steroid injection. The procedure involved the administration of corticosteroids into the epidural space to reduce inflammation and alleviate pain. This targeted intervention aimed to provide relief and improve the patient's functional status.

5. Procedure: Vascular Intervention for Pseudosarcomatous Fibromatosis with Severe Pain and Vascular Compression

Indication: Patient with Pseudosarcomatous Fibromatosis presented with severe pain due to vascular compression. Vascular intervention, such as angioplasty or stenting, was performed to restore adequate blood flow and relieve pain caused by vascular compromise. The procedure aimed to alleviate symptoms and improve the patient's overall vascular health.

6. Procedure: Surgical Debulking for Pseudosarcomatous Fibromatosis with Severe Pain and Large Tumor Burden

Indication: Patient with Pseudosarcomatous Fibromatosis and a large tumor burden causing severe pain underwent surgical debulking. The procedure involved removing a portion of the tumor to reduce its size, alleviate pain, and improve the patient's quality of life. The surgical intervention aimed to manage symptoms and facilitate subsequent treatment modalities.

7. Procedure: Minimally Invasive Nerve Decompression for Pseudosarcomatous Fibromatosis with Severe Nerve Pain

Indication: Patient with Pseudosarcomatous Fibromatosis presented with severe nerve pain due to compression. Minimally invasive nerve decompression surgery was performed to relieve pressure on the affected nerves, restore normal nerve function, and alleviate pain. This surgical intervention aimed to improve the patient's overall comfort and function.

8. Procedure: Joint Replacement Surgery for Pseudosarcomatous Fibromatosis with Severe Joint Pain and Dysfunction

Indication: Patient with Pseudosarcomatous Fibromatosis experiencing severe joint pain and dysfunction underwent joint replacement surgery. The affected joint, such as the hip or knee, was replaced with a prosthetic implant to alleviate pain, improve mobility, and restore joint function. The surgical intervention aimed to enhance the patient's quality of life and functional capacity.

9. Procedure: Surgical Stabilization for Pseudosarcomatous Fibromatosis with Severe Pain and Instability

Indication: Patient with Pseudosarcomatous Fibromatosis presented with severe pain and joint instability. Surgical stabilization, such as ligament reconstruction or fusion, was performed to restore stability, alleviate pain, and improve overall joint function. The surgical intervention aimed to provide long-term relief and enhance the patient's functional outcomes.

10. Procedure: Image-Guided Biopsy for Pseudosarcomatous Fibromatosis with Severe Pain and Diagnostic Uncertainty

Indication: Patient with Pseudosarcomatous Fibromatosis and severe pain underwent an image-guided biopsy. The procedure involved obtaining tissue samples from the affected area for diagnostic purposes, aiding in confirming the diagnosis and guiding further treatment decisions. The biopsy aimed to provide a definitive diagnosis and optimize the management of the patient's pain.

1. Procedure: Surgical Debridement and Drainage for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis presenting with severe infection in the extreme moving joint underwent surgical debridement and drainage. The procedure involved removing infected tissue, irrigating the joint, and placing drains to promote healing and prevent further spread of infection. The intervention aimed to control the infection and improve joint function.

2. Procedure: Joint Lavage and Antibiotic Spacer Placement for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with severe infection in the extreme moving joint due to Pseudosarcomatous Fibromatosis received joint lavage and antibiotic spacer placement. The procedure involved thoroughly irrigating the joint to remove infected material and placing an antibiotic-loaded spacer to deliver targeted antibiotic therapy. This surgical intervention aimed to control the infection and facilitate joint healing.

3. Procedure: Arthroscopic Debridement for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe infection in the extreme moving joint underwent arthroscopic debridement. The procedure involved using a minimally invasive approach to remove infected tissue, clean the joint, and promote healing. Arthroscopic debridement aimed to control the infection and restore joint function.

4. Procedure: Open Joint Washout and Antibiotic Irrigation for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with severe infection in the extreme moving joint associated with Pseudosarcomatous Fibromatosis underwent open joint washout and antibiotic irrigation. The surgical intervention involved surgically accessing the joint, thoroughly cleaning it, and irrigating with antibiotic solution to eliminate the infection. This procedure aimed to eradicate the infection and improve joint health.

5. Procedure: Joint Explantation and Prosthetic Joint Replacement for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with severe infection in the extreme moving joint secondary to Pseudosarcomatous Fibromatosis underwent joint explantation and prosthetic joint replacement. The procedure involved removing the infected joint components and replacing them with a prosthetic joint to eradicate the infection and restore joint function. The intervention aimed to alleviate pain and improve mobility.

6. Procedure: Intra-articular Antibiotic Injection for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with severe infection in the extreme moving joint due to Pseudosarcomatous Fibromatosis received an intra-articular antibiotic injection. The procedure involved injecting antibiotics directly into the joint space to deliver targeted therapy and combat the infection. Intra-articular antibiotic injection aimed to control the infection and promote joint healing.

7. Procedure: Soft Tissue Debridement and Wound Closure for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with severe infection in the extreme moving joint associated with Pseudosarcomatous Fibromatosis underwent soft tissue debridement and wound closure. The surgical intervention involved removing infected soft tissue, irrigating the area, and closing the wound to facilitate healing and prevent further infection spread. This procedure aimed to control the infection and promote tissue recovery.

8. Procedure: Intravenous Antibiotic Therapy and Joint Immobilization for Pseudosarcomatous Fibromatosis

with Severe Infection in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe infection in the extreme moving joint received intravenous antibiotic therapy and joint immobilization. The treatment plan involved administering targeted antibiotics intravenously to combat the infection and immobilizing the joint to promote rest and healing. This approach aimed to control the infection and reduce joint-related symptoms.

9. Procedure: Joint Aspiration and Culture for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with severe infection in the extreme moving joint secondary to Pseudosarcomatous Fibromatosis underwent joint aspiration and culture. The procedure involved removing fluid from the joint space and sending it for laboratory analysis to identify the causative organism and guide antibiotic treatment. Joint aspiration and culture aimed to obtain diagnostic information and target the infection effectively.

10. Procedure: Systemic Antibiotic Therapy and Joint Immobilization for Pseudosarcomatous Fibromatosis with Severe Infection in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe infection in the extreme moving joint received systemic antibiotic therapy and joint immobilization. The treatment approach involved administering antibiotics orally or intravenously to combat the infection systemically and immobilizing the joint to promote rest and healing. This combined intervention aimed to control the infection and improve joint-related symptoms.

1. Procedure: Anti-inflammatory Joint Injection for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe joint inflammation received an anti-inflammatory joint injection. The procedure involved injecting corticosteroids or other anti-inflammatory medications directly into the joint to reduce inflammation and alleviate pain. This intervention aimed to control the inflammatory response and improve joint function.

2. Procedure: Synovectomy for Pseudosarcomatous Fibromatosis with Severe Inflammation and Synovial Proliferation in the Extreme Moving Joint

Indication: Patient with severe inflammation and synovial proliferation in the extreme moving joint due to Pseudosarcomatous Fibromatosis underwent synovectomy. The surgical intervention involved removing the inflamed synovial tissue to reduce inflammation, alleviate pain, and improve joint mobility. Synovectomy aimed to address the underlying inflammatory process and restore joint health.

3. Procedure: Immunosuppressive Therapy for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe inflammation in the extreme moving joint received immunosuppressive therapy. The treatment approach involved administering medications that suppress the immune system to control the inflammatory response. Immunosuppressive therapy aimed to reduce joint inflammation, alleviate symptoms, and prevent further damage.

4. Procedure: Ultrasound-guided Joint Injection with Platelet-rich Plasma (PRP) for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with severe joint inflammation associated with Pseudosarcomatous Fibromatosis received an ultrasound-guided joint injection with platelet-rich plasma (PRP). The procedure involved injecting PRP, which contains growth factors and anti-inflammatory properties, directly into the joint to reduce inflammation and promote tissue healing. This intervention aimed to modulate the inflammatory response and enhance joint recovery.

5. Procedure: Nonsteroidal Anti-inflammatory Drug (NSAID) Therapy for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe joint inflammation received nonsteroidal anti-inflammatory drug (NSAID) therapy. The treatment approach involved administering oral or topical NSAIDs to reduce inflammation, alleviate pain, and improve joint function. NSAID therapy aimed to control the inflammatory process and provide symptomatic relief.

6. Procedure: Cold Therapy (Cryotherapy) for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with severe joint inflammation due to Pseudosarcomatous Fibromatosis received cold therapy (cryotherapy). The treatment involved applying cold packs or using cryotherapy devices to the affected joint, which helped reduce inflammation, numb the area, and alleviate pain. Cold therapy aimed to provide immediate relief from inflammatory symptoms and improve joint comfort.

7. Procedure: Intra-articular Steroid Injection for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe joint inflammation received an intra-articular steroid injection. The procedure involved injecting corticosteroids directly into the joint to suppress inflammation, reduce pain, and improve joint function. Intra-articular steroid injection aimed to provide targeted anti-inflammatory effects and alleviate symptoms.

8. Procedure: Topical Anti-inflammatory Cream for Pseudosar

comatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with severe joint inflammation related to Pseudosarcomatous Fibromatosis received topical anti-inflammatory cream. The treatment approach involved applying a medicated cream or gel to the affected joint, which delivered anti-inflammatory agents locally to reduce inflammation and relieve pain. Topical anti-inflammatory cream aimed to provide localized relief and improve joint comfort.

9. Procedure: Physical Therapy and Rehabilitation for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with Pseudosarcomatous Fibromatosis and severe joint inflammation received physical therapy and rehabilitation. The treatment plan involved a personalized program of exercises, manual therapy, and modalities to reduce inflammation, improve joint mobility, and enhance functional outcomes. Physical therapy aimed to address inflammation, restore joint function, and promote long-term joint health.

10. Procedure: Laser Therapy for Pseudosarcomatous Fibromatosis with Severe Inflammation in the Extreme Moving Joint

Indication: Patient with severe joint inflammation associated with Pseudosarcomatous Fibromatosis received laser therapy. The treatment involved using low-level laser therapy (LLLT) or high-power laser therapy (HPLT) to deliver focused light energy to the affected joint, promoting cellular healing, reducing inflammation, and relieving pain. Laser therapy aimed to modulate the inflammatory response and enhance joint recovery.

1. Follow-up Plan: High-Risk Surveillance for Pseudosarcomatous Fibromatosis with Severe Inflammatory Markers

Indication: Patient diagnosed with severe inflammatory markers associated with Pseudosarcomatous Fibromatosis requires a high-risk surveillance plan. Follow-up will involve frequent monitoring of inflammatory markers, imaging studies, and clinical assessments to track disease progression and response to treatment. The frequency and duration of follow-up visits will be tailored based on the severity of the inflammatory markers and the patient's overall condition.

2. Follow-up Plan: Regular Imaging and Symptom Monitoring for Pseudosarcomatous Fibromatosis with Moderate Inflammation and Joint Dysfunction

Indication: Patient diagnosed with moderate inflammation and joint dysfunction due to Pseudosarcomatous Fibromatosis requires regular follow-up visits. The follow-up plan will include periodic imaging studies, such as MRI or ultrasound, to assess disease progression and joint health. Additionally, symptom monitoring will be conducted to evaluate pain levels, range of motion, and functional limitations. The frequency of follow-up visits will depend on the severity of symptoms and treatment response.

3. Follow-up Plan: Intensive Rehabilitation and Functional Assessments for Pseudosarcomatous Fibromatosis with Mild Inflammation and Impaired Function

Indication: Patient diagnosed with mild inflammation and impaired joint function related to Pseudosarcomatous Fibromatosis requires an intensive follow-up plan. This will involve regular rehabilitation sessions with a physical therapist to improve joint mobility, strength, and overall function. Functional assessments will be conducted periodically to evaluate progress and determine the need for adjustments in the rehabilitation program. The frequency of follow-up visits will be based on the patient's response to therapy and their functional goals.

4. Follow-up Plan: Close Monitoring and Laboratory Tests for Pseudosarcomatous Fibromatosis with Severe Systemic Inflammation

Indication: Patient diagnosed with severe systemic inflammation associated with Pseudosarcomatous Fibromatosis requires close monitoring and laboratory tests. Follow-up visits will involve regular assessments of inflammatory markers, blood tests, and clinical evaluations to evaluate disease activity and response to treatment. The frequency of follow-up visits will depend on the severity of systemic inflammation and the patient's overall health condition.

5. Follow-up Plan: Periodic Clinical Evaluations and Pain Assessments for Pseudosarcomatous Fibromatosis with Chronic Inflammation and Pain

Indication: Patient diagnosed with chronic inflammation and persistent pain due to Pseudosarcomatous Fibromatosis requires periodic follow-up visits. The follow-up plan will involve regular clinical evaluations to assess disease activity, monitor joint health, and adjust treatment as necessary. Pain assessments will be conducted to evaluate the effectiveness of pain management strategies and ensure optimal pain control. The frequency of follow-up visits will depend on the severity of inflammation and the patient's pain levels.

6. Follow-up Plan: Early Intervention and Regular Check-ups for Pseudosarcomatous Fibromatosis with Mild Inflammatory Signs

Indication: Patient diagnosed with mild inflammatory signs related to Pseudosarcomatous Fibromatosis requires early intervention and regular check-ups. Follow-up visits will involve monitoring disease progression, evaluating treatment response, and adjusting the management plan as needed. The frequency of follow-up visits will be determined based on the severity of inflammatory signs and the patient's overall condition.

7. Follow-up Plan: Long-term Surveillance and Periodic Imaging for Pseudosarcomatous Fibromatosis with History of Severe Inflammation and Recurrence

Indication: Patient with a history of severe inflammation and recurrent episodes related to Pseudosarcomatous Fibromatosis

requires long-term surveillance and periodic imaging. The follow-up plan will involve regular imaging studies, such as MRI or CT scans, to monitor for disease recurrence, assess the extent of inflammation, and guide further treatment decisions. The frequency of follow-up visits and imaging will be based on the patient's history, previous treatment outcomes, and the risk of recurrence.

8. Follow-up Plan: Symptom-Based Monitoring and Periodic Clinical Assessments for Pseudosarcomatous Fibromatosis with Fluctuating Inflammation

Indication: Patient diagnosed with Pseudosarcomatous Fibromatosis and fluctuating inflammation requires symptom-based monitoring and periodic clinical assessments. Follow-up visits will be scheduled based on the patient's symptoms and disease activity. Regular clinical evaluations will be conducted to assess joint health, functional status, and treatment response. The frequency of follow-up visits will be tailored to the individual patient's needs.

9. Follow-up Plan: Targeted Therapy and Regular Disease Monitoring for Pseudosarcomatous Fibromatosis with Persistent Inflammation

Indication: Patient diagnosed with persistent inflammation associated with Pseudosarcomatous Fibromatosis requires targeted therapy and regular disease monitoring. The follow-up plan will involve administering specific medications to target the inflammatory process and prevent disease progression. Regular monitoring of inflammatory markers, clinical evaluations, and imaging studies will be conducted to assess treatment response and adjust the therapeutic approach as necessary. The frequency of follow-up visits will depend on the severity of inflammation and the patient's response to treatment.

10. Follow-up Plan: Long-term Rheumatology Care and Periodic Assessments for Pseudosarcomatous Fibromatosis with Chronic Inflammation

Indication: Patient diagnosed with chronic inflammation due to Pseudosarcomatous Fibromatosis requires long-term rheumatology care and periodic assessments. The follow-up plan will involve regular visits to a rheumatologist for comprehensive disease management. Periodic assessments, including clinical evaluations, laboratory tests, and imaging studies, will be conducted to monitor disease activity, assess joint involvement, and optimize treatment strategies. The frequency of follow-up visits will be determined based on the patient's individual needs and treatment response.

## M72.6 Necrotizing fasciitis

1. Patient presented with severe pain, erythema, and edema on the lower extremity. Diagnosis of necrotizing fasciitis confirmed through clinical examination and imaging. Immediate surgical debridement performed followed by broad-spectrum antibiotics. Patient stable post-operation.

2. Necrotizing fasciitis suspected in a patient with systemic signs of infection and localized skin necrosis. Prompt surgical exploration and debridement revealed extensive tissue involvement. Empirical antibiotic therapy initiated. Close monitoring for signs of sepsis and wound healing.

3. Urgent intervention performed for necrotizing fasciitis in an immunocompromised patient. Wide excision of necrotic tissue performed, and wound left open for subsequent vacuum-assisted closure therapy. Intravenous antibiotics initiated. Frequent assessment for wound healing progress and signs of systemic infection.

4. Operative intervention for necrotizing fasciitis carried out in a patient with a history of diabetes and peripheral vascular disease. Extensive debridement performed with meticulous care to preserve viable tissue. Negative pressure wound therapy applied post-operatively. Intensive diabetic management initiated.

5. Surgical exploration and debridement performed for necrotizing fasciitis in the abdominal wall. Extensive tissue necrosis encountered, necessitating multiple debridement sessions. Systemic antibiotics administered, and the patient closely monitored for signs of peritonitis and wound healing.

6. Necrotizing fasciitis confirmed in a patient with recent trauma. Emergency surgical debridement carried out to remove devitalized tissue. Adjunctive therapies, including hyperbaric oxygen therapy, initiated. Close observation for wound infection and potential complications.

7. Operative intervention performed for necrotizing fasciitis in a patient with a history of intravenous drug abuse. Aggressive surgical debridement performed, and the wound left open for delayed primary closure. Intravenous antibiotics started, and harm reduction counseling provided.

8. Necrotizing fasciitis suspected in a patient with severe pain, erythema, and crepitus in the perineal area. Immediate surgical exploration and debridement revealed extensive involvement of the perineum and pelvic floor. Intensive wound care, including negative pressure therapy, initiated post-operatively.

9. Urgent surgical intervention undertaken for necrotizing fasciitis in a patient with a compromised immune system. Extensive debridement performed, and the wound left open for daily dressings. Broad-spectrum antibiotics initiated. Frequent monitoring for signs of systemic infection and wound healing.

10. Necrotizing fasciitis diagnosed in a patient following a surgical procedure. Emergency surgical exploration and debridement performed to remove necrotic tissue and control the infection. Intravenous antibiotics administered, and the patient closely monitored for wound healing and potential complications.

1. Prompt surgical intervention initiated for necrotizing fasciitis in a patient with a history of chronic kidney disease. Extensive debridement performed, and wound managed with advanced wound care techniques. Hemodialysis optimized for improved wound healing and antibiotic delivery.

2. Necrotizing fasciitis suspected in a patient with a compromised immune system and cellulitis. Urgent surgical exploration revealed deep tissue involvement, necessitating aggressive debridement. Intravenous antibiotics initiated, and the patient closely monitored for signs of sepsis and wound healing progress.

3. Operative management undertaken for necrotizing fasciitis in a patient with a recent surgical wound. Immediate surgical debridement performed, and wound left open for secondary intention healing. Advanced wound care modalities initiated, and multidisciplinary team involved for comprehensive care.

4. Severe necrotizing fasciitis identified in a patient with necrotic ulcers and foul-smelling discharge. Emergency surgical intervention conducted, involving extensive debridement and irrigation. Vacuum-assisted closure therapy implemented to promote wound healing. Broad-spectrum antibiotics administered to control infection.

5. Necrotizing fasciitis diagnosed in a patient with a history of peripheral arterial disease. Prompt surgical exploration and debridement performed, with vascular consultation for revascularization if required. Strict glucose control initiated to optimize wound healing and prevent further complications.

6. Operative intervention carried out for necrotizing fasciitis in a patient with a compromised lymphatic system. Extensive debridement performed, and the wound managed with specialized lymphedema therapy. Antibiotic therapy tailored based on culture results and patient's immune status.

7. Necrotizing fasciitis suspected in a patient with a recent history of abdominal surgery and signs of sepsis. Urgent exploratory laparotomy conducted, revealing extensive tissue involvement. Aggressive surgical debridement performed, followed by intravenous antibiotics and intensive care unit admission.

8. Surgical intervention performed for necrotizing fasciitis in a patient with a history of chronic liver disease. Wide surgical debridement conducted, with careful consideration for impaired liver function. Post-operative liver support and close monitoring for signs of hepatic decompensation.

9. Necrotizing fasciitis confirmed in a patient with a compromised immune system and periorbital involvement. Immediate surgical debridement and reconstruction undertaken, involving a multidisciplinary team approach with ophthalmology and plastic surgery. Intravenous antibiotics administered, and close ophthalmic monitoring initiated.

10. Operative management initiated for necrotizing fasciitis in a patient with a history of inflammatory bowel disease. Surgical debridement performed, with consideration for potential bowel resection. Collaboration with gastroenterology for optimal disease control and wound healing.

1. Necrotizing fasciitis patient underwent surgical intervention under general anesthesia with appropriate dosage, ensuring optimal pain control and muscle relaxation during the procedure. Post-operative analgesia provided with a multimodal approach, including regional nerve blocks and intravenous pain medications.

2. In a medically complex case of necrotizing fasciitis, the patient received a carefully tailored anesthesia plan, utilizing a balanced technique with reduced dosages of inhalation agents and opioids. Close monitoring of vital signs and depth of anesthesia ensured patient safety and stability throughout the procedure.

3. Surgical management of necrotizing fasciitis involved regional anesthesia with lower dosages of local anesthetic agents, providing targeted pain relief while minimizing systemic effects. Intravenous sedation maintained at a lighter level to allow cooperation and neurological assessment during the procedure.

4. Necrotizing fasciitis patient underwent emergency surgery under general anesthesia, adjusting the dosage based on individual factors such as age, body weight, and comorbidities. Close hemodynamic monitoring allowed for precise titration of anesthetic agents and analgesics, ensuring patient stability during the procedure.

5. Anesthesia for surgical debridement in necrotizing fasciitis involved a balanced approach, utilizing lower doses of inhalation agents and opioids while emphasizing the use of intravenous analgesics. The goal was to maintain adequate pain control while minimizing potential side effects and facilitating a smoother recovery.

6. Regional anesthesia was employed for surgical intervention in a necrotizing fasciitis patient, utilizing lower dosages of local anesthetic agents to achieve effective anesthesia while reducing the risk of systemic toxicity. Adjunctive medications were carefully selected and administered to ensure patient comfort and safety.

7. In a challenging case of necrotizing fasciitis, the anesthesia dosage was carefully adjusted to account for the patient's altered pharmacokinetics and potential drug interactions. A balanced anesthesia technique was employed, incorporating lower doses of inhalation agents and opioids while optimizing regional anesthesia and analgesia.

8. Surgical management of necrotizing fasciitis required general anesthesia with modified dosages to accommodate the patient's compromised cardiovascular function. Hemodynamic monitoring and frequent adjustments in drug administration ensured hemodynamic stability throughout the procedure.

9. Anesthesia for the surgical debridement in a necrotizing fasciitis patient was tailored to minimize the impact on renal function. Reduced dosages of nephrotoxic medications were utilized, and the choice of intravenous anesthetics and analgesics was adjusted to maintain renal perfusion and minimize potential complications.

10. In a necrotizing fasciitis case with significant respiratory compromise, anesthesia dosage was carefully titrated to avoid excessive respiratory depression. Inhalation agents were utilized sparingly, while regional anesthesia techniques and intravenous analgesics played a more prominent role in achieving effective pain control and patient comfort.

1. Operative intervention for necrotizing fasciitis with bone erosion required careful surgical planning. Extensive debridement performed, including removal of necrotic bone tissue. Reconstruction with bone grafts and appropriate fixation carried out to restore skeletal integrity.

2. Necrotizing fasciitis with bone erosion necessitated urgent surgical intervention. Aggressive debridement conducted, with meticulous attention to bone involvement. Antibiotic-loaded bone cement used for reconstruction, followed by a comprehensive post-operative plan for bone healing and rehabilitation.

3. In a severe case of necrotizing fasciitis with bone erosion, a multidisciplinary approach involving orthopedic and plastic surgery was employed. Surgical debridement, bone resection, and soft tissue reconstruction performed to address both the infection and bone loss. Post-operative bone stabilization and rehabilitation implemented.

4. Surgical exploration for necrotizing fasciitis revealed extensive soft tissue and bone erosion. Aggressive debridement conducted, including removal of devitalized bone fragments. Stabilization of the affected area with external fixation or internal hardware required for structural support and subsequent bone healing.

5. Necrotizing fasciitis with bone erosion necessitated an extensive surgical intervention. Wide debridement performed, addressing both soft tissue necrosis and underlying bone involvement. Subsequent bone grafting and appropriate fixation employed to promote bone regeneration and restore functional integrity.

6. In a complex case of necrotizing fasciitis with bone erosion, surgical management involved a combination of debridement, bone resection, and reconstructive techniques. Autograft or allograft transplantation performed to fill bone defects, followed by a tailored post-operative plan for bone healing and rehabilitation.

7. Necrotizing fasciitis with bone erosion required meticulous surgical debridement, targeting both soft tissue and underlying bone involvement. Use of antibiotic beads or spacers implemented to deliver localized antibiotic therapy and promote bone regeneration. Close follow-up for monitoring bone healing progress.

8. Surgical intervention for necrotizing fasciitis revealed bone erosion, necessitating bone resection and debridement. Application of bioengineered bone substitutes or grafts employed to facilitate bone regeneration. Post-operative management involved a multidisciplinary team to optimize bone healing and functional recovery.

9. Severe necrotizing fasciitis with extensive bone erosion required immediate surgical intervention. Aggressive debridement performed to remove infected and necrotic bone fragments. Reconstruction with bone grafts, bone substitutes, or osteoconductive materials utilized to promote bone healing and structural stability.

10. In a challenging case of necrotizing fasciitis with bone erosion, surgical debridement extended to healthy bone margins. Bone grafts or substitutes were utilized to fill bone defects and promote healing. A comprehensive rehabilitation program initiated to optimize functional recovery and restore bone strength.

1. Patient with necrotizing fasciitis presented with severe bone pain requiring immediate surgical intervention. Extensive debridement performed to address both the infection and alleviate bone pain. Post-operative pain management implemented, including multimodal analgesia and close monitoring for pain control.

2. Necrotizing fasciitis with severe bone pain necessitated urgent surgical exploration and debridement. Meticulous attention given to the affected bone, with the goal of relieving pain and controlling the infection. Post-operative pain relief provided through a combination of oral and intravenous analgesics.

3. Surgical management undertaken for necrotizing fasciitis with severe bone pain. Aggressive debridement performed, including removal of necrotic bone tissue, to alleviate pain and halt disease progression. Collaborative approach with pain management specialists for optimized post-operative pain control.

4. Severe bone pain in a patient with necrotizing fasciitis required immediate surgical intervention. Comprehensive debridement conducted to address both infected soft tissue and underlying bone pathology. Post-operative pain management focused on providing adequate analgesia to alleviate bone pain.

5. Necrotizing fasciitis patient presented with debilitating bone pain. Urgent surgical debridement performed to relieve pain and halt disease progression. Close collaboration with the pain management team for a multimodal approach to pain control, including pharmacological and non-pharmacological interventions.

6. Surgical intervention undertaken for necrotizing fasciitis with severe bone pain. Extensive debridement carried out, targeting both infected soft tissue and affected bone to alleviate pain. Post-operative pain management involved a combination of analgesics and adjunctive therapies tailored to the patient's needs.

7. Severe bone pain in a patient with necrotizing fasciitis required immediate surgical attention. Aggressive debridement performed to address bone pathology and alleviate pain. Comprehensive post-operative pain management plan implemented, utilizing a multimodal approach for optimal pain relief.

8. Necrotizing fasciitis with severe bone pain necessitated urgent surgical intervention. Meticulous debridement conducted, targeting both infected tissue and bone involvement to alleviate pain. Post-operative pain management involved a personalized regimen to ensure effective pain control.

9. Patient presented with necrotizing fasciitis and severe bone pain. Emergency surgical exploration and debridement performed to address the underlying pathology and alleviate pain. Multimodal pain management approach implemented, including both systemic and regional techniques.

10. Surgical management undertaken for necrotizing fasciitis with debilitating bone pain. Aggressive debridement carried out, targeting both infected tissue and bone to provide relief. Collaborative approach with pain management specialists for optimal post-operative pain control and patient comfort.

1. Surgical intervention was performed for a patient with necrotizing fasciitis to address severe bone pain. Extensive debridement conducted, including removal of necrotic tissue and affected bone. Post-operative pain management focused on alleviating bone pain and facilitating recovery.

2. Necrotizing fasciitis patient underwent immediate surgical intervention to relieve severe bone pain. Comprehensive debridement carried out, targeting both infected soft tissue and underlying bone pathology. Post-operative pain control managed with a combination of analgesics and regional anesthesia techniques.

3. In a case of necrotizing fasciitis with severe bone pain, surgical intervention was necessary. Extensive debridement performed, addressing both the infection and bone involvement. Post-operative pain management tailored to the patient's needs for optimal pain relief.

4. Surgical intervention undertaken for a patient with necrotizing fasciitis and debilitating bone pain. Aggressive debridement conducted, including removal of necrotic tissue and affected bone segments. Post-operative pain control optimized through a multimodal approach.

5. Severe bone pain in a necrotizing fasciitis patient necessitated surgical intervention. Comprehensive debridement performed, targeting both infected soft tissue and bone pathology. Post-operative pain management plan implemented to address bone pain and promote healing.

6. Immediate surgical intervention conducted for a patient with necrotizing fasciitis and severe bone pain. Extensive debridement carried out to alleviate pain and control the infection. Post-operative pain management focused on providing adequate analgesia during the recovery period.

7. Surgical intervention undertaken for necrotizing fasciitis with severe bone pain. Meticulous debridement performed, targeting both infected tissue and bone involvement. Post-operative pain management tailored to address bone pain and ensure patient comfort.

8. Necrotizing fasciitis patient underwent surgical intervention to address severe bone pain. Aggressive debridement conducted, including removal of necrotic tissue and affected bone. Post-operative pain control managed with a combination of pharmacological and non-pharmacological approaches.

9. In a challenging case of necrotizing fasciitis with severe bone pain, surgical intervention was carried out. Extensive debridement performed to alleviate pain and remove infected tissue, including bone involvement. Post-operative pain management tailored to meet the patient's specific needs.

10. Surgical intervention was performed for a patient with necrotizing fasciitis and debilitating bone pain. Thorough debridement conducted, targeting both infected soft tissue and affected bone. Post-operative pain management implemented to provide optimal relief and support healing.

1. Immediate surgical intervention was initiated for a patient with necrotizing fasciitis and excruciating bone pain. Extensive debridement conducted, including removal of necrotic tissue and affected bone fragments. Post-operative pain management focused on multimodal analgesia and close monitoring for adequate pain control.

2. Necrotizing fasciitis patient underwent urgent surgical intervention to alleviate severe bone pain. Aggressive debridement performed, targeting both infected soft tissue and underlying bone pathology. Post-operative pain control achieved through a combination of opioid and non-opioid analgesics, tailored to the patient's pain profile.

3. Surgical intervention was undertaken for necrotizing fasciitis with severe bone pain. Thorough debridement carried out, addressing both infected tissue and bone involvement. Post-operative pain management implemented, combining systemic analgesics, regional anesthesia techniques, and non-pharmacological modalities.

4. Severe bone pain in a patient with necrotizing fasciitis necessitated immediate surgical intervention. Extensive debridement conducted, including excision of necrotic bone. Post-operative pain management incorporated a multimodal approach, including oral and intravenous analgesics and physical therapy.

5. Surgical management was performed for necrotizing fasciitis with debilitating bone pain. Aggressive debridement carried out to alleviate pain and control the infection. Post-operative pain control achieved through tailored analgesic regimens, with consideration for the patient's pain threshold and comorbidities.

6. Necrotizing fasciitis patient underwent surgical intervention to address severe bone pain. Thorough debridement conducted, targeting both infected soft tissue and bone erosion. Post-operative pain management involved a multidisciplinary approach, combining pharmacological and non-pharmacological interventions.

7. Immediate surgical intervention was undertaken for necrotizing fasciitis with severe bone pain. Extensive debridement performed to relieve pain and halt disease progression. Post-operative pain control managed through a tailored analgesic plan, considering the patient's pain intensity and previous analgesic response.

8. Surgical intervention was performed for a patient with necrotizing fasciitis and excruciating bone pain. Aggressive debridement conducted, including removal of necrotic bone fragments. Post-operative pain management involved a combination of intravenous and oral analgesics, ensuring adequate pain relief.

9. In a complex case of necrotizing fasciitis with severe bone pain, surgical intervention was required. Comprehensive debridement carried out to alleviate pain and address bone erosion. Post-operative pain control managed with a multimodal approach, including patient-controlled analgesia and regional anesthesia techniques.

10. Necrotizing fasciitis patient underwent urgent surgical intervention to relieve debilitating bone pain. Thorough debridement conducted, targeting both infected soft tissue and affected bone. Post-operative pain management implemented through a personalized analgesic regimen, addressing the patient's specific pain requirements.

1. Urgent surgical intervention was performed for a patient with necrotizing fasciitis and a severe infection involving the extreme moving joint. Extensive debridement and joint irrigation carried out to control the infection and preserve joint function. Post-operative antibiotic therapy and close monitoring for signs of recurrent infection implemented.

2. In a critical case of necrotizing fasciitis with a severe infection affecting the extreme moving joint, immediate surgical intervention was initiated. Aggressive debridement and joint washout performed to eradicate the infection. Post-operative care involved targeted antibiotic therapy and rehabilitation to restore joint mobility.

3. Surgical management was undertaken for a patient with necrotizing fasciitis and a severe infection in the extreme moving joint. Extensive debridement, joint irrigation, and removal of infected tissues conducted to control the infection. Post-operative monitoring for joint stability and comprehensive antibiotic treatment administered.

4. Severe infection involving the extreme moving joint in a necrotizing fasciitis patient necessitated urgent surgical intervention. Thorough debridement and joint decontamination carried out to eradicate the infection source. Post-operative care involved a combination of intravenous antibiotics and rehabilitative measures to promote joint recovery.

5. Necrotizing fasciitis patient presented with a severe infection on the extreme moving joint, requiring immediate surgical intervention. Aggressive debridement and joint lavage performed to eliminate the infection and prevent further joint damage. Post-operative management included targeted antibiotic therapy and close orthopedic follow-up.

6. Surgical intervention was performed for a patient with necrotizing fasciitis and a severe infection affecting the extreme moving joint. Extensive debridement and irrigation of the joint carried out to control the infection and mitigate joint destruction. Post-operative care involved tailored antibiotic therapy and rehabilitation for joint functionality.

7. In a challenging case of necrotizing fasciitis with a severe infection in the extreme moving joint, surgical intervention was undertaken. Thorough debridement and joint washout performed to eradicate the infection source. Post-operative management involved a multidisciplinary approach, including orthopedic care and infectious disease consultation.

8. Necrotizing fasciitis patient with a severe infection involving the extreme moving joint underwent urgent surgical intervention. Aggressive debridement and joint irrigation performed to eliminate the infectious source. Post-operative care involved a combination of targeted antibiotic therapy, immobilization, and rehabilitation to optimize joint recovery.

9. Surgical management was initiated for a necrotizing fasciitis patient with a severe infection on the extreme moving joint. Extensive debridement and joint decontamination conducted to control the infection and prevent joint destruction. Post-operative follow-up involved close monitoring for signs of recurrent infection and joint function restoration.

10. Severe infection in the extreme moving joint due to necrotizing fasciitis necessitated immediate surgical intervention. Thorough debridement and joint lavage performed to eradicate the infectious agent and preserve joint integrity. Post-operative care included antimicrobial therapy and rehabilitation tailored to the joint's specific needs.

1. Surgical intervention was performed for a patient with necrotizing fasciitis and severe inflammation in the affected area. Extensive debridement conducted to address both the infection and alleviate inflammation. Post-operative anti-inflammatory measures implemented to promote healing and reduce inflammatory response.

2. Necrotizing fasciitis patient presented with severe inflammation requiring urgent surgical intervention. Aggressive debridement performed, targeting both infected soft tissue and the inflammatory component. Post-operative management involved anti-inflammatory medications and localized therapies to reduce inflammation and promote recovery.

3. In a complex case of necrotizing fasciitis with severe inflammation, surgical intervention was undertaken. Meticulous debridement conducted, addressing both infected tissue and the inflammatory response. Post-operative management involved a combination of anti-inflammatory medications and supportive measures.

4. Surgical intervention was initiated for necrotizing fasciitis with significant inflammation. Thorough debridement performed to alleviate inflammation and control the infection. Post-operative anti-inflammatory treatment administered to reduce swelling and promote healing.

5. Necrotizing fasciitis patient presented with severe inflammation in the affected area, necessitating surgical intervention. Comprehensive debridement conducted, targeting both infected tissue and the inflammatory response. Post-operative anti-inflammatory strategies employed to manage inflammation and support tissue recovery.

6. Surgical management was performed for necrotizing fasciitis with marked inflammation. Aggressive debridement carried out to alleviate inflammation and control the infection. Post-operative anti-inflammatory measures implemented to reduce swelling and optimize healing.

7. Severe inflammation in a patient with necrotizing fasciitis required immediate surgical intervention. Extensive debridement performed to address both the infection and the inflammatory component. Post-operative management involved anti-inflammatory medications and supportive therapies to reduce inflammation and promote tissue repair.

8. Necrotizing fasciitis patient underwent surgical intervention to alleviate severe inflammation. Thorough debridement conducted, targeting both infected tissue and the inflammatory response. Post-operative anti-inflammatory treatment administered to minimize swelling and promote healing.

9. In a challenging case of necrotizing fasciitis with significant inflammation, surgical intervention was necessary. Comprehensive debridement performed to address both infected tissue and the inflammatory process. Post-operative anti-inflammatory medications and modalities employed to manage inflammation and facilitate recovery.

10. Surgical intervention was undertaken for necrotizing fasciitis with severe inflammation in the affected area. Meticulous debridement conducted, targeting both infected soft tissue and the inflammatory response. Post-operative management involved a combination of anti-inflammatory medications and adjunctive therapies to control inflammation and support tissue healing.

1. The patient was diagnosed with severe necrotizing fasciitis. Given the severity of the diagnosis, frequent follow-up visits and close monitoring of the wound were recommended to assess the response to treatment and ensure proper healing.

2. The diagnosis of necrotizing fasciitis revealed a moderate level of severity. Regular follow-up appointments were advised to evaluate the progress of the infection and adjust the treatment plan accordingly, while also monitoring for potential complications.

3. The patient's necrotizing fasciitis diagnosis indicated a mild level of severity. Follow-up consultations were scheduled to assess the response to initial treatment and to determine the need for additional interventions or adjustments in the management plan.

4. Severe necrotizing fasciitis was diagnosed in the patient. Given the critical nature of the condition, frequent and closely spaced follow-up visits were recommended to closely monitor the response to treatment, manage complications, and ensure optimal recovery.

5. The diagnosis of necrotizing fasciitis revealed a moderately severe condition. Follow-up appointments were scheduled to assess the efficacy of the treatment approach and to address any potential concerns or complications that may arise during the recovery process.

6. The patient's necrotizing fasciitis diagnosis indicated a relatively mild severity level. Follow-up visits were planned to monitor the progress of the infection, evaluate the response to treatment, and provide further guidance or interventions as necessary.

7. The severity of the necrotizing fasciitis diagnosis was deemed critical. Frequent follow-up assessments were recommended to closely monitor the patient's condition, manage potential complications, and adjust the treatment plan based on the evolving clinical picture.

8. The diagnosis of necrotizing fasciitis revealed a moderate level of severity. Regular follow-up appointments were advised to closely monitor the patient's response to treatment, evaluate wound healing progress, and address any emerging issues promptly.

9. The patient's necrotizing fasciitis diagnosis indicated a mild severity level. Follow-up consultations were scheduled to assess the response to initial treatment, monitor for any signs of worsening infection, and ensure appropriate wound care management.

10. Severe necrotizing fasciitis was diagnosed, necessitating intensive follow-up care. Regular visits were planned to closely monitor the patient's condition, assess treatment effectiveness, and promptly address any potential complications or signs of disease progression.

## M72.8 Other fibroblastic disorders

Operative Note 1:

Procedure: Excision of Fibroblastic Nodule

Indication: Patient presented with a palpable nodule in the soft tissue. Preoperative biopsy revealed fibroblastic proliferation. The lesion was excised using a longitudinal incision, preserving surrounding tissue. Hemostasis was achieved. The wound was closed in layers. Pathological examination confirmed the diagnosis. Postoperative recovery was uneventful.

Operative Note 2:

Procedure: Debulking of Fibroblastic Tumor

Indication: Large fibroblastic tumor causing pain and functional impairment. A curvilinear incision was made over the tumor. Tumor debulking was performed meticulously, minimizing damage to adjacent structures. Hemostasis was achieved. The wound was closed in layers. Postoperative recovery was satisfactory. Histopathology confirmed fibroblastic tumor with clear margins.

Operative Note 3:

Procedure: Reconstruction of Fibroblastic Scar

Indication: Patient with a fibroblastic scar resulting in contracture and functional limitation. Scar release was performed through a Z-plasty technique. Fibrous tissue was excised, and meticulous closure was achieved. Postoperative wound care was emphasized. Follow-up revealed improved range of motion and patient satisfaction.

Operative Note 4:

Procedure: Excisional Biopsy of Fibroblastic Lesion

Indication: Suspicious fibroblastic lesion observed on imaging. Excisional biopsy was performed through a linear incision. The lesion was completely excised with clear margins. Hemostasis was achieved. The wound was closed primarily. Histopathological analysis confirmed fibroblastic lesion with no evidence of malignancy.

Operative Note 5:

Procedure: Soft Tissue Reconstruction for Fibroblastic Pseudotumor

Indication: Fibroblastic pseudotumor causing pain and swelling. Wide excision of the tumor was performed, followed by reconstruction with a local fasciocutaneous flap. Vascular anastomosis was performed. Adequate coverage and closure were achieved. Postoperative recovery was uneventful. The patient reported significant pain relief and improved function.

Operative Note 6:

Procedure: Resection of Fibroblastic Tumor

Indication: Large fibroblastic tumor causing cosmetic deformity. Tumor resection was performed through a curvilinear incision. Careful dissection was carried out to preserve adjacent structures. Hemostasis was achieved. The wound was closed primarily. Postoperative recovery was smooth, and the patient was satisfied with the cosmetic outcome.

Operative Note 7:

Procedure: Release of Fibroblastic Contracture

Indication: Fibroblastic contracture causing restricted joint mobility. A longitudinal incision was made, and the fibrous bands were released. Extensive scar tissue was excised, allowing improved range of motion. The wound was closed in layers. Postoperative physical therapy was initiated for optimal rehabilitation.

Operative Note 8:

Procedure: Excision of Fibroblastic Proliferation

Indication: Patient with a fibroblastic proliferation causing pain and functional impairment. Excision was performed through an elliptical incision, encompassing the lesion. Hemostasis was achieved, and the wound was closed primarily. Histopathology confirmed fibroblastic proliferation with negative margins. Postoperative recovery was uneventful.

Operative Note 9:

Procedure: Debridement and Closure of Fibroblastic Ulcer

Indication: Fibroblastic ulcer with undermining edges and necrotic tissue. Thorough debridement was performed, removing devitalized tissue. The wound bed was meticulously cleaned and dressed. Closure was achieved using tension-reducing techniques. Postoperative wound care instructions were provided. Follow-up

showed progressive healing and granulation tissue formation.

Operative Note 10:

Procedure: Release of Fibroblastic Adhesion

Indication: Fibroblastic adhesion causing pain and restricted movement. A small incision was made over the adhesion site. Gentle dissection was carried out, releasing the adhesion without injury to nearby structures. The wound was closed primarily. Postoperative physical therapy was advised for rehabilitation. The patient reported improved pain and range of motion.

Operative Note 11:

Procedure: Excision of Fibroblastic Hamartoma

Indication: Patient presented with a palpable mass consistent with fibroblastic hamartoma. An elliptical incision was made around the lesion, ensuring complete excision. Hemostasis was achieved, and the wound was closed primarily. Histopathological examination confirmed the diagnosis. The patient had an uneventful postoperative course with no signs of recurrence.

Operative Note 12:

Procedure: Repair of Fibroblastic Hernia

Indication: Fibroblastic hernia causing pain and discomfort. A transverse incision was made, exposing the hernia sac. The sac was carefully dissected and reduced. Fascial defect repair was performed using interrupted sutures. The wound was closed in layers. The patient had an uncomplicated recovery and was discharged with appropriate postoperative instructions.

Operative Note 13:

Procedure: Biopsy of Fibroblastic Tumor

Indication: Suspicion of fibroblastic tumor based on clinical and radiological findings. A percutaneous needle biopsy was performed under ultrasound guidance. Tissue samples were obtained for histopathological evaluation. The procedure was well-tolerated, and the patient experienced minimal discomfort. Pathology results confirmed the diagnosis of fibroblastic tumor.

Operative Note 14:

Procedure: Excision of Fibroblastic Papule

Indication: Patient presented with a persistent fibroblastic papule on the skin. The lesion was excised using a shave excision technique. Hemostasis was achieved, and the wound was closed with sutures. The patient had an uneventful postoperative course, and histopathological examination confirmed the fibroblastic nature of the papule.

Operative Note 15:

Procedure: Debridement and Reconstruction of Fibroblastic Wound

Indication: Fibroblastic wound with necrotic tissue and poor healing. Thorough wound debridement was performed, followed by application of a biologic dressing. Reconstruction was achieved using a split-thickness skin graft. Adequate coverage and closure were achieved. The patient underwent regular dressing changes and showed progressive wound healing.

Operative Note 16:

Procedure: Resection of Fibroblastic Tumor with Limb Salvage

Indication: Large fibroblastic tumor involving the extremity. Wide local excision was performed, preserving neurovascular structures. Tumor margins were confirmed to be clear. Limb salvage was achieved with soft tissue reconstruction using a free flap. Postoperative recovery was uneventful, and the patient regained satisfactory function of the affected limb.

Operative Note 17:

Procedure: Excision of Fibroblastic Scar Contracture

Indication: Fibroblastic scar contracture resulting in functional impairment. Scar release was performed through Z-plasty and contracture excision. The wound was closed meticulously, avoiding excessive tension. Physical therapy was initiated postoperatively. The patient experienced improved range of motion and functional outcomes during follow-up evaluations.

Operative Note 18:

Procedure: Curettage and Electrodesiccation of Fibroblastic Lesion

Indication: Fibroblastic lesion with suspicious features. Curettage was performed to remove the lesion, followed by electrodesiccation for hemostasis and destruction of residual tissue. The wound was left to heal by secondary intention. Pathological examination confirmed the fibroblastic nature of the lesion with negative margins.

Operative Note 19:

Procedure: Excision of Fibroblastic Nodule with Skin Graft

Indication: Large fibroblastic nodule with associated skin ulceration. Excision of the nodule was performed, followed by wound bed preparation. A split-thickness skin graft was applied

to achieve wound closure. The graft was secured and dressed appropriately. The patient showed progressive healing and graft take during follow-up assessments.

Operative Note 20:

Procedure: Release of Fibroblastic Tethering Band

Indication: Fibroblastic tethering band causing functional limitation. A small incision was made over the band, and careful dissection was performed to release the tethering effect. The incision was closed with sutures. The patient reported immediate improvement in range of motion, and postoperative rehabilitation was initiated for optimal recovery.

Operative Note 21:

Procedure: Excision of Fibroblastic Lesion under Local Anesthesia

Indication: Fibroblastic lesion on the skin requiring excision. The patient was positioned comfortably, and the surgical site was infiltrated with local anesthetic. A elliptical incision was made around the lesion, ensuring complete excision. Hemostasis was achieved, and the wound was closed primarily. The patient tolerated the procedure well without any complications.

Operative Note 22:

Procedure: Debridement and Closure of Fibroblastic Ulcer under Regional Anesthesia

Indication: Fibroblastic ulcer with necrotic tissue requiring debridement and closure. The patient underwent regional anesthesia, providing effective pain control. Thorough debridement was performed, followed by meticulous wound cleansing. Closure was achieved using tension-reducing techniques. The patient remained comfortable throughout the procedure, and postoperative recovery was satisfactory.

Operative Note 23:

Procedure: Resection of Fibroblastic Tumor under General Anesthesia

Indication: Large fibroblastic tumor necessitating surgical resection. The patient was induced under general anesthesia with endotracheal intubation. A curvilinear incision was made, allowing adequate exposure of the tumor. Tumor resection was performed, ensuring clear margins. Hemostasis was achieved, and layered closure was performed. The patient recovered well in the post-anesthesia care unit.

Operative Note 24:

Procedure: Release of Fibroblastic Contracture under Conscious Sedation

Indication: Fibroblastic contracture requiring release for improved mobility. The patient received conscious sedation, achieving a relaxed and pain-free state. A longitudinal incision was made over the contracture site, and careful dissection was carried out. The fibrous bands were released, and the wound was closed meticulously. The patient remained comfortable throughout the procedure.

Operative Note 25:

Procedure: Excisional Biopsy of Fibroblastic Lesion under Moderate Sedation

Indication: Suspicious fibroblastic lesion requiring excisional biopsy. The patient received moderate sedation for optimal comfort. A linear incision was made, and the lesion was completely excised. Hemostasis was achieved, and the wound was closed primarily. The patient tolerated the procedure well and experienced minimal discomfort.

Operative Note 26:

Procedure: Reconstruction of Fibroblastic Scar under Local Anesthesia with Sedation

Indication: Fibroblastic scar requiring reconstruction for functional improvement. The patient received local anesthesia at the surgical site and sedation for relaxation. Scar release and reconstruction were performed, followed by meticulous wound closure. The patient remained calm and comfortable throughout the procedure, with no complications observed.

Operative Note 27:

Procedure: Debulking of Fibroblastic Tumor under Deep Sedation

Indication: Large fibroblastic tumor necessitating debulking for symptom relief. The patient received deep sedation to achieve a controlled and pain-free state. Tumor debulking was performed, minimizing damage to surrounding structures. Hemostasis was achieved, and the wound was closed meticulously. The patient had a smooth recovery with no sedation-related issues.

Operative Note 28:

Procedure: Excision of Fibroblastic Papule under Local Anesthesia with Minimal Sedation

Indication: Fibroblastic papule requiring excision for cosmetic reasons. The patient received local anesthesia with minimal sedation for relaxation. The papule was excised using a shave excision technique. Hemostasis was achieved, and the wound was closed with sutures. The patient was comfortable throughout the procedure and experienced minimal sedation effects.

Operative Note 29:

Procedure: Release of Fibroblastic Adhesion under General An

esthesia with Light Sedation

Indication: Fibroblastic adhesion causing functional limitation. The patient was induced under general anesthesia and received light sedation to maintain a relaxed state. A small incision was made, and the adhesion was released with meticulous dissection. The wound was closed in layers. The patient had a smooth recovery with no complications.

Operative Note 30:

Procedure: Excision of Fibroblastic Hamartoma under Spinal Anesthesia

Indication: Fibroblastic hamartoma necessitating surgical excision. The patient received spinal anesthesia for pain control. An elliptical incision was made, and the hamartoma was excised. Hemostasis was achieved, and layered closure was performed. The patient remained comfortable throughout the procedure, and postoperative recovery was uneventful.

Operative Note 31:

Procedure: Resection of Fibroblastic Tumor with Bone Erosion under General Anesthesia

Indication: Fibroblastic tumor with associated bone erosion necessitating surgical intervention. The patient was induced under general anesthesia with endotracheal intubation. A curvilinear incision was made, providing access to the tumor and the eroded bone. Tumor resection and bone debridement were performed, followed by reconstruction using bone grafting. Hemostasis was achieved, and layered closure was performed. The patient recovered well in the post-anesthesia care unit.

Operative Note 32:

Procedure: Excision of Fibroblastic Lesion with Adjacent Bone Erosion under Local Anesthesia

Indication: Fibroblastic lesion with evidence of adjacent bone erosion requiring excision. The patient received local anesthesia at the surgical site. An elliptical incision was made, encompassing the lesion and the eroded bone area. Complete excision of the lesion and bone debridement were performed. Hemostasis was achieved, and the wound was closed primarily. The patient tolerated the procedure well, and postoperative recovery was satisfactory.

Operative Note 33:

Procedure: Debridement and Reconstruction of Fibroblastic Ulcer with Underlying Bone Erosion under Regional Anesthesia

Indication: Fibroblastic ulcer with associated bone erosion necessitating debridement and reconstruction. The patient underwent regional anesthesia, providing effective pain control. Thorough wound debridement was performed, including the removal of necrotic tissue and infected bone fragments. Reconstruction was achieved using a combination of soft tissue coverage and bone grafting. The patient remained comfortable throughout the procedure, and postoperative recovery was satisfactory.

Operative Note 34:

Procedure: Curettage and Bone Grafting for Fibroblastic Lesion with Bone Erosion under General Anesthesia

Indication: Fibroblastic lesion with bone erosion requiring curettage and bone grafting. The patient was induced under general anesthesia with endotracheal intubation. A curvilinear incision was made, exposing the lesion and the eroded bone. Curettage of the lesion and bone debridement were performed. Bone grafting was carried out to promote bone regeneration. Hemostasis was achieved, and the wound was closed in layers. The patient had an uneventful postoperative course.

Operative Note 35:

Procedure: Resection of Fibroblastic Tumor with Bone Erosion and Internal Fixation under General Anesthesia

Indication: Large fibroblastic tumor with significant bone erosion requiring resection and internal fixation. The patient was induced under general anesthesia with endotracheal intubation. An extensive incision was made, providing access to the tumor and the eroded bone. Tumor resection, bone debridement, and internal fixation were performed. Hemostasis was achieved, and layered closure was performed. The patient recovered well in the post-anesthesia care unit.

Operative Note 36:

Procedure: Excisional Biopsy of Fibroblastic Lesion with Bone Erosion under Local Anesthesia

Indication: Suspicious fibroblastic lesion with evidence of underlying bone erosion requiring excisional biopsy. The patient received local anesthesia at the surgical site. A linear incision was made, encompassing the lesion and the eroded bone area. Complete excision of the lesion and bone biopsy were performed. Hemostasis was achieved, and the wound was closed primarily. The patient tolerated the procedure well, and postoperative recovery was satisfactory.

Operative Note 37:

Procedure: Reconstruction of Fibroblastic Scar with Underlying Bone Erosion under Regional Anesthesia

Indication:

Fibroblastic scar with associated bone erosion necessitating reconstruction. The patient underwent regional anesthesia, providing effective pain control. Scar release and reconstruction were performed, including the management of the underlying bone erosion. Soft tissue coverage and bone grafting were utilized to achieve optimal reconstruction. The patient remained comfortable throughout the procedure, and postoperative recovery was satisfactory.

Operative Note 38:

Procedure: Debulking of Fibroblastic Tumor with Bone Erosion under General Anesthesia

Indication: Large fibroblastic tumor with significant bone erosion requiring debulking for symptom relief. The patient was induced under general anesthesia with endotracheal intubation. Tumor debulking and bone debridement were performed, minimizing damage to adjacent structures. Hemostasis was achieved, and the wound was closed meticulously. The patient had a smooth recovery with no anesthesia-related issues.

Operative Note 39:

Procedure: Excision of Fibroblastic Papule with Adjacent Bone Erosion under Local Anesthesia

Indication: Fibroblastic papule with evidence of adjacent bone erosion requiring excision. The patient received local anesthesia with minimal sedation for relaxation. An elliptical incision was made, encompassing the papule and the eroded bone area. Complete excision of the papule and bone debridement were performed. Hemostasis was achieved, and the wound was closed with sutures. The patient was comfortable throughout the procedure, and experienced minimal sedation effects.

Operative Note 40:

Procedure: Release of Fibroblastic Adhesion with Adjacent Bone Erosion under General Anesthesia with Light Sedation

Indication: Fibroblastic adhesion causing functional limitation with evidence of adjacent bone erosion. The patient was induced under general anesthesia and received light sedation for relaxation. A small incision was made, and careful dissection was performed to release the adhesion. Concurrent bone debridement was carried out to address the erosion. The wound was closed in layers. The patient had a smooth recovery with no complications.

Operative Note 41:

Procedure: Excision of Fibroblastic Lesion with Severe Bone Pain under General Anesthesia

Indication: Fibroblastic lesion causing severe bone pain necessitating surgical excision. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the lesion and the affected bone. Complete excision of the lesion was performed. Postoperatively, the patient reported relief from severe bone pain, and the recovery was uneventful.

Operative Note 42:

Procedure: Debridement and Reconstruction of Fibroblastic Ulcer with Severe Bone Pain under Regional Anesthesia

Indication: Fibroblastic ulcer with severe bone pain requiring debridement and reconstruction. The patient underwent regional anesthesia, providing effective pain control. Thorough debridement of the ulcer and adjacent necrotic bone was performed. Reconstruction was achieved using appropriate techniques. Postoperatively, the patient experienced significant improvement in bone pain and had satisfactory wound healing.

Operative Note 43:

Procedure: Resection of Fibroblastic Tumor with Severe Bone Pain under General Anesthesia

Indication: Large fibroblastic tumor causing severe bone pain necessitating surgical resection. The patient was induced under general anesthesia with endotracheal intubation. A curvilinear incision was made, allowing adequate exposure of the tumor and the affected bone. Tumor resection was performed, and the affected bone was addressed accordingly. The patient reported relief from severe bone pain postoperatively.

Operative Note 44:

Procedure: Curettage and Bone Grafting for Fibroblastic Lesion with Severe Bone Pain under General Anesthesia

Indication: Fibroblastic lesion causing severe bone pain requiring curettage and bone grafting. The patient was induced under general anesthesia with endotracheal intubation. A curvilinear incision was made, exposing the lesion and the affected bone. Curettage of the lesion was performed, followed by bone grafting to address the affected bone. The patient experienced significant improvement in severe bone pain after the procedure.

Operative Note 45:

Procedure: Resection of Fibroblastic Scar with Severe Bone Pain under General Anesthesia

Indication: Fibroblastic scar causing severe bone pain requiring surgical resection. The patient was induced under general anesthesia with endotracheal intubation. A surgical incision was made, allowing access to the scar and the underlying affected bone. Scar resection was performed, addressing the source of severe bone pain. The patient reported relief from severe bone pain in the postoperative period.

Operative Note 46:

Procedure: Excisional Biopsy of Fibroblastic Lesion with Severe Bone Pain under Local Anesthesia

Indication: Suspicious fibroblastic lesion causing severe bone pain requiring excisional biopsy. The patient received local anesthesia at the surgical site. A linear incision was made, encompassing the lesion and the affected bone area. Complete excision of the lesion and bone biopsy were performed. The patient reported relief from severe bone pain postoperatively.

Operative Note 47:

Procedure: Reconstruction of Fibroblastic Ulcer with Severe Bone Pain under Regional Anesthesia

Indication: Fibroblastic ulcer with severe bone pain requiring reconstruction. The patient underwent regional anesthesia, providing effective pain control. Scar release, wound debridement, and reconstruction were performed, addressing the underlying bone involvement. Postoperatively, the patient reported relief from severe bone pain and had satisfactory wound healing.

Operative Note 48:

Procedure: Debulking of Fibroblastic Tumor with Severe Bone Pain under General Anesthesia

Indication: Large fibro

blastic tumor causing severe bone pain necessitating debulking for symptom relief. The patient was induced under general anesthesia with endotracheal intubation. Tumor debulking was performed, providing relief from severe bone pain. The patient had a smooth recovery in the post-anesthesia care unit.

Operative Note 49:

Procedure: Excision of Fibroblastic Papule with Severe Bone Pain under Local Anesthesia

Indication: Fibroblastic papule causing severe bone pain requiring excision. The patient received local anesthesia with minimal sedation for relaxation. An elliptical incision was made, encompassing the papule and the affected bone area. Complete excision of the papule was performed, addressing the source of severe bone pain. The patient reported relief from severe bone pain postoperatively.

Operative Note 50:

Procedure: Release of Fibroblastic Adhesion with Severe Bone Pain under General Anesthesia with Light Sedation

Indication: Fibroblastic adhesion causing severe bone pain necessitating release. The patient was induced under general anesthesia and received light sedation for relaxation. A small incision was made, and careful dissection was performed to release the adhesion. Postoperatively, the patient reported relief from severe bone pain, and the recovery was uneventful.

Operative Note 51:

Procedure: Surgical Resection of Fibroblastic Tumor with Adjacent Bone Erosion and Severe Bone Pain under General Anesthesia

Indication: Large fibroblastic tumor with associated bone erosion and severe bone pain necessitating surgical resection. The patient was induced under general anesthesia with endotracheal intubation. An extensive incision was made, providing adequate exposure to the tumor and the affected bone. Complete tumor resection, bone debridement, and pain management measures were undertaken. The patient reported relief from severe bone pain postoperatively.

Operative Note 52:

Procedure: Surgical Excision and Reconstruction of Fibroblastic Lesion with Bone Erosion and Severe Bone Pain under General Anesthesia

Indication: Fibroblastic lesion with bone erosion and severe bone pain requiring surgical excision and reconstruction. The patient was induced under general anesthesia with endotracheal intubation. An appropriate incision was made, providing access to the lesion and the eroded bone. Complete excision of the lesion, bone debridement, and subsequent reconstruction were performed. The patient experienced significant relief from severe bone pain after the procedure.

Operative Note 53:

Procedure: Surgical Debridement and Bone Grafting for Fibroblastic Ulcer with Underlying Bone Erosion and Severe Bone Pain under Regional Anesthesia

Indication: Fibroblastic ulcer with underlying bone erosion and severe bone pain necessitating surgical debridement and bone grafting. The patient received regional anesthesia for effective pain control. Thorough debridement of the ulcer, bone debridement, and bone grafting were performed. The patient reported relief from severe bone pain and had satisfactory wound healing in the postoperative period.

Operative Note 54:

Procedure: Surgical Curettage and Reconstruction of Fibroblastic Lesion with Bone Erosion and Severe Bone Pain under General Anesthesia

Indication: Fibroblastic lesion with bone erosion and severe bone pain requiring surgical curettage and reconstruction. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the lesion and the eroded bone. Complete curettage of the lesion, bone debridement, and subsequent reconstruction were performed. The patient experienced relief from severe bone pain and had satisfactory postoperative recovery.

Operative Note 55:

Procedure: Surgical Release of Fibroblastic Adhesion with Adjacent Bone Erosion and Severe Bone Pain under General Anesthesia

Indication: Fibroblastic adhesion with adjacent bone erosion and severe bone pain necessitating surgical release. The patient was induced under general anesthesia with endotracheal intubation. A small incision was made, allowing meticulous dissection to release the adhesion and address the bone erosion. The patient reported relief from severe bone pain postoperatively.

Operative Note 56:

Procedure: Surgical Excisional Biopsy of Fibroblastic Lesion with Bone Erosion and Severe Bone Pain under Local Anesthesia

Indication: Suspicious fibroblastic lesion with bone erosion and severe bone pain requiring surgical excisional biopsy. The patient received local anesthesia at the surgical site. An appropriate incision was made, encompassing the lesion and the eroded bone area. Complete excision of the lesion and bone biopsy were performed. The patient experienced relief from severe bone pain postoperatively.

Operative Note 57:

Procedure: Surgical Reconstruction of Fibroblastic Scar with Underlying Bone Erosion and Severe Bone Pain under Regional Anesthesia

Indication: Fibroblastic scar with underlying bone erosion and severe bone pain necessitating surgical reconstruction. The patient underwent regional anesthesia for effective pain

control. Scar release, wound debridement, bone management, and subsequent reconstruction were performed. The patient reported relief from severe bone pain and had satisfactory wound healing in the postoperative period.

Operative Note 58:

Procedure: Surgical Debulking of Fibroblastic Tumor with Bone Erosion and Severe Bone Pain under General Anesthesia

Indication: Large fibroblastic tumor with bone erosion and severe bone pain requiring surgical debulking for symptom relief. The patient was induced under general anesthesia with endotracheal intubation. Tumor debulking, bone debridement, and pain management measures were undertaken. The patient experienced significant relief from severe bone pain postoperatively.

Operative Note 59:

Procedure: Surgical Excision of Fibroblastic Papule with Adjacent Bone Erosion and Severe Bone Pain under Local Anesthesia

Indication: Fibroblastic papule with adjacent bone erosion and severe bone pain requiring surgical excision. The patient received local anesthesia with minimal sedation for relaxation. An elliptical incision was made, encompassing the papule and the eroded bone area. Complete excision of the papule and adjacent bone management were performed. The patient experienced relief from severe bone pain postoperatively.

Operative Note 60:

Procedure: Surgical Reconstruction of Fibroblastic Ulcer with Bone Erosion and Severe Bone Pain under General Anesthesia

Indication: Fibroblastic ulcer with bone erosion and severe bone pain necessitating surgical reconstruction. The patient was induced under general anesthesia with endotracheal intubation. Thorough ulcer debridement, bone debridement, and subsequent reconstruction were performed. The patient experienced relief from severe bone pain and had satisfactory wound healing in the postoperative period.

Operative Note 61:

Procedure: Surgical Resection of Fibroblastic Tumor with Severe Bone Pain and Reconstruction under General Anesthesia

Indication: Large fibroblastic tumor causing severe bone pain necessitating surgical resection and reconstruction. The patient was induced under general anesthesia with endotracheal intubation. An extensive incision was made, providing optimal exposure to the tumor. Complete tumor resection and subsequent reconstruction were performed. The patient reported significant relief from severe bone pain postoperatively.

Operative Note 62:

Procedure: Surgical Excision and Bone Grafting of Fibroblastic Lesion with Severe Bone Pain under General Anesthesia

Indication: Fibroblastic lesion causing severe bone pain requiring surgical excision and bone grafting. The patient was induced under general anesthesia with endotracheal intubation. An appropriate incision was made, allowing access to the lesion. Complete excision of the lesion and bone grafting were performed. The patient experienced relief from severe bone pain postoperatively.

Operative Note 63:

Procedure: Surgical Debridement and Reconstruction of Fibroblastic Ulcer with Severe Bone Pain under Regional Anesthesia

Indication: Fibroblastic ulcer causing severe bone pain necessitating surgical debridement and reconstruction. The patient underwent regional anesthesia for effective pain control. Thorough debridement of the ulcer and subsequent reconstruction were performed. The patient reported relief from severe bone pain and had satisfactory wound healing in the postoperative period.

Operative Note 64:

Procedure: Surgical Curettage and Bone Grafting for Fibroblastic Lesion with Severe Bone Pain under General Anesthesia

Indication: Fibroblastic lesion causing severe bone pain requiring surgical curettage and bone grafting. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the lesion. Complete curettage of the lesion and subsequent bone grafting were performed. The patient experienced relief from severe bone pain postoperatively.

Operative Note 65:

Procedure: Surgical Release of Fibroblastic Adhesion with Severe Bone Pain and Reconstruction under General Anesthesia

Indication: Fibroblastic adhesion causing severe bone pain necessitating surgical release and reconstruction. The patient was induced under general anesthesia with endotracheal intubation. A small incision was made, allowing careful dissection to release the adhesion. Concurrent reconstruction was performed to address the source of severe bone pain. The patient reported relief from severe bone pain postoperatively.

Operative Note 66:

Procedure: Surgical Excisional Biopsy of Fibroblastic Lesion with Severe Bone Pain under Local Anesthesia

Indication: Suspicious fibroblastic lesion causing severe bone pain requiring surgical excisional biopsy. The patient received local anesthesia at the surgical site. An appropriate incision was made, encompassing the lesion. Complete excision of the lesion and subsequent biopsy were performed. The patient experienced relief from severe bone pain postoperatively.

Operative Note 67:

Procedure: Surgical Reconstruction of Fibroblastic Scar with Severe Bone Pain under Regional Anesthesia

Indication: Fibroblastic scar causing severe bone pain necessitating surgical reconstruction. The patient underwent regional anesthesia for effective pain control. Scar release, wound debridement, and subsequent reconstruction were performed. The patient reported relief from severe bone pain and had satisfactory wound healing in the postoperative period.

Operative Note 68:

Procedure: Surgical Debulking of Fibroblastic Tumor with Severe Bone Pain under General Anesthesia

Indication: Large fibroblastic tumor causing severe bone pain necessitating surgical debulking for symptom relief. The patient was induced under general

anesthesia with endotracheal intubation. Tumor debulking was performed, providing relief from severe bone pain. The patient had a smooth recovery in the post-anesthesia care unit.

Operative Note 69:

Procedure: Surgical Excision of Fibroblastic Papule with Severe Bone Pain under Local Anesthesia

Indication: Fibroblastic papule causing severe bone pain requiring surgical excision. The patient received local anesthesia with minimal sedation for relaxation. An elliptical incision was made, encompassing the papule. Complete excision of the papule was performed, addressing the source of severe bone pain. The patient experienced relief from severe bone pain postoperatively.

Operative Note 70:

Procedure: Surgical Reconstruction of Fibroblastic Ulcer with Severe Bone Pain under General Anesthesia

Indication: Fibroblastic ulcer causing severe bone pain necessitating surgical reconstruction. The patient was induced under general anesthesia with endotracheal intubation. Thorough ulcer debridement and subsequent reconstruction were performed. The patient experienced relief from severe bone pain and had satisfactory wound healing in the postoperative period.

Operative Note 71:

Procedure: Surgical Debridement and Joint Lavage for Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint necessitating surgical debridement and joint lavage. The patient was induced under general anesthesia with endotracheal intubation. An extensive incision was made, allowing access to the infected joint. Thorough debridement of infected tissues and joint lavage were performed. The patient received appropriate antibiotic therapy postoperatively.

Operative Note 72:

Procedure: Surgical Drainage and Irrigation of Severe Joint Infection on the Extreme Moving Joint under Regional Anesthesia

Indication: Severe infection on the extreme moving joint requiring surgical drainage and irrigation. The patient underwent regional anesthesia for effective pain control. A sterile incision was made, facilitating drainage of purulent material and subsequent joint irrigation. The patient received intravenous antibiotics for postoperative infection management.

Operative Note 73:

Procedure: Arthroscopic Debridement and Lavage of Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint necessitating arthroscopic debridement and lavage. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous debridement, and lavage the joint with saline solution. Postoperatively, the patient received appropriate antibiotic therapy.

Operative Note 74:

Procedure: Surgical Joint Exploration and Debridement for Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint requiring surgical joint exploration and debridement. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the infected joint. Thorough exploration, debridement of infected tissues, and irrigation were performed. The patient received appropriate antibiotic therapy postoperatively.

Operative Note 75:

Procedure: Surgical Joint Washout and Abscess Drainage for Severe Infection on the Extreme Moving Joint under Regional Anesthesia

Indication: Severe infection on the extreme moving joint necessitating surgical joint washout and abscess drainage. The patient underwent regional anesthesia for effective pain control. An incision was made, allowing access to the infected joint and associated abscess. Thorough washout of the joint and drainage of the abscess were performed. The patient received intravenous antibiotics for postoperative infection management.

Operative Note 76:

Procedure: Arthroscopic Irrigation and Debridement of Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint requiring arthroscopic irrigation and debridement. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous irrigation, and debridement of infected tissues. Postoperatively, the patient received appropriate antibiotic therapy.

Operative Note 77:

Procedure: Surgical Joint Debridement and Drainage for Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint necessitating surgical joint debridement and drainage. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the infected joint. Meticulous debridement of infected tissues and drainage were performed. The patient received appropriate antibiotic therapy postoperatively.

Operative Note 78:

Procedure: Surgical Arthrotomy and Lavage of Severe Infection on the Extreme Moving Joint under Regional Anesthesia

Indication: Severe infection on the extreme

moving joint requiring surgical arthrotomy and lavage. The patient underwent regional anesthesia for effective pain control. A sterile incision was made, providing access to the infected joint. Thorough lavage of the joint with antibiotic solution was performed. The patient received intravenous antibiotics for postoperative infection management.

Operative Note 79:

Procedure: Arthroscopic Debridement and Drainage of Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint necessitating arthroscopic debridement and drainage. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous debridement of infected tissues, and drainage of pus. Postoperatively, the patient received appropriate antibiotic therapy.

Operative Note 80:

Procedure: Surgical Joint Exploration and Lavage for Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint requiring surgical joint exploration and lavage. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the infected joint. Thorough exploration and lavage of the joint with saline solution were performed. The patient received appropriate antibiotic therapy postoperatively.

Operative Note 81:

Procedure: Surgical Debridement and Inflammation Control of Severe Joint Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint requiring surgical debridement and control of inflammation. The patient was induced under general anesthesia with endotracheal intubation. An extensive incision was made, allowing access to the infected joint. Thorough debridement of infected tissues and measures to control inflammation were performed. The patient received appropriate antibiotic therapy and anti-inflammatory medications postoperatively.

Operative Note 82:

Procedure: Arthroscopic Inflammation Management and Debridement of Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint necessitating arthroscopic inflammation management and debridement. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous debridement, and apply anti-inflammatory measures. Postoperatively, the patient received appropriate antibiotic therapy and anti-inflammatory medications.

Operative Note 83:

Procedure: Surgical Joint Lavage and Inflammation Reduction for Severe Infection on the Extreme Moving Joint under Regional Anesthesia

Indication: Severe infection on the extreme moving joint requiring surgical joint lavage and reduction of inflammation. The patient underwent regional anesthesia for effective pain control. A sterile incision was made, facilitating joint lavage and application of anti-inflammatory measures. The patient received intravenous antibiotics and anti-inflammatory medications for postoperative management.

Operative Note 84:

Procedure: Surgical Joint Washout and Inflammation Control for Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint necessitating surgical joint washout and control of inflammation. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, allowing access to the infected joint. Thorough washout of the joint and measures to control inflammation were performed. The patient received appropriate antibiotic therapy and anti-inflammatory medications postoperatively.

Operative Note 85:

Procedure: Arthroscopic Inflammation Reduction and Debridement of Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint requiring arthroscopic inflammation reduction and debridement. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous debridement, and apply anti-inflammatory measures. Postoperatively, the patient received appropriate antibiotic therapy and anti-inflammatory medications.

Operative Note 86:

Procedure: Surgical Inflammation Management and Drainage of Severe Infection on the Extreme Moving Joint under Regional Anesthesia

Indication: Severe infection on the extreme moving joint necessitating surgical inflammation management and drainage. The patient underwent regional anesthesia for effective pain control. An incision was made, providing access to the infected joint and facilitating inflammation management. Thorough drainage of purulent material was performed. The patient received intravenous antibiotics and anti-inflammatory medications for postoperative management.

Operative Note 87:

Procedure: Surgical Joint Debridement and Inflammation Control for Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint requiring surgical joint debridement and control of inflammation. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, allowing access to the infected joint. Meticulous debridement of infected tissues and measures to control inflammation were performed. The patient received appropriate antibiotic therapy and anti-inflammatory medications postoperatively.

Operative Note 88

:

Procedure: Arthroscopic Inflammation Reduction and Drainage of Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint necessitating arthroscopic inflammation reduction and drainage. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous inflammation reduction, and facilitate drainage of purulent material. Postoperatively, the patient received appropriate antibiotic therapy and anti-inflammatory medications.

Operative Note 89:

Procedure: Surgical Joint Exploration and Inflammation Control for Severe Infection on the Extreme Moving Joint under General Anesthesia

Indication: Severe infection on the extreme moving joint requiring surgical joint exploration and control of inflammation. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the infected joint. Thorough exploration of the joint and measures to control inflammation were performed. The patient received appropriate antibiotic therapy and anti-inflammatory medications postoperatively.

Operative Note 90:

Procedure: Surgical Joint Lavage and Inflammation Management for Severe Infection on the Extreme Moving Joint under Regional Anesthesia

Indication: Severe infection on the extreme moving joint necessitating surgical joint lavage and management of inflammation. The patient underwent regional anesthesia for effective pain control. A sterile incision was made, facilitating joint lavage and application of anti-inflammatory measures. The patient received intravenous antibiotics and anti-inflammatory medications for postoperative management.

Operative Note 91:

Procedure: Surgical Excision of Fibroblastic Tumor with Severe Bone Erosion and Inflammation under General Anesthesia

Indication: Fibroblastic tumor causing severe bone erosion and inflammation necessitating surgical excision. The patient was induced under general anesthesia with endotracheal intubation. An elliptical incision was made, encompassing the tumor. Complete excision of the tumor, bone grafting, and measures to control inflammation were performed. The patient's postoperative follow-up will depend on the severity of the bone erosion and the presence of any residual tumor.

Operative Note 92:

Procedure: Arthroscopic Debridement and Joint Lavage for Severe Infection on the Extreme Moving Joint with Concomitant Inflammation under General Anesthesia

Indication: Severe infection on the extreme moving joint with concomitant inflammation requiring arthroscopic debridement and joint lavage. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous debridement, lavage, and measures to control inflammation. The patient's postoperative follow-up will be determined by the severity of the infection and the response to treatment.

Operative Note 93:

Procedure: Surgical Reconstruction of Fibroblastic Ulcer with Severe Bone Erosion and Inflammation under General Anesthesia

Indication: Fibroblastic ulcer causing severe bone erosion and inflammation necessitating surgical reconstruction. The patient was induced under general anesthesia with endotracheal intubation. Thorough ulcer debridement, bone grafting, and measures to control inflammation were performed. The patient's postoperative follow-up will depend on the extent of bone erosion, wound healing, and resolution of inflammation.

Operative Note 94:

Procedure: Surgical Joint Washout and Debridement for Severe Infection on the Extreme Moving Joint with Persistent Inflammation under Regional Anesthesia

Indication: Severe infection on the extreme moving joint with persistent inflammation requiring surgical joint washout and debridement. The patient underwent regional anesthesia for effective pain control. An incision was made, allowing access to the infected joint. Thorough washout, debridement, and measures to control inflammation were performed. The patient's postoperative follow-up will be determined by the resolution of infection and inflammation.

Operative Note 95:

Procedure: Arthroscopic Inflammation Reduction and Joint Lavage for Severe Infection on the Extreme Moving Joint with Recurrent Inflammation under General Anesthesia

Indication: Severe infection on the extreme moving joint with recurrent inflammation necessitating arthroscopic inflammation reduction and joint lavage. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous inflammation reduction, lavage, and measures to control recurrent inflammation. The patient's postoperative follow-up will depend on the resolution of infection and inflammation.

Operative Note 96:

Procedure: Surgical Debridement and Abscess Drainage for Severe Infection on the Extreme Moving Joint with Inflammatory Complications under General Anesthesia

Indication: Severe infection on the extreme moving joint with inflammatory complications requiring surgical debridement and abscess drainage. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the infected joint and associated abscess. Thorough debridement, drainage, and measures to control inflammation were performed. The patient's postoperative follow-up will depend on the resolution of infection, abscess, and associated inflammatory complications.

Operative Note 97:

Procedure: Surgical Joint Exploration and Inflammation Control for Severe In

fection on the Extreme Moving Joint with Persistent Inflammation under General Anesthesia

Indication: Severe infection on the extreme moving joint with persistent inflammation requiring surgical joint exploration and inflammation control. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the infected joint. Thorough exploration, debridement, lavage, and measures to control inflammation were performed. The patient's postoperative follow-up will be determined by the resolution of infection and persistent inflammation.

Operative Note 98:

Procedure: Arthroscopic Inflammation Management and Joint Lavage for Severe Infection on the Extreme Moving Joint with Recurrent Inflammation under General Anesthesia

Indication: Severe infection on the extreme moving joint with recurrent inflammation necessitating arthroscopic inflammation management and joint lavage. The patient was induced under general anesthesia with endotracheal intubation. Arthroscopic instruments were used to access the infected joint, perform meticulous inflammation management, lavage, and measures to control recurrent inflammation. The patient's postoperative follow-up will depend on the resolution of infection and recurrent inflammation.

Operative Note 99:

Procedure: Surgical Joint Debridement and Inflammation Control for Severe Infection on the Extreme Moving Joint with Persistent Inflammation under General Anesthesia

Indication: Severe infection on the extreme moving joint with persistent inflammation requiring surgical joint debridement and inflammation control. The patient was induced under general anesthesia with endotracheal intubation. An incision was made, providing access to the infected joint. Thorough debridement of infected tissues, lavage, and measures to control persistent inflammation were performed. The patient's postoperative follow-up will be determined by the resolution of infection and persistent inflammation.

Operative Note 100:

Procedure: Surgical Joint Lavage and Inflammation Reduction for Severe Infection on the Extreme Moving Joint with Recurrent Inflammation under Regional Anesthesia

Indication: Severe infection on the extreme moving joint with recurrent inflammation requiring surgical joint lavage and inflammation reduction. The patient underwent regional anesthesia for effective pain control. A sterile incision was made, facilitating joint lavage and measures to control recurrent inflammation. The patient's postoperative follow-up will depend on the resolution of infection, recurrent inflammation, and response to treatment.

## M72.9 Fibroblastic disorder, unspecified

1. Operative Note - Fibroblastic Disorder Excision:

A 2 cm fibroblastic lesion on the patient's left forearm was excised under local anesthesia. The lesion was carefully dissected from the surrounding tissue using sharp dissection. Hemostasis was achieved with electrocautery. The wound was closed with interrupted sutures. The excised specimen was sent for histopathological analysis. The patient tolerated the procedure well and was discharged with appropriate postoperative instructions.

2. Operative Note - Fibroblastic Disorder Debridement:

The patient presented with a fibroblastic disorder on the right foot. After proper sterile preparation and local anesthesia, the lesion was debrided down to healthy tissue using sharp and blunt dissection. Hemostasis was ensured, and the wound was thoroughly irrigated with saline. A sterile dressing was applied, and the patient was advised on wound care and follow-up.

3. Operative Note - Fibroblastic Disorder Skin Graft:

A large fibroblastic disorder on the patient's lower back required surgical intervention. After adequate anesthesia, the lesion was excised down to healthy tissue. A split-thickness skin graft harvested from the thigh was applied to the defect and secured with sutures. The graft site was dressed, and the patient was given postoperative care instructions.

4. Operative Note - Fibroblastic Disorder Laser Ablation:

The patient presented with multiple fibroblastic disorders on the face. Laser ablation was performed under local anesthesia using a CO2 laser. The lesions were targeted individually, and multiple passes were made to ensure complete eradication. Hemostasis was achieved, and the patient was educated on wound care and expected post-laser effects.

5. Operative Note - Fibroblastic Disorder Cryotherapy:

Cryotherapy was performed on a fibroblastic disorder located on the patient's left hand. The lesion was freeze-thawed using liquid nitrogen for three cycles. Careful monitoring of the freezing and thawing process was ensured to prevent damage to the surrounding healthy tissue. The patient was advised on post-cryotherapy wound care and scheduled for follow-up evaluation.

6. Operative Note - Fibroblastic Disorder Excision with Mohs Surgery:

A fibroblastic disorder involving the patient's scalp was excised using Mohs micrographic surgery technique. The lesion was removed in stages, with each stage followed by immediate microscopic examination to ensure complete removal while preserving healthy tissue. Once the tumor was cleared, the wound was closed primarily, and the patient was scheduled for subsequent reconstructive procedures.

7. Operative Note - Fibroblastic Disorder Radiofrequency Ablation:

Under local anesthesia, radiofrequency ablation was performed on a fibroblastic disorder located on the patient's chest. The lesion was precisely targeted, and radiofrequency energy was delivered to induce thermal destruction of the abnormal tissue. Hemostasis was achieved, and a sterile dressing was applied. The patient was instructed on post-procedure wound care and potential side effects.

8. Operative Note - Fibroblastic Disorder Scar Revision:

A fibroblastic disorder scar on the patient's forearm was revised surgically. The scar tissue was excised using sharp dissection, and the wound edges were meticulously realigned. Closure was achieved with fine sutures, ensuring an aesthetic outcome. The patient was counseled on scar management techniques and postoperative care, including regular wound cleansing and scar massage.

9. Operative Note - Fibroblastic Disorder Electrodesiccation and Curettage:

Electrodesiccation and curettage were performed on a fibroblastic disorder lesion located on the patient's back. After adequate anesthesia, the lesion was thoroughly curetted to remove the abnormal tissue. Electro

desiccation was then applied to the base of the wound to cauterize any remaining tumor cells. The wound was dressed, and the patient was instructed on wound care and follow-up.

10. Operative Note - Fibroblastic Disorder Dermabrasion:

Dermabrasion was performed on a fibroblastic disorder scar on the patient's face. The scar tissue was abraded using a high-speed rotary instrument, carefully removing the superficial layers to promote new skin growth. Hemostasis was ensured, and a protective ointment was applied. The patient was provided with post-dermabrasion care instructions, including sun protection and wound moisturization.

1. Operative Note - Fibroblastic Disorder Excision and Primary Closure:

A fibroblastic disorder measuring 3 cm in diameter was excised from the patient's left thigh under general anesthesia. The lesion was carefully dissected, ensuring clear margins. Hemostasis was achieved, and the wound was closed primarily using interrupted sutures. The patient tolerated the procedure well and was discharged with appropriate wound care instructions.

2. Operative Note - Fibroblastic Disorder Carbon Dioxide Laser Resurfacing:

Carbon dioxide laser resurfacing was performed on a fibroblastic disorder scar on the patient's abdomen. The scar tissue was ablated layer by layer using the laser, promoting collagen remodeling and improvement in skin texture. Post-procedure wound care instructions, including regular moisturization and sun protection, were provided to the patient.

3. Operative Note - Fibroblastic Disorder Incision and Drainage:

The patient presented with a fibroblastic disorder abscess on the right upper arm. After local anesthesia, an incision was made over the fluctuant area, and purulent material was drained. The abscess cavity was irrigated with saline, and a drain was placed. The wound was dressed, and the patient was prescribed antibiotics and instructed on drain care.

4. Operative Note - Fibroblastic Disorder Scar Revision with Z-plasty:

A fibroblastic disorder scar on the patient's neck was revised using a Z-plasty technique. The scar was excised, and triangular flaps were created to redistribute tension along relaxed skin tension lines. The flaps were rotated and sutured in place, resulting in an improved scar appearance. The patient was educated on postoperative care and scar massage.

5. Operative Note - Fibroblastic Disorder Excision with Skin Grafting:

A large fibroblastic disorder on the patient's leg necessitated excision and skin grafting. The lesion was carefully excised down to healthy tissue, and a full-thickness skin graft harvested from the thigh was secured in place. The graft was bolstered with a sterile dressing, and the patient was advised on graft care and immobilization.

6. Operative Note - Fibroblastic Disorder Intralesional Injection:

Intralesional injection of corticosteroids was performed on a fibroblastic disorder nodule on the patient's hand. After proper anesthesia, a small gauge needle was used to deliver the medication directly into the lesion. The procedure was well-tolerated, and the patient was instructed on post-injection care and scheduled for follow-up evaluation.

7. Operative Note - Fibroblastic Disorder Laser Hair Removal:

Laser hair removal was performed on a fibroblastic disorder site on the patient's upper lip. A diode laser was used to target and selectively destroy hair follicles within the affected area. Protective measures were taken to minimize heat exposure to the surrounding tissue. The patient was counseled on post-laser care, including sun protection and potential temporary side effects.

8. Operative Note - Fibroblastic Disorder Tissue Expansion and Reconstruction:

A fibroblastic disorder defect on the patient's scalp required tissue expansion for optimal reconstruction. A tissue expander was inserted beneath the healthy skin adjacent to the defect and gradually inflated over several weeks. Once adequate expansion was achieved, the expander was removed, and the expanded tissue was used to reconstruct the defect. Postoperative wound care instructions were given.

9. Operative Note - Fibroblastic Disorder Cryosurgery:

Cryosurgery was performed on a fibroblastic disorder lesion on the patient's lower leg. The lesion was frozen using liquid nitrogen for several

cycles, ensuring sufficient depth of freezing. Thawing was allowed between each cycle to enhance cellular destruction. The wound was dressed, and the patient was advised on post-cryosurgery wound care and expected healing progression.

10. Operative Note - Fibroblastic Disorder Scar Revision with Subcision:

A fibroblastic disorder scar on the patient's forearm was revised using subcision technique. After local anesthesia, a needle was inserted beneath the scar to break up fibrous adhesions, releasing tension and promoting skin elevation. Hemostasis was achieved, and the wound was dressed. The patient was instructed on postoperative care, including scar massage and sun protection.

1. Operative Note - Fibroblastic Disorder Excision under Local Anesthesia:

A fibroblastic disorder measuring 2 cm in diameter was excised from the patient's forearm under local anesthesia. The lesion was carefully dissected, ensuring clear margins. Hemostasis was achieved, and the wound was closed primarily using interrupted sutures. The patient remained comfortable throughout the procedure, and postoperative wound care instructions were provided.

2. Operative Note - Fibroblastic Disorder Laser Ablation under Moderate Sedation:

Under moderate sedation, laser ablation was performed on a fibroblastic disorder located on the patient's face. The lesions were targeted individually, and multiple passes were made to ensure complete eradication. Hemostasis was achieved, and the patient remained comfortable and responsive during the procedure. Post-procedure wound care instructions were given.

3. Operative Note - Fibroblastic Disorder Cryotherapy under General Anesthesia:

Cryotherapy was performed on a fibroblastic disorder located on the patient's hand under general anesthesia. The lesion was freeze-thawed using liquid nitrogen for three cycles. Careful monitoring of the freezing and thawing process was ensured. The patient remained stable throughout the procedure, and post-cryotherapy wound care instructions were provided.

4. Operative Note - Fibroblastic Disorder Excision with Mohs Surgery under Local Anesthesia with IV Sedation:

A fibroblastic disorder involving the patient's scalp was excised using Mohs micrographic surgery technique under local anesthesia with intravenous sedation. The lesion was removed in stages, with each stage followed by immediate microscopic examination to ensure complete removal while preserving healthy tissue. The patient remained comfortable and responsive throughout the procedure.

5. Operative Note - Fibroblastic Disorder Radiofrequency Ablation under Regional Anesthesia:

Under regional anesthesia, radiofrequency ablation was performed on a fibroblastic disorder located on the patient's chest. The lesion was precisely targeted, and radiofrequency energy was delivered to induce thermal destruction of the abnormal tissue. The patient remained comfortable and pain-free in the treated area throughout the procedure. Post-procedure wound care instructions were given.

6. Operative Note - Fibroblastic Disorder Skin Graft under General Anesthesia:

A large fibroblastic disorder on the patient's lower back required surgical intervention under general anesthesia. After adequate anesthesia induction, the lesion was excised down to healthy tissue. A split-thickness skin graft harvested from the thigh was applied to the defect and secured with sutures. The patient remained stable throughout the procedure, and postoperative care instructions were provided.

7. Operative Note - Fibroblastic Disorder Electrodesiccation and Curettage under Local Anesthesia with Conscious Sedation:

Under local anesthesia with conscious sedation, electrodesiccation and curettage were performed on a fibroblastic disorder lesion located on the patient's back. The lesion was thoroughly curetted to remove the abnormal tissue, followed by electrodesiccation of the base. The patient remained comfortable and cooperative throughout the procedure, and post-procedure wound care instructions were given.

8. Operative Note - Fibroblastic Disorder Scar Revision with Local Anesthesia and Minimal Sedation:

A fibroblastic disorder scar on the patient's forearm was revised surgically under local anesthesia with minimal sedation. The scar tissue was excised using sharp dissection, and the wound edges were meticulously realigned. Closure was achieved with fine sutures. The patient remained calm and comfortable during the procedure, and postoperative care instructions were provided.

9. Operative Note - Fibroblastic Disorder Dermabrasion under Local Anesthesia with

Deep Sedation:

Dermabrasion was performed on a fibroblastic disorder scar on the patient's face under local anesthesia with deep sedation. The scar tissue was abraded using a high-speed rotary instrument, carefully removing the superficial layers to promote new skin growth. The patient remained sedated and comfortable throughout the procedure. Post-dermabrasion wound care instructions were given.

10. Operative Note - Fibroblastic Disorder Excision and Primary Closure under General Anesthesia with Intubation:

A fibroblastic disorder measuring 3 cm in diameter was excised from the patient's left thigh under general anesthesia with endotracheal intubation. The lesion was carefully dissected, ensuring clear margins. Hemostasis was achieved, and the wound was closed primarily using interrupted sutures. The patient remained stable and ventilated during the procedure, and postoperative wound care instructions were provided.

1. Operative Note - Fibroblastic Disorder Excision with Bone Curettage:

A fibroblastic disorder with associated bone erosion was identified in the patient's tibia. Under general anesthesia, an incision was made, exposing the lesion and eroded bone. The lesion was excised, and bone curettage was performed to remove the affected bone tissue. Hemostasis was achieved, and the wound was closed with appropriate fixation. Postoperative care included immobilization and scheduled follow-up.

2. Operative Note - Fibroblastic Disorder Resection with Bone Reconstruction:

A fibroblastic disorder involving bone erosion was observed in the patient's mandible. After general anesthesia, a segmental resection of the affected bone was performed. Reconstruction was achieved using a bone graft harvested from the iliac crest, secured with plates and screws. The patient tolerated the procedure well, and postoperative care involved monitoring for graft integration and jaw function.

3. Operative Note - Fibroblastic Disorder Excision with Bone Cement Augmentation:

A fibroblastic disorder with bone erosion was identified in the patient's femur. Under general anesthesia, the lesion was excised, and bone cement augmentation was performed to stabilize the affected bone. The cement was carefully injected into the void left by the lesion, providing structural support. The patient's pain was significantly reduced postoperatively, and appropriate weight-bearing precautions were advised.

4. Operative Note - Fibroblastic Disorder Cryoablation with Bone Grafting:

Cryoablation was performed on a fibroblastic disorder with bone erosion in the patient's humerus. Under general anesthesia, the lesion and affected bone were targeted with cryotherapy, inducing controlled freezing and subsequent destruction. Following cryoablation, bone grafting was performed using allograft material to fill the bone defect. The patient was provided with postoperative care instructions and scheduled for follow-up imaging.

5. Operative Note - Fibroblastic Disorder Laser Ablation with Bone Stabilization:

Laser ablation was performed on a fibroblastic disorder with bone erosion in the patient's spine. Under general anesthesia, the lesion was targeted with laser energy to ablate the abnormal tissue. Subsequently, bone stabilization was achieved using spinal instrumentation to restore stability. The patient's pain levels improved postoperatively, and appropriate rehabilitation was initiated.

6. Operative Note - Fibroblastic Disorder Excision and Bone Grafting:

A fibroblastic disorder with bone erosion was identified in the patient's radius. Under general anesthesia, the lesion was carefully excised, ensuring clear margins. Subsequently, bone grafting was performed using autograft from the patient's iliac crest to fill the bone defect. The patient's range of motion was preserved, and postoperative care included immobilization and rehabilitation.

7. Operative Note - Fibroblastic Disorder Resection and Bone Segment Replacement:

A fibroblastic disorder involving bone erosion was observed in the patient's clavicle. After general anesthesia, a segmental resection of the affected bone was performed. The defect was reconstructed using a bone segment graft from the fibula, carefully fixed in place. The patient's shoulder function was preserved, and appropriate postoperative care was initiated.

8. Operative Note - Fibroblastic Disorder Curettage with Bone Graft Placement:

Curettage was performed on a fibroblastic disorder with bone erosion in the patient's sacrum. Under general anesthesia, the lesion and affected bone were thoroughly curetted to remove the abnormal tissue. Subsequently, a bone graft was placed within the bone defect to promote healing and structural integrity

. The patient's pain was significantly reduced postoperatively, and follow-up imaging was scheduled.

9. Operative Note - Fibroblastic Disorder Excision with Bone Allograft Reconstruction:

A fibroblastic disorder involving bone erosion was identified in the patient's humerus. Under general anesthesia, the lesion was excised, ensuring adequate margins. Bone allograft reconstruction was performed to restore bone stability and structural integrity. The patient tolerated the procedure well, and postoperative care included monitoring for graft incorporation and functional rehabilitation.

10. Operative Note - Fibroblastic Disorder Radiofrequency Ablation with Bone Stabilization:

Radiofrequency ablation was performed on a fibroblastic disorder with bone erosion in the patient's vertebra. Under general anesthesia, the lesion was targeted using radiofrequency energy to achieve controlled thermal destruction. Following ablation, bone stabilization was achieved using spinal instrumentation to restore stability. The patient's pain levels improved, and postoperative care involved appropriate rehabilitation and monitoring.

1. Operative Note - Fibroblastic Disorder Excision with Nerve Block for Severe Bone Pain:

A fibroblastic disorder with severe bone pain was identified in the patient's femur. Under general anesthesia, the lesion was excised, ensuring clear margins. Additionally, a nerve block was administered to provide targeted pain relief. The patient experienced significant pain reduction postoperatively, and appropriate rehabilitation was initiated.

2. Operative Note - Fibroblastic Disorder Cryoablation with Epidural Analgesia for Severe Bone Pain:

Cryoablation was performed on a fibroblastic disorder with severe bone pain in the patient's spine. Under general anesthesia, the lesion and affected bone were targeted with cryotherapy to induce controlled freezing and destruction. Epidural analgesia was also administered to manage severe bone pain. The patient reported improved pain control following the procedure.

3. Operative Note - Fibroblastic Disorder Excision with Intravenous Patient-Controlled Analgesia for Severe Bone Pain:

A fibroblastic disorder with severe bone pain was identified in the patient's humerus. Under general anesthesia, the lesion was excised with clear margins. Intravenous patient-controlled analgesia (PCA) was initiated to provide on-demand pain relief. The patient reported improved pain control and was closely monitored for analgesic effectiveness and side effects.

4. Operative Note - Fibroblastic Disorder Radiofrequency Ablation with Local Anesthesia and Regional Nerve Block for Severe Bone Pain:

Radiofrequency ablation was performed on a fibroblastic disorder with severe bone pain in the patient's tibia. Under local anesthesia, the lesion was targeted using radiofrequency energy to induce thermal destruction. Additionally, a regional nerve block was administered to alleviate severe bone pain. The patient experienced significant pain reduction postoperatively.

5. Operative Note - Fibroblastic Disorder Resection with Spinal Cord Stimulation for Severe Bone Pain:

A fibroblastic disorder involving severe bone pain was observed in the patient's vertebra. Under general anesthesia, a segmental resection of the affected bone was performed. Subsequently, spinal cord stimulation was implemented to manage severe bone pain. The patient reported improved pain control and was closely monitored for optimal stimulation settings.

6. Operative Note - Fibroblastic Disorder Excision with Continuous Peripheral Nerve Block for Severe Bone Pain:

A fibroblastic disorder with severe bone pain was identified in the patient's clavicle. Under general anesthesia, the lesion was excised, ensuring clear margins. A continuous peripheral nerve block was established to provide prolonged pain relief. The patient reported significant pain reduction and improved overall comfort postoperatively.

7. Operative Note - Fibroblastic Disorder Cryoablation with Intrathecal Drug Delivery for Severe Bone Pain:

Cryoablation was performed on a fibroblastic disorder with severe bone pain in the patient's sacrum. Under general anesthesia, the lesion and affected bone were targeted with cryotherapy. Additionally, an intrathecal drug delivery system was implanted to provide continuous medication administration for severe bone pain management. The patient reported improved pain control and quality of life.

8. Operative Note - Fibroblastic Disorder Excision with Regional Analgesia Catheter Placement for Severe Bone Pain:

A fibroblastic disorder with severe bone pain was observed in the patient's radius. Under general anesthesia, the lesion was excised, ensuring clear margins. A regional analgesia catheter was also placed to provide continuous local anesthetic infusion for severe bone pain relief. The patient reported significant pain reduction postoperatively.

9. Operative Note -

Fibroblastic Disorder Resection with Neurolysis for Severe Bone Pain:

A fibroblastic disorder involving severe bone pain was identified in the patient's ulna. Under general anesthesia, a segmental resection of the affected bone was performed. Neurolysis was also performed to relieve severe bone pain by releasing nerve compression. The patient reported improved pain control and functional recovery following the procedure.

10. Operative Note - Fibroblastic Disorder Cryoablation with Intravenous Analgesia for Severe Bone Pain:

Cryoablation was performed on a fibroblastic disorder with severe bone pain in the patient's femur. Under general anesthesia, the lesion and affected bone were targeted using cryotherapy. Intravenous analgesia was administered to manage severe bone pain. The patient reported reduced pain intensity and improved comfort after the procedure.

1. Operative Note - Fibroblastic Disorder Excision with Wide Surgical Margins:

A fibroblastic disorder with infiltrative growth was identified in the patient's forearm. Under general anesthesia, a wide excision with clear surgical margins was performed to remove the lesion and surrounding abnormal tissue. Hemostasis was achieved, and the wound was closed primarily using sutures. The patient was advised on postoperative care and scheduled for follow-up evaluation.

2. Operative Note - Fibroblastic Disorder Debulking Surgery:

A fibroblastic disorder with extensive size and bulk was observed in the patient's thigh. Under general anesthesia, debulking surgery was performed to reduce the size of the lesion and alleviate symptoms. Multiple incisions were made to access the fibroblastic tissue, which was meticulously excised. The wound was closed, and the patient was provided with instructions for wound care and postoperative management.

3. Operative Note - Fibroblastic Disorder Laser Excision and Vaporization:

A fibroblastic disorder with irregular surface and superficial growth was identified on the patient's face. Under local anesthesia, laser excision and vaporization were performed to precisely remove the abnormal tissue layer by layer. Hemostasis was achieved, and the patient experienced minimal scarring. Postoperative care included wound care instructions and regular follow-up for evaluation.

4. Operative Note - Fibroblastic Disorder Resection and Reconstruction with Flap:

A fibroblastic disorder involving the patient's scalp required surgical intervention. Under general anesthesia, a wide resection of the lesion was performed, ensuring clear margins. Reconstruction was achieved using a local flap technique, where adjacent healthy tissue was mobilized to cover the defect. The flap was sutured in place, and the patient was advised on postoperative care and follow-up appointments.

5. Operative Note - Fibroblastic Disorder Mohs Micrographic Surgery:

A fibroblastic disorder with ill-defined borders was observed on the patient's nose. Under local anesthesia, Mohs micrographic surgery was performed to remove the lesion layer by layer, ensuring complete excision while preserving healthy tissue. Each excised layer was immediately examined under a microscope. Once clear margins were achieved, the wound was closed, and the patient was provided with postoperative care instructions.

6. Operative Note - Fibroblastic Disorder Endoscopic Excision:

A fibroblastic disorder involving the patient's sinus cavity required surgical intervention. Under general anesthesia, endoscopic excision was performed to access and remove the lesion from within the sinus cavity. Specialized instruments and a camera were used for precise visualization and excision. Hemostasis was achieved, and the patient was advised on postoperative care and scheduled for follow-up evaluation.

7. Operative Note - Fibroblastic Disorder Curettage and Bone Grafting:

A fibroblastic disorder with associated bone erosion was identified in the patient's tibia. Under general anesthesia, curettage of the lesion and bone erosion was performed using specialized instruments. Subsequently, a bone graft was placed to fill the defect and promote bone healing. The wound was closed, and the patient was provided with postoperative care instructions.

8. Operative Note - Fibroblastic Disorder Excision with Skin Grafting:

A fibroblastic disorder involving the patient's leg required surgical intervention. Under general anesthesia, the lesion was excised, ensuring clear margins. Due to the size of the defect, a split-thickness skin graft harvested from the patient's thigh was applied to facilitate wound closure and healing. The graft was secured in place, and the patient was instructed on postoperative wound care and follow-up visits

.

9. Operative Note - Fibroblastic Disorder Resection and Limb Salvage Surgery:

A fibroblastic disorder involving the patient's arm posed a threat to limb viability. Under general anesthesia, extensive resection of the lesion was performed, preserving vital structures. Limb salvage techniques were employed to reconstruct the defect, ensuring functional and aesthetic outcomes. The patient underwent rehabilitation and was closely monitored for postoperative complications and long-term limb function.

10. Operative Note - Fibroblastic Disorder Excision with Electrodesiccation and Curettage:

A fibroblastic disorder with multiple lesions was observed on the patient's back. Under local anesthesia, the lesions were excised using a scalpel, ensuring complete removal. Electrodesiccation and curettage were then performed to eliminate any remaining abnormal tissue and promote wound healing. Hemostasis was achieved, and the patient was instructed on postoperative wound care and follow-up appointments.

1. Operative Note - Fibroblastic Disorder Excision with Mohs Micrographic Surgery:

A fibroblastic disorder with ill-defined borders was observed on the patient's arm. Under local anesthesia, Mohs micrographic surgery was performed to remove the lesion layer by layer, ensuring complete excision while preserving healthy tissue. Each excised layer was immediately examined under a microscope. Once clear margins were achieved, the wound was closed, and the patient was provided with postoperative care instructions.

2. Operative Note - Fibroblastic Disorder Debulking and Chemotherapy Infusion:

A fibroblastic disorder with extensive size and infiltrative growth was identified in the patient's abdomen. Under general anesthesia, debulking surgery was performed to remove a significant portion of the lesion. Additionally, a chemotherapy infusion was administered directly into the remaining lesion site to target any residual abnormal cells. The patient was closely monitored for chemotherapy-related side effects.

3. Operative Note - Fibroblastic Disorder Excision with Skin Flap Reconstruction:

A fibroblastic disorder involving the patient's lower leg required surgical intervention. Under general anesthesia, the lesion was excised with clear margins. Reconstruction was achieved using a local skin flap technique, where nearby healthy tissue was mobilized and rotated to cover the defect. The flap was sutured in place, and the patient was advised on postoperative wound care and follow-up appointments.

4. Operative Note - Fibroblastic Disorder Resection and Skeletal Muscle Transfer:

A fibroblastic disorder involving the patient's hand required surgical intervention. Under regional anesthesia, the lesion was resected, ensuring clear margins. To restore hand function, a skeletal muscle transfer procedure was performed using a healthy muscle from the forearm. The transferred muscle was attached to the necessary tendons to provide functional stability and movement.

5. Operative Note - Fibroblastic Disorder Cryoablation with Arthroscopic Intervention:

Cryoablation was performed on a fibroblastic disorder with joint involvement in the patient's knee. Under general anesthesia, cryotherapy was applied to freeze and destroy the abnormal tissue. Arthroscopic intervention was also performed simultaneously to address any intra-articular pathology and restore joint function. The patient underwent postoperative rehabilitation and was monitored for pain relief and improved mobility.

6. Operative Note - Fibroblastic Disorder Excision with Vacuum-Assisted Closure (VAC) Therapy:

A fibroblastic disorder with significant tissue loss was observed on the patient's lower back. Under general anesthesia, the lesion was excised, and a vacuum-assisted closure (VAC) therapy system was applied. The VAC system helped promote wound healing by applying negative pressure to the wound, stimulating tissue growth and removing excess fluid. The patient received appropriate wound care instructions.

7. Operative Note - Fibroblastic Disorder Resection with Microvascular Reconstruction:

A fibroblastic disorder involving the patient's tongue required surgical intervention. Under general anesthesia, a partial resection of the affected tongue was performed, ensuring clear margins. Microvascular reconstruction was then carried out using a free flap graft from the patient's forearm. The graft was meticulously connected to restore blood supply and preserve tongue function.

8. Operative Note - Fibroblastic Disorder Excision with Percutaneous Radiofrequency Ablation:

A fibroblastic disorder with multiple lesions was identified on the patient's chest. Under local anesthesia, percutaneous radiofrequency ablation was performed to target and destroy the abnormal tissue using heat energy. The lesions were successfully ablated, and the patient experienced minimal scarring. Postoperative care involved wound monitoring and instructions for follow-up evaluation.

9. Operative Note -

Fibroblastic Disorder Debulking with Intralesional Injections:

A fibroblastic disorder with extensive size and recurrent growth was observed in the patient's thigh. Under general anesthesia, debulking surgery was performed to reduce the size of the lesion. Intralesional injections of corticosteroids were administered during the procedure to help control inflammation and suppress further growth. The patient received instructions for postoperative wound care and was scheduled for regular follow-up visits.

10. Operative Note - Fibroblastic Disorder Resection with Adjunctive Radiation Therapy:

A fibroblastic disorder involving the patient's chest wall required surgical intervention. Under general anesthesia, a wide resection of the lesion was performed, ensuring clear surgical margins. Due to the aggressive nature of the fibroblastic disorder, adjunctive radiation therapy was recommended postoperatively to target any remaining abnormal cells and reduce the risk of recurrence. The patient was referred to the radiation oncology department for further treatment planning.

1. Operative Note - Fibroblastic Disorder Debridement and Joint Lavage for Severe Joint Infection:

A fibroblastic disorder with severe infection was identified in the patient's knee joint. Under general anesthesia, thorough debridement of the affected joint was performed to remove infected tissue and debris. Joint lavage with sterile saline solution was then carried out to cleanse the joint and minimize the bacterial load. The patient was prescribed appropriate antibiotics and scheduled for close follow-up.

2. Operative Note - Fibroblastic Disorder Excision with Joint Exploration and Antibiotic Impregnated Spacer Placement:

A fibroblastic disorder involving severe infection was observed in the patient's shoulder joint. Under general anesthesia, the lesion was excised with clear margins. Joint exploration revealed extensive infection, necessitating the placement of an antibiotic impregnated spacer to provide local antibiotic therapy and maintain joint space. The patient was prescribed a course of systemic antibiotics and scheduled for regular follow-up evaluations.

3. Operative Note - Fibroblastic Disorder Resection with Arthrodesis for Severe Infected Joint:

A fibroblastic disorder with severe infection was identified in the patient's ankle joint. Under general anesthesia, wide resection of the affected joint was performed, ensuring complete removal of infected tissue. Arthrodesis was then performed to fuse the bones in the joint, eliminating movement and promoting healing. The patient was initiated on appropriate antibiotic therapy and scheduled for postoperative wound care and follow-up visits.

4. Operative Note - Fibroblastic Disorder Excision with Total Joint Replacement for Severe Infected Joint:

A fibroblastic disorder involving severe infection was observed in the patient's hip joint. Under general anesthesia, excision of the lesion was performed, ensuring clear margins. Total joint replacement surgery was then carried out to replace the infected joint with a prosthetic joint. The patient received intravenous antibiotics perioperatively and was closely monitored for signs of infection and proper healing.

5. Operative Note - Fibroblastic Disorder Debridement with Vacuum-Assisted Closure (VAC) Therapy for Severe Infected Joint:

A fibroblastic disorder with severe infection was identified in the patient's elbow joint. Under general anesthesia, thorough debridement of infected tissues was performed, and a vacuum-assisted closure (VAC) therapy system was applied to promote wound healing and reduce infection. The patient was initiated on appropriate antibiotic therapy and scheduled for regular wound care and follow-up evaluations.

6. Operative Note - Fibroblastic Disorder Excision with Intraoperative Antibiotic Irrigation for Severe Infected Joint:

A fibroblastic disorder involving severe infection was observed in the patient's wrist joint. Under regional anesthesia, excision of the lesion was performed with clear margins. Intraoperative antibiotic irrigation was administered to thoroughly cleanse the joint and reduce the bacterial load. The patient received appropriate antibiotic therapy postoperatively and was scheduled for regular follow-up visits.

7. Operative Note - Fibroblastic Disorder Resection with Joint Arthroscopy and Antibiotic Bead Placement for Severe Infected Joint:

A fibroblastic disorder with severe infection was identified in the patient's shoulder joint. Under general anesthesia, resection of the lesion was performed, ensuring clear margins. Joint arthroscopy was performed to visualize the joint and assess the extent of infection. Antibiotic beads were then placed in the joint space to provide local antibiotic therapy. The patient received intravenous antibiotics and was closely monitored for infection control.

8. Operative Note - Fibroblastic Disorder Excision with Spacer Placement and Two-Stage Revision for Severe Infected Joint:

A fibroblastic disorder involving severe infection was observed in the patient's knee joint. Under general anesthesia, excision of the lesion was performed with clear margins. An antibiotic-loaded spacer was placed to provide local antibiotic therapy and maintain joint space. The patient underwent a two-stage revision process, including systemic antibiotics, to eradicate the infection and prepare for eventual joint replacement.

9. Operative Note - Fibroblastic Disorder Debridement with Antibiotic Bead Removal and Joint Fusion for Severe Infected Joint:

A fibroblastic disorder with severe infection was identified in the patient's ankle joint. Under general anesthesia, extensive debridement of infected tissues was performed, including the removal of previously placed antibiotic beads. Joint fusion was then carried out to eliminate movement and promote healing. The patient received intravenous antibiotics and was closely monitored for infection resolution and joint stability.

10. Operative Note - Fibroblastic Disorder Resection with Antibiotic Spacer Exchange and Soft Tissue Reconstruction for Severe Infected Joint:

A fibroblastic disorder involving severe infection was observed in the patient's hip joint. Under general anesthesia, resection of the lesion was performed with clear margins. Antibiotic spacer exchange was carried out to maintain local antibiotic therapy and joint space. Soft tissue reconstruction was performed to address any significant tissue loss. The patient received appropriate antibiotic therapy and was scheduled for wound care and follow-up visits.

1. Operative Note - Fibroblastic Disorder Excision with Corticosteroid Injection for Severe Inflammation:

A fibroblastic disorder with severe inflammation was identified in the patient's forearm. Under local anesthesia, the lesion was excised with clear margins. Additionally, a corticosteroid injection was administered at the surgical site to reduce local inflammation. The wound was closed, and the patient was instructed on postoperative wound care and follow-up evaluations.

2. Operative Note - Fibroblastic Disorder Debridement with Nonsteroidal Anti-Inflammatory Drug (NSAID) Irrigation for Moderate Inflammation:

A fibroblastic disorder involving moderate inflammation was observed in the patient's leg. Under general anesthesia, thorough debridement of the affected tissue was performed to remove the inflammatory components. The surgical site was then irrigated with a nonsteroidal anti-inflammatory drug (NSAID) solution to alleviate local inflammation. The patient received postoperative instructions for wound care and pain management.

3. Operative Note - Fibroblastic Disorder Excision with Intraoperative Steroid Injection for Chronic Inflammation:

A fibroblastic disorder with chronic inflammation was identified in the patient's hand. Under regional anesthesia, the lesion was excised with clear margins. Intraoperative steroid injection was administered at the surgical site to address the chronic inflammatory response. The wound was closed, and the patient was scheduled for follow-up visits to monitor the healing process.

4. Operative Note - Fibroblastic Disorder Resection with Immunomodulatory Therapy for Recurrent Inflammation:

A fibroblastic disorder involving recurrent inflammation was observed in the patient's foot. Under general anesthesia, resection of the lesion was performed, ensuring clear margins. Immunomodulatory therapy was initiated postoperatively to regulate the inflammatory response and prevent recurrences. The patient was provided with instructions for wound care, medication administration, and scheduled follow-up evaluations.

5. Operative Note - Fibroblastic Disorder Excision with Topical Anti-Inflammatory Dressing for Mild Inflammation:

A fibroblastic disorder with mild inflammation was identified in the patient's neck. Under local anesthesia, the lesion was excised with clear margins. A topical anti-inflammatory dressing was applied to the surgical site to provide local relief and reduce inflammation. The patient was instructed on postoperative wound care and follow-up appointments for evaluation.

6. Operative Note - Fibroblastic Disorder Debridement with Cold Compress Application for Acute Inflammation:

A fibroblastic disorder involving acute inflammation was observed in the patient's shoulder. Under general anesthesia, thorough debridement of the affected tissue was performed to remove inflammatory elements. Cold compress application was initiated postoperatively to reduce acute inflammation. The patient received instructions for pain management and wound care.

7. Operative Note - Fibroblastic Disorder Excision with Anti-inflammatory Medication Infiltration for Persistent Inflammation:

A fibroblastic disorder with persistent inflammation was identified in the patient's thigh. Under regional anesthesia, the lesion was excised with clear margins. Anti-inflammatory medication infiltration was performed at the surgical site to address the persistent inflammatory response. The wound was closed, and the patient was advised on postoperative care and follow-up evaluations.

8. Operative Note - Fibroblastic Disorder Resection with Systemic Anti-inflammatory Medication for Diffuse Inflammation:

A fibroblastic disorder involving diffuse inflammation was observed in the patient's abdomen. Under general anesthesia, resection of the lesion was performed with clear margins. Systemic anti-inflammatory medication was initiated postoperatively to target the overall inflammatory response. The patient received instructions for postoperative recovery and was scheduled for regular follow-up visits.

9. Operative Note - Fibroblastic Disorder Debridement with Phototherapy for Inflammation Reduction:

A fibroblastic disorder with significant inflammation was identified in the patient's back. Under regional anesthesia, thorough debridement of the affected tissue was performed to remove inflamed components. Phototherapy was applied postoperatively to reduce inflammation and promote healing. The patient received instructions for wound care and follow-up evaluations.

10. Operative Note - Fibroblastic Disorder Excision with Immunosuppressive Medication for Excessive Inflammation:

A fibroblastic disorder involving excessive inflammation was observed in the patient's hip. Under general anesthesia, excision of the lesion was performed with clear margins. Immunosuppressive medication was initiated postoperatively to suppress the inflammatory response. The patient was closely monitored for medication side effects and scheduled for follow-up appointments.

1. Operative Note - Fibroblastic Disorder Excision with Regular Follow-Up:

A fibroblastic disorder with localized involvement was identified on the patient's forearm. Under local anesthesia, the lesion was excised with clear margins. The patient was advised to schedule regular follow-up visits for wound assessment and monitoring of potential recurrence.

2. Operative Note - Fibroblastic Disorder Resection with Intensive Follow-Up:

A fibroblastic disorder involving deep tissue infiltration was observed in the patient's leg. Under general anesthesia, wide resection of the lesion was performed to ensure complete removal. Due to the severity and potential for recurrence, the patient was recommended to have intensive follow-up evaluations, including imaging studies and clinical examinations.

3. Operative Note - Fibroblastic Disorder Debulking with Frequent Follow-Up and Imaging:

A fibroblastic disorder with extensive size and infiltrative growth was identified in the patient's abdomen. Under general anesthesia, debulking surgery was performed to remove a significant portion of the lesion. Given the potential for residual disease, the patient was advised to have frequent follow-up visits along with periodic imaging studies to monitor the progression and response to treatment.

4. Operative Note - Fibroblastic Disorder Excision with Long-Term Surveillance:

A fibroblastic disorder involving the patient's hand required surgical intervention. Under regional anesthesia, the lesion was excised with clear margins. Due to the potential for aggressive behavior, the patient was recommended to undergo long-term surveillance, including regular follow-up visits, imaging studies, and close monitoring of clinical symptoms.

5. Operative Note - Fibroblastic Disorder Resection with Extended Follow-Up and Biopsy:

A fibroblastic disorder with atypical features was observed in the patient's shoulder. Under general anesthesia, resection of the lesion was performed, ensuring clear margins. Given the uncertainty regarding the pathology, the patient was scheduled for extended follow-up visits and a biopsy of the excised tissue to aid in the diagnosis and guide further management.

6. Operative Note - Fibroblastic Disorder Excision with Multidisciplinary Team Follow-Up:

A fibroblastic disorder involving the patient's thigh required surgical intervention. Under general anesthesia, excision of the lesion was performed with clear margins. Given the complexity of the case and potential for functional impairment, the patient was recommended to have follow-up evaluations with a multidisciplinary team, including orthopedic surgeons, rehabilitation specialists, and oncologists.

7. Operative Note - Fibroblastic Disorder Debridement with Enhanced Surveillance:

A fibroblastic disorder with multifocal involvement was identified in the patient's back. Under general anesthesia, thorough debridement of the affected tissue was performed. Due to the high risk of recurrence and metastasis, the patient was advised to have enhanced surveillance, including frequent follow-up visits, imaging studies, and close monitoring of regional lymph nodes.

8. Operative Note - Fibroblastic Disorder Resection with Lifelong Monitoring:

A fibroblastic disorder involving the patient's chest wall required surgical intervention. Under general anesthesia, a wide resection of the lesion was performed, ensuring clear surgical margins. Given the potential for local recurrence and distant metastasis, the patient was recommended to undergo lifelong monitoring, including regular follow-up visits, imaging studies, and surveillance of potential associated conditions.

9. Operative Note - Fibroblastic Disorder Excision with Genetic Counseling and Periodic Screening:

A fibroblastic disorder with suspected genetic predisposition was observed in the patient's neck. Under local anesthesia, the lesion was excised with clear margins. Due to the possibility of

an underlying genetic component, the patient was referred for genetic counseling and advised to undergo periodic screening and follow-up evaluations to detect any associated conditions.

10. Operative Note - Fibroblastic Disorder Debulking with Individualized Follow-Up Plan:

A fibroblastic disorder with complex clinical presentation and involvement of critical structures was identified in the patient's face. Under general anesthesia, debulking surgery was performed to improve cosmesis and alleviate functional impairments. Given the uniqueness of the case, an individualized follow-up plan was established, incorporating regular visits with specialists in plastic surgery, dermatology, and ophthalmology to address specific concerns and optimize outcomes.

## M73.0 Gonococcal bursitis

1. Operative Note: Patient underwent arthroscopic lavage and debridement of the left knee for Gonococcal bursitis. A standard anterolateral portal was established, and copious irrigation was performed. Debridement of the infected bursa was carried out, removing purulent material and necrotic tissue. The joint was thoroughly irrigated with saline, and a drain was placed. The wound was closed in layers. Patient tolerated the procedure well and was transferred to the recovery area.

2. Operative Note: The patient underwent open surgical intervention for Gonococcal bursitis of the elbow. A medial incision was made, and the bursa was exposed. The infected bursa was carefully excised, and any abscess formation was drained. The surgical site was irrigated with a sterile saline solution. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient's postoperative recovery was uneventful.

3. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's hip. The infected bursa was accessed through a lateral incision. The bursa was debrided, and irrigation was carried out using an antibiotic solution. Any loose bodies or purulent material were removed. The incision was meticulously closed, and a sterile dressing was applied. The patient was advised on postoperative care and discharged in stable condition.

4. Operative Note: The patient underwent an arthroscopic procedure for Gonococcal bursitis in the shoulder joint. Standard portals were established, and the joint was examined. The bursa was found to be infected, and a thorough lavage was performed using saline solution. Debridement of any necrotic tissue or pus was carried out. The procedure was completed without complications, and the patient was transferred to the recovery area.

5. Operative Note: Open surgical intervention was performed to address Gonococcal bursitis in the patient's ankle. An incision was made, and the infected bursa was identified. The bursa was excised, and the surgical site was irrigated with a sterile solution. Absorbable sutures were used to close the incision, and a sterile dressing was applied. The patient was advised on weight-bearing restrictions and discharged with appropriate postoperative instructions.

6. Operative Note: The patient underwent arthroscopic treatment for Gonococcal bursitis in the wrist joint. Arthroscopy portals were established, and the joint was visualized. The infected bursa was identified and carefully debrided using arthroscopic instruments. The joint was thoroughly irrigated with saline, and a drain was placed. The portals were closed with sutures, and a sterile dressing was applied. The patient recovered well from the procedure.

7. Operative Note: Open surgical intervention was performed to address Gonococcal bursitis in the patient's patellar region. A midline incision was made, and the infected bursa was identified. The bursa was excised, and meticulous hemostasis was achieved. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient was instructed on postoperative care and follow-up appointments.

8. Operative Note: The patient underwent an arthroscopic procedure for Gonococcal bursitis in the temporomandibular joint. Arthroscopy portals were established, and the joint was visualized. The infected bursa was debrided, and thorough irrigation was performed. Any loose bodies or debris were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient's jaw mobility and pain significantly

improved postoperatively.

9. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's sacroiliac joint. An incision was made, and the infected bursa was accessed. Debridement of the bursa and surrounding tissues was carried out, and irrigation was performed using a sterile solution. The incision was closed with sutures, and a sterile dressing was applied. The patient experienced relief from pain and was discharged with appropriate postoperative instructions.

10. Operative Note: Open surgical intervention was performed to address Gonococcal bursitis in the patient's clavicular region. A curvilinear incision was made over the bursa, and the infected bursa was exposed. Debridement of the bursa and adjacent tissues was performed, ensuring complete removal of purulent material. The wound was irrigated with saline, and the incision was closed using sutures. The patient's symptoms improved following the procedure.

1. Operative Note: The patient underwent an open surgical procedure for Gonococcal bursitis in the sternoclavicular joint. A transverse incision was made, and the infected bursa was identified. Debridement of the bursa was performed, removing purulent material and necrotic tissue. Copious irrigation was carried out using an antibiotic solution. The wound was closed in layers, and a sterile dressing was applied. The patient's postoperative course was uneventful.

2. Operative Note: Arthroscopic treatment was performed for Gonococcal bursitis in the patient's temporomandibular joint. Arthroscopy portals were created, and the joint was visualized. The infected bursa was debrided, and thorough irrigation was performed using saline solution. Any loose fragments were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient experienced improved jaw function postoperatively.

3. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's olecranon region. An incision was made, and the infected bursa was identified and excised. Thorough irrigation was performed with an antibiotic solution. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient was instructed on postoperative care, including range-of-motion exercises.

4. Operative Note: The patient underwent an arthroscopic lavage and debridement procedure for Gonococcal bursitis in the hip joint. Arthroscopy portals were established, and the joint was examined. The infected bursa was thoroughly irrigated, and necrotic tissue and pus were removed. The joint was visualized to ensure complete debridement. The portals were closed with sutures, and the patient's pain and mobility significantly improved.

5. Operative Note: Open surgical intervention was performed to address Gonococcal bursitis in the patient's thoracic spine region. A midline incision was made, and the infected bursa was accessed. Debridement of the bursa and surrounding tissues was carried out, followed by irrigation using a sterile solution. The incision was closed with sutures, and a sterile dressing was applied. The patient's neurological symptoms improved postoperatively.

6. Operative Note: The patient underwent an arthroscopic procedure for Gonococcal bursitis in the ankle joint. Arthroscopy portals were established, and the joint was visualized. The infected bursa was carefully debrided using arthroscopic instruments. Thorough irrigation was performed, and any loose bodies or debris were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient had improved ankle stability and decreased pain after the procedure.

7. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's sacral region. A longitudinal incision was made, and the infected bursa was exposed. Debridement of the bursa and adjacent tissues was carried out, ensuring complete removal of pus and necrotic material. The wound was thoroughly irrigated with a sterile solution. The incision was closed in layers, and the patient's symptoms significantly improved postoperatively.

8. Operative Note: The patient underwent an open surgical intervention for Gonococcal bursitis in the interphalangeal joint of the thumb. An incision was made, and the infected bursa was identified and excised. The bursa was sent for culture and sensitivity testing. The wound was irrigated

, and meticulous hemostasis was achieved. The incision was closed using sutures, and a sterile dressing was applied. The patient's thumb function improved after the procedure.

9. Operative Note: Arthroscopic treatment was performed for Gonococcal bursitis in the patient's metacarpophalangeal joint. Arthroscopy portals were created, and the joint was visualized. The infected bursa was debrided, and thorough irrigation was performed using saline solution. Any loose fragments or debris were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient had improved finger range of motion following the procedure.

10. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's popliteal region. An incision was made, and the infected bursa was accessed. Debridement of the bursa and surrounding tissues was carried out, followed by irrigation with an antibiotic solution. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient's symptoms resolved, and no signs of infection were observed during the postoperative period.

1. Operative Note: The patient underwent an open surgical procedure for Gonococcal bursitis in the sternoclavicular joint under general anesthesia. A transverse incision was made, and the infected bursa was identified. Debridement of the bursa was performed, removing purulent material and necrotic tissue. Copious irrigation was carried out using an antibiotic solution. The wound was closed in layers, and a sterile dressing was applied. The patient's postoperative course was uneventful.

2. Operative Note: Arthroscopic treatment was performed for Gonococcal bursitis in the patient's temporomandibular joint under local anesthesia with sedation. Arthroscopy portals were created, and the joint was visualized. The infected bursa was debrided, and thorough irrigation was performed using saline solution. Any loose fragments were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient experienced improved jaw function postoperatively.

3. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's olecranon region under regional anesthesia. An incision was made, and the infected bursa was identified and excised. Thorough irrigation was performed with an antibiotic solution. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient was instructed on postoperative care, including range-of-motion exercises.

4. Operative Note: The patient underwent an arthroscopic lavage and debridement procedure for Gonococcal bursitis in the hip joint under spinal anesthesia. Arthroscopy portals were established, and the joint was examined. The infected bursa was thoroughly irrigated, and necrotic tissue and pus were removed. The joint was visualized to ensure complete debridement. The portals were closed with sutures, and the patient's pain and mobility significantly improved.

5. Operative Note: Open surgical intervention was performed to address Gonococcal bursitis in the patient's thoracic spine region under general anesthesia. A midline incision was made, and the infected bursa was accessed. Debridement of the bursa and surrounding tissues was carried out, followed by irrigation using a sterile solution. The incision was closed with sutures, and a sterile dressing was applied. The patient's neurological symptoms improved postoperatively.

6. Operative Note: The patient underwent an arthroscopic procedure for Gonococcal bursitis in the ankle joint under local anesthesia. Arthroscopy portals were established, and the joint was visualized. The infected bursa was carefully debrided using arthroscopic instruments. Thorough irrigation was performed, and any loose bodies or debris were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient had improved ankle stability and decreased pain after the procedure.

7. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's sacral region under general anesthesia. A longitudinal incision was made, and the infected bursa was exposed. Debridement of the bursa and adjacent tissues was carried out, ensuring complete removal of pus and necrotic material. The wound was thoroughly irrigated with a sterile solution. The incision was closed in layers, and the patient's symptoms significantly improved postoperatively.

8. Operative Note: The patient underwent an open surgical intervention for Gonococcal bursitis in the interphalangeal joint of the thumb under local anesthesia with sedation.

An incision was made, and the infected bursa was identified and excised. The bursa was sent for culture and sensitivity testing. The wound was irrigated, and meticulous hemostasis was achieved. The incision was closed using sutures, and a sterile dressing was applied. The patient's thumb function improved after the procedure.

9. Operative Note: Arthroscopic treatment was performed for Gonococcal bursitis in the patient's metacarpophalangeal joint under regional anesthesia. Arthroscopy portals were created, and the joint was visualized. The infected bursa was debrided, and thorough irrigation was performed using saline solution. Any loose fragments or debris were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient had improved finger range of motion following the procedure.

10. Operative Note: A surgical procedure was performed to address Gonococcal bursitis in the patient's popliteal region under general anesthesia. An incision was made, and the infected bursa was accessed. Debridement of the bursa and surrounding tissues was carried out, followed by irrigation with an antibiotic solution. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient's symptoms resolved, and no signs of infection were observed during the postoperative period.

1. Operative Note: The patient underwent open surgical intervention for Gonococcal bursitis with bone erosion in the sternoclavicular joint. A transverse incision was made, and the infected bursa with associated bone erosion was visualized. Debridement of the bursa and necrotic bone was performed meticulously. Copious irrigation was carried out using an antibiotic solution. The wound was closed in layers, and a sterile dressing was applied. The patient's postoperative course was uneventful.

2. Operative Note: Arthroscopic treatment was performed for Gonococcal bursitis with bone erosion in the knee joint. Arthroscopy portals were created, and the joint was examined. The infected bursa with associated bone erosion was debrided using arthroscopic instruments. Thorough irrigation was performed, and loose fragments were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient experienced improved knee stability and reduced pain postoperatively.

3. Operative Note: A surgical procedure was performed to address Gonococcal bursitis with bone erosion in the elbow region. An incision was made, and the infected bursa with underlying bone erosion was accessed. Debridement of the bursa and necrotic bone was carried out. Thorough irrigation was performed, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient was instructed on postoperative care and rehabilitation exercises.

4. Operative Note: The patient underwent an arthroscopic lavage and debridement procedure for Gonococcal bursitis with bone erosion in the shoulder joint. Arthroscopy portals were established, and the joint was visualized. The infected bursa with associated bone erosion was thoroughly irrigated, and necrotic tissue and loose fragments were removed. The joint was visualized to ensure complete debridement. The portals were closed with sutures, and the patient's pain and range of motion improved postoperatively.

5. Operative Note: Open surgical intervention was performed to address Gonococcal bursitis with bone erosion in the hip region. A curvilinear incision was made, and the infected bursa with underlying bone erosion was exposed. Debridement of the bursa and necrotic bone was performed meticulously. Thorough irrigation was carried out using a sterile solution. The incision was closed using sutures, and a sterile dressing was applied. The patient's symptoms improved, and radiographic assessment showed bone healing.

6. Operative Note: The patient underwent an arthroscopic procedure for Gonococcal bursitis with bone erosion in the wrist joint. Arthroscopy portals were established, and the joint was visualized. The infected bursa with associated bone erosion was debrided using arthroscopic instruments. Thorough irrigation was performed, and loose bone fragments were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient had improved wrist function and decreased pain following the procedure.

7. Operative Note: A surgical procedure was performed to address Gonococcal bursitis with bone erosion in the ankle region. An incision was made, and the infected bursa with underlying bone erosion was identified. Debridement of the bursa and necrotic bone was carried out, ensuring complete removal of infected tissues. Thorough irrigation was performed, and loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient's symptoms improved, and radiographic

examination showed signs of bone regeneration.

8. Operative Note: The patient underwent open surgical intervention for Gonococcal bursitis with bone erosion in the sacroiliac joint. A midline incision was made, and the infected bursa with associated bone erosion was accessed. Debridement of the bursa and necrotic bone was performed meticulously. Thorough irrigation was carried out using an antibiotic solution. The incision was closed in layers, and a sterile dressing was applied. The patient's symptoms improved, and radiographic assessment showed signs of bone healing.

9. Operative Note: Arthroscopic treatment was performed for Gonococcal bursitis with bone erosion in the metatarsophalangeal joint of the foot. Arthroscopy portals were created, and the joint was visualized. The infected bursa with associated bone erosion was debrided using arthroscopic instruments. Thorough irrigation was performed, and any loose fragments were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient had improved foot function and reduced pain postoperatively.

10. Operative Note: A surgical procedure was performed to address Gonococcal bursitis with bone erosion in the vertebral region. A longitudinal incision was made, and the infected bursa with underlying bone erosion was exposed. Debridement of the bursa and necrotic bone was carried out meticulously. Thorough irrigation was performed with a sterile solution. The incision was closed in layers, and a sterile dressing was applied. The patient's symptoms improved, and radiographic examination showed signs of bone regeneration.

1. Operative Note: The patient underwent open surgical intervention for severe bone pain associated with Gonococcal bursitis in the sternoclavicular joint. A transverse incision was made, and the infected bursa was visualized. Debridement of the bursa and necrotic tissue was performed meticulously. Copious irrigation was carried out using an antibiotic solution. The wound was closed in layers, and a sterile dressing was applied. The patient experienced significant relief from bone pain postoperatively.

2. Operative Note: Arthroscopic treatment was performed for severe bone pain associated with Gonococcal bursitis in the knee joint. Arthroscopy portals were created, and the joint was examined. The infected bursa was debrided, and thorough irrigation was performed using saline solution. Any loose fragments were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient reported a marked reduction in bone pain and improved knee function after the procedure.

3. Operative Note: A surgical procedure was performed to address severe bone pain associated with Gonococcal bursitis in the elbow region. An incision was made, and the infected bursa was accessed. Debridement of the bursa and necrotic tissue was carried out. Thorough irrigation was performed, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient experienced significant relief from bone pain and improved range of motion.

4. Operative Note: The patient underwent an arthroscopic lavage and debridement procedure for severe bone pain associated with Gonococcal bursitis in the shoulder joint. Arthroscopy portals were established, and the joint was visualized. The infected bursa was thoroughly irrigated, and necrotic tissue and pus were removed. The joint was visualized to ensure complete debridement. The portals were closed with sutures, and the patient reported a substantial decrease in bone pain and improved shoulder mobility.

5. Operative Note: Open surgical intervention was performed to address severe bone pain associated with Gonococcal bursitis in the hip region. A curvilinear incision was made, and the infected bursa was exposed. Debridement of the bursa and necrotic tissue was performed meticulously. Thorough irrigation was carried out using a sterile solution. The incision was closed using sutures, and a sterile dressing was applied. The patient reported significant relief from bone pain and improved hip function postoperatively.

6. Operative Note: The patient underwent an arthroscopic procedure for severe bone pain associated with Gonococcal bursitis in the wrist joint. Arthroscopy portals were established, and the joint was visualized. The infected bursa was debrided using arthroscopic instruments. Thorough irrigation was performed, and any loose bodies or debris were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient reported a substantial reduction in bone pain and improved wrist function.

7. Operative Note: A surgical procedure was performed to address severe bone pain associated with Gonococcal bursitis in the ankle region. An incision was made, and the infected bursa was identified. Debridement of the bursa and necrotic tissue was carried out, ensuring complete removal of infected materials. Thorough irrigation was performed, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient experienced significant relief from bone pain and improved ankle

stability.

8. Operative Note: The patient underwent open surgical intervention for severe bone pain associated with Gonococcal bursitis in the sacroiliac joint. A midline incision was made, and the infected bursa was accessed. Debridement of the bursa and necrotic tissue was performed meticulously. Thorough irrigation was carried out using an antibiotic solution. The incision was closed in layers, and a sterile dressing was applied. The patient reported significant relief from bone pain and improved mobility.

9. Operative Note: Arthroscopic treatment was performed for severe bone pain associated with Gonococcal bursitis in the metatarsophalangeal joint of the foot. Arthroscopy portals were created, and the joint was visualized. The infected bursa was debrided using arthroscopic instruments. Thorough irrigation was performed, and any loose fragments were removed. The portals were closed with sutures, and a sterile dressing was applied. The patient reported a marked reduction in bone pain and improved foot function postoperatively.

10. Operative Note: A surgical procedure was performed to address severe bone pain associated with Gonococcal bursitis in the vertebral region. A longitudinal incision was made, and the infected bursa was exposed. Debridement of the bursa and necrotic tissue was carried out meticulously. Thorough irrigation was performed with a sterile solution. The incision was closed in layers, and a sterile dressing was applied. The patient reported significant relief from bone pain and improved overall comfort.

1. Operative Note: The patient underwent surgical intervention for Gonococcal bursitis in the shoulder joint. A standard deltopectoral approach was utilized to access the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed. Copious irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved shoulder mobility and decreased pain postoperatively.

2. Operative Note: A surgical intervention was performed for Gonococcal bursitis in the hip region. A lateral approach was employed, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved hip function and reduced pain following the procedure.

3. Operative Note: The patient underwent surgical intervention for Gonococcal bursitis in the ankle joint. An anterior approach was utilized, providing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed carefully. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved ankle stability and decreased pain postoperatively.

4. Operative Note: A surgical intervention was performed for Gonococcal bursitis in the elbow region. A posterior approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were carried out meticulously. Thorough irrigation was performed using an antibiotic solution. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved elbow function and reduced pain following the procedure.

5. Operative Note: The patient underwent surgical intervention for Gonococcal bursitis in the knee joint. A standard medial parapatellar approach was employed, providing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved knee stability and decreased pain postoperatively.

6. Operative Note: A surgical intervention was performed for Gonococcal bursitis in the wrist joint. A dorsal approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed carefully. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved wrist function and reduced pain following the procedure.

7. Operative Note: The patient underwent surgical intervention for Gonococcal bursitis in the metatarsophalangeal joint of the foot. A dorsal approach was employed, providing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved foot function and decreased pain postoperatively.

8. Operative Note: A surgical intervention was performed for Gonococcal bursitis in the

sacroiliac joint. A posterior approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed meticulously. Thorough irrigation was performed using an antibiotic solution. The incision was closed in layers, and a sterile dressing was applied. The patient had improved mobility and reduced pain following the procedure.

9. Operative Note: The patient underwent surgical intervention for Gonococcal bursitis in the sternoclavicular joint. An anterior approach was employed, providing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed carefully. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient experienced improved bone stability and decreased pain postoperatively.

10. Operative Note: A surgical intervention was performed for Gonococcal bursitis in the vertebral region. A posterior approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient had improved comfort and reduced pain following the procedure.

1. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis in the shoulder joint. A standard deltopectoral approach was utilized to access the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient experienced improved shoulder mobility and reduced pain postoperatively.

2. Operative Note: A surgical intervention was performed for chronic Gonococcal bursitis in the hip region. An anterior approach was employed, providing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient had improved hip function and reduced pain following the procedure.

3. Operative Note: The patient underwent surgical intervention for recurrent Gonococcal bursitis in the ankle joint. A lateral approach was utilized, allowing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed carefully. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient experienced improved ankle stability and decreased pain postoperatively.

4. Operative Note: A surgical intervention was performed for chronic Gonococcal bursitis in the elbow region. A posterior approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were carried out meticulously. Thorough irrigation was performed using an antibiotic solution. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved elbow function and reduced pain following the procedure.

5. Operative Note: The patient underwent surgical intervention for persistent Gonococcal bursitis in the knee joint. A standard medial parapatellar approach was employed, providing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved knee stability and decreased pain postoperatively.

6. Operative Note: A surgical intervention was performed for refractory Gonococcal bursitis in the wrist joint. A dorsal approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed carefully. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved wrist function and reduced pain following the procedure.

7. Operative Note: The patient underwent surgical intervention for recurrent Gonococcal bursitis in the metatarsophalangeal joint of the foot. A dorsal approach was employed, providing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved foot function and decreased pain postoperatively.

8. Operative Note: A surgical intervention was

performed for chronic Gonococcal bursitis in the sacroiliac joint. A posterior approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed meticulously. Thorough irrigation was performed using an antibiotic solution. The incision was closed in layers, and a sterile dressing was applied. The patient had improved mobility and reduced pain following the procedure.

9. Operative Note: The patient underwent surgical intervention for persistent Gonococcal bursitis in the sternoclavicular joint. An anterior approach was employed, providing access to the infected bursa. Debridement of the bursa and removal of necrotic tissue were performed carefully. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient experienced improved bone stability and decreased pain postoperatively.

10. Operative Note: A surgical intervention was performed for refractory Gonococcal bursitis in the vertebral region. A posterior approach was utilized, allowing access to the infected bursa. Debridement of the bursa and excision of necrotic tissue were performed meticulously. Thorough irrigation was carried out, and any loose fragments were removed. The incision was closed using sutures, and a sterile dressing was applied. The patient had improved comfort and reduced pain following the procedure.

1. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis with infection on the extreme moving joint of the shoulder. An extended deltopectoral approach was employed to access the infected bursa. Extensive debridement of the bursa and excision of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed in layers, and a sterile dressing was applied. The patient experienced improved range of motion and decreased pain postoperatively.

2. Operative Note: A surgical intervention was performed for severe Gonococcal bursitis with infection on the extreme moving joint of the hip. An anterior approach was utilized, providing access to the infected bursa. Thorough debridement of the bursa and removal of necrotic tissue were carried out. Extensive irrigation with antibiotic solution was performed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved hip mobility and reduced pain following the procedure.

3. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis with infection on the extreme moving joint of the ankle. A lateral approach was employed, allowing access to the infected bursa. Thorough debridement of the bursa and excision of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved ankle stability and decreased pain postoperatively.

4. Operative Note: A surgical intervention was performed for severe Gonococcal bursitis with infection on the extreme moving joint of the elbow. A posterior approach was utilized, providing access to the infected bursa. Extensive debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved elbow function and reduced pain following the procedure.

5. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis with infection on the extreme moving joint of the knee. A standard medial parapatellar approach was employed, allowing access to the infected bursa. Thorough debridement of the bursa and excision of necrotic tissue were performed carefully. Copious irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved knee mobility and decreased pain postoperatively.

6. Operative Note: A surgical intervention was performed for severe Gonococcal bursitis with infection on the extreme moving joint of the wrist. A dorsal approach was utilized, providing access to the infected bursa. Extensive debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved wrist function and reduced pain following the procedure.

7. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis with infection on the extreme moving joint of the metatarsophalangeal joint. A dorsal approach was employed, allowing access to the infected bursa. Thorough debridement of the bursa and excision of necrotic tissue were performed carefully. Copious irrigation with antibiotic solution was carried out. The incision was closed

using sutures, and a sterile dressing was applied. The patient experienced improved foot mobility and decreased pain postoperatively.

8. Operative Note: A surgical intervention was performed for severe Gonococcal bursitis with infection on the extreme moving joint of the temporomandibular joint. A preauricular approach was utilized, providing access to the infected bursa. Extensive debridement of the bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved jaw mobility and reduced pain following the procedure.

9. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis with infection on the extreme moving joint of the cervical spine. An anterior approach was employed, allowing access to the infected bursa. Thorough debridement of the bursa and excision of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved neck mobility and decreased pain postoperatively.

10. Operative Note: A surgical intervention was performed for severe Gonococcal bursitis with infection on the extreme moving joint of the temporomandibular joint. A preauricular approach was utilized, providing access to the infected bursa. Extensive debridement of the bursa and removal of necrotic tissue were performed carefully. Thorough irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved jaw function and reduced pain following the procedure.

1. Operative Note: The patient underwent surgical intervention for Gonococcal bursitis with severe inflammatory response in the shoulder joint. An extended deltopectoral approach was utilized to access the infected bursa. Extensive debridement of the inflamed bursa and excision of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed in layers, and a sterile dressing was applied. The patient experienced improved range of motion and decreased inflammation postoperatively.

2. Operative Note: A surgical intervention was performed for chronic Gonococcal bursitis with moderate inflammation in the hip region. An anterior approach was employed, providing access to the infected bursa. Thorough debridement of the inflamed bursa and removal of necrotic tissue were carried out. Extensive irrigation with antibiotic solution was performed. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved hip mobility and reduced inflammation following the procedure.

3. Operative Note: The patient underwent surgical intervention for recurrent Gonococcal bursitis with mild inflammation in the ankle joint. A lateral approach was utilized, allowing access to the infected bursa. Thorough debridement of the inflamed bursa and excision of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved ankle stability and decreased inflammation postoperatively.

4. Operative Note: A surgical intervention was performed for chronic Gonococcal bursitis with severe inflammation in the elbow region. A posterior approach was utilized, providing access to the infected bursa. Extensive debridement of the inflamed bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved elbow function and reduced inflammation following the procedure.

5. Operative Note: The patient underwent surgical intervention for persistent Gonococcal bursitis with moderate inflammation in the knee joint. A standard medial parapatellar approach was employed, allowing access to the infected bursa. Thorough debridement of the inflamed bursa and excision of necrotic tissue were performed carefully. Copious irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. The patient experienced improved knee mobility and decreased inflammation postoperatively.

6. Operative Note: A surgical intervention was performed for refractory Gonococcal bursitis with mild inflammation in the wrist joint. A dorsal approach was utilized, providing access to the infected bursa. Extensive debridement of the inflamed bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient had improved wrist function and reduced inflammation following the procedure.

7. Operative Note: The patient underwent surgical intervention for recurrent Gonococcal bursitis with severe inflammation in the metatarsophalangeal joint. A dorsal approach was employed, allowing access to the infected bursa. Thorough debridement of the inflamed bursa and excision of necrotic tissue were performed carefully. Copious irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied.

The patient experienced improved foot function and decreased inflammation postoperatively.

8. Operative Note: A surgical intervention was performed for chronic Gonococcal bursitis with moderate inflammation in the sacroiliac joint. A posterior approach was utilized, providing access to the infected bursa. Extensive debridement of the inflamed bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed in layers, and a sterile dressing was applied. The patient had improved mobility and reduced inflammation following the procedure.

9. Operative Note: The patient underwent surgical intervention for persistent Gonococcal bursitis with mild inflammation in the sternoclavicular joint. An anterior approach was employed, providing access to the infected bursa. Thorough debridement of the inflamed bursa and excision of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient experienced improved bone stability and decreased inflammation postoperatively.

10. Operative Note: A surgical intervention was performed for refractory Gonococcal bursitis with severe inflammation in the vertebral region. A posterior approach was utilized, providing access to the infected bursa. Extensive debridement of the inflamed bursa and removal of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. The patient had improved comfort and reduced inflammation following the procedure.

1. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis in the shoulder joint. Extensive debridement of the infected bursa and excision of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed in layers, and a sterile dressing was applied. Postoperatively, the patient will require regular follow-up visits, including physical therapy and close monitoring of symptoms and inflammation markers to assess the response to treatment and adjust the management plan accordingly.

2. Operative Note: A surgical intervention was performed for moderate Gonococcal bursitis in the hip joint. Thorough debridement of the infected bursa and removal of necrotic tissue were performed carefully. Adequate irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient will have a follow-up appointment in two weeks to evaluate the progress and determine the need for additional interventions or adjustments in medication.

3. Operative Note: The patient underwent surgical intervention for mild Gonococcal bursitis in the ankle joint. Debridement of the infected bursa and excision of necrotic tissue were performed meticulously. Thorough irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. A follow-up visit in four weeks is scheduled to assess the response to treatment and ensure resolution of symptoms. If necessary, further interventions or imaging studies will be considered.

4. Operative Note: A surgical intervention was performed for chronic Gonococcal bursitis in the elbow joint. Extensive debridement of the infected bursa and removal of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient will have weekly follow-up appointments for the next four weeks to monitor the healing process, assess pain levels, and determine the need for further interventions or adjustments in the treatment plan.

5. Operative Note: The patient underwent surgical intervention for recurrent Gonococcal bursitis in the knee joint. Thorough debridement of the infected bursa and excision of necrotic tissue were performed carefully. Adequate irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. A follow-up appointment in six weeks is scheduled to evaluate the response to treatment, assess joint stability, and consider additional imaging studies or interventions if required.

6. Operative Note: A surgical intervention was performed for refractory Gonococcal bursitis in the wrist joint. Extensive debridement of the infected bursa and removal of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient will require frequent follow-up visits every two weeks initially, with subsequent intervals extended based on the response to treatment, inflammation markers, and clinical evaluation.

7. Operative Note: The patient underwent surgical intervention for severe Gonococcal bursitis in the metatarsophalangeal joint. Thorough debridement of the infected bursa and excision of necrotic tissue were performed meticulously. Adequate irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. Postoperatively, the patient will have a follow-up appointment in one week to assess wound healing, pain levels, and inflammatory markers, and

to determine the need for further interventions or adjustments in the treatment plan.

8. Operative Note: A surgical intervention was performed for chronic Gonococcal bursitis in the temporomandibular joint. Extensive debridement of the infected bursa and removal of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient will require frequent follow-up visits every three weeks initially, with subsequent intervals extended based on the response to treatment, pain levels, and functional improvements.

9. Operative Note: The patient underwent surgical intervention for persistent Gonococcal bursitis in the sacroiliac joint. Thorough debridement of the infected bursa and excision of necrotic tissue were performed carefully. Adequate irrigation with antibiotic solution was carried out. The incision was closed using sutures, and a sterile dressing was applied. A follow-up appointment in eight weeks is scheduled to evaluate the response to treatment, assess the joint stability, and consider further interventions or therapeutic modalities based on the patient's progress and symptoms.

10. Operative Note: A surgical intervention was performed for refractory Gonococcal bursitis in the sternoclavicular joint. Extensive debridement of the infected bursa and removal of necrotic tissue were performed meticulously. Copious irrigation with antibiotic solution was carried out. The incision was closed using absorbable sutures, and a sterile dressing was applied. The patient will require regular follow-up appointments every four weeks initially, with subsequent intervals extended based on the response to treatment, pain levels, and resolution of inflammation markers.

## (AR-Variation in Inflamation) M73.1 Syphilitic bursitis

1. Operative Note: Syphilitic Bursitis Excision

Procedure: Aseptic precautions followed. A linear incision was made over the syphilitic bursa. The bursa was excised completely, ensuring clear margins. Hemostasis achieved using electrocautery. Wound irrigated with saline and closed in layers. Specimen sent for histopathological analysis. Postoperative dressing applied. Patient transferred to recovery in stable condition. Antibiotics and prophylactic tetanus administered. Instructions given for follow-up and wound care.

2. Operative Note: Syphilitic Bursitis Drainage

Procedure: Aseptic technique employed. An elliptical incision was made over the infected syphilitic bursa. Pus was evacuated, and the bursa irrigated thoroughly with saline solution. A Penrose drain was placed to ensure continuous drainage. Wound closed primarily, and sterile dressing applied. Patient tolerated the procedure well. Postoperative instructions given, including antibiotic therapy and wound care.

3. Operative Note: Syphilitic Bursitis Debridement

Procedure: Aseptic measures adhered to. A curvilinear incision was made over the syphilitic bursa. Necrotic tissue and debris were meticulously debrided using sharp and blunt dissection. Hemostasis ensured. Bursa irrigated copiously with saline. Wound closed in layers. Postoperatively, the patient was stable and transferred to recovery. Antibiotics and pain management initiated. Follow-up and wound care instructions provided.

4. Operative Note: Syphilitic Bursitis Arthroscopy

Procedure: Aseptic precautions followed. Arthroscopic portals established. Syphilitic bursa visualized using a 30-degree arthroscope. Synovectomy performed to excise the infected bursa. Copious irrigation with saline to ensure thorough cleaning. Hemostasis achieved using electrocautery. Portals closed, and sterile dressing applied. Patient recovered well and was given postoperative instructions for wound care and rehabilitation.

5. Operative Note: Syphilitic Bursitis Bursectomy

Procedure: Sterile technique maintained. A curvilinear incision made over the syphilitic bursa. The bursa was dissected meticulously and excised en bloc, ensuring complete removal. Hemostasis secured using electrocautery. Closure performed in layers, and sterile dressing applied. The patient tolerated the procedure without complications. Antibiotics and pain management initiated postoperatively. Follow-up scheduled for wound evaluation and suture removal.

6. Operative Note: Syphilitic Bursitis Curettage

Procedure: Aseptic measures adhered to. A small incision made over the syphilitic bursa. Curettes used to scrape and remove the diseased tissue and granulation material. Thorough irrigation performed with saline. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered well and transferred to recovery. Antibiotics and analgesics administered. Detailed instructions provided for wound care and follow-up.

7. Operative Note: Syphilitic Bursitis Synovectomy

Procedure: Aseptic precautions maintained. A longitudinal incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Hemostasis achieved using electrocautery. Thorough irrigation performed with saline. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient was stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation.

8. Operative Note: Syphilitic Bursitis Arthrot

omy

Procedure: Sterile technique observed. A medial incision made over the syphilitic bursa. The bursa was accessed by careful dissection of surrounding tissues. Infected bursa excised completely. Hemostasis ensured. Wound irrigated and closed in layers. Postoperatively, the patient remained stable. Antibiotics and pain management initiated. Follow-up scheduled for wound evaluation, suture removal, and further management.

9. Operative Note: Syphilitic Bursitis Needle Aspiration

Procedure: Aseptic measures followed. A 21-gauge needle inserted into the syphilitic bursa under ultrasound guidance. Pus aspirated and sent for culture and sensitivity analysis. Bursa irrigated with saline. Sterile dressing applied. Patient tolerated the procedure well. Antibiotics initiated based on culture results. Instructions given for wound care and follow-up evaluation.

10. Operative Note: Syphilitic Bursitis Biopsy

Procedure: Aseptic precautions maintained. An elliptical incision made over the syphilitic bursa. Multiple tissue samples obtained for histopathological analysis. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered without complications. Antibiotics initiated. Postoperative instructions provided for wound care and follow-up evaluation of biopsy results.

1. Operative Note: Syphilitic Bursitis Flap Reconstruction

Procedure: Aseptic technique followed. A transverse incision made over the syphilitic bursa. The bursa was excised, and surrounding healthy tissue mobilized to create a flap for reconstruction. Flap inset and secured with sutures. Hemostasis ensured. Postoperative dressing applied. Patient transferred to recovery in stable condition. Antibiotics and analgesics administered. Follow-up scheduled for flap assessment and wound healing evaluation.

2. Operative Note: Syphilitic Bursitis Cyst Wall Excision

Procedure: Aseptic measures maintained. A circular incision made over the syphilitic bursa. The cyst wall carefully excised, ensuring complete removal. Hemostasis achieved using electrocautery. Wound irrigated and closed primarily. Sterile dressing applied. The patient tolerated the procedure well. Postoperative instructions given, including antibiotics and wound care management. Follow-up planned for wound evaluation and suture removal.

3. Operative Note: Syphilitic Bursitis Arthrodesis

Procedure: Sterile technique observed. Arthrodesis approached using a dorsal incision over the syphilitic bursa. Diseased bursa excised, and adjacent joint surfaces prepared for fusion. Bone graft inserted, and fixation achieved using plates and screws. Wound closed in layers. Postoperatively, the patient remained stable. Antibiotics and pain management initiated. Instructions provided for weight-bearing restrictions and follow-up evaluation.

4. Operative Note: Syphilitic Bursitis Bursectomy with Flap Closure

Procedure: Aseptic precautions followed. An elliptical incision made over the syphilitic bursa. The bursa excised completely, preserving healthy tissue. A local flap raised and inset to close the defect. Hemostasis secured. Wound irrigated and closed in layers. Postoperative dressing applied. The patient tolerated the procedure without complications. Antibiotics and analgesics initiated. Follow-up scheduled for flap assessment and wound healing evaluation.

5. Operative Note: Syphilitic Bursitis Exploration and Lavage

Procedure: Aseptic technique maintained. A longitudinal incision made over the syphilitic bursa. The bursa explored, and extensive lavage performed using sterile saline solution. Debridement of any visible necrotic tissue carried out. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics initiated. Detailed instructions provided for wound care and follow-up evaluation.

6. Operative Note: Syphilitic Bursitis Excision with Skin Grafting

Procedure: Sterile technique observed. A transverse incision made over the syphilitic bursa. The bursa excised, ensuring clear margins. Hemostasis achieved using electrocautery. Defect covered with a split-thickness skin graft harvested from the thigh. Graft secured with sutures and dressing applied. The patient tolerated the procedure well. Antibiotics and pain management initiated. Follow-up planned for graft assessment and wound healing evaluation.

7. Operative Note: Syphilitic Bursitis Tenotomy

Procedure: Aseptic measures adhered to. A longitudinal incision made over the syphilitic bursa. The tendon dissected and tenotomy performed to release tension. Bursa excised, and hemostasis ensured. Wound closed primarily, and sterile dressing applied. The patient recovered without complications. Antibiotics and pain control initiated. Post

operative instructions provided for wound care and follow-up evaluation.

8. Operative Note: Syphilitic Bursitis Bursectomy with Tendon Repair

Procedure: Aseptic precautions maintained. A curvilinear incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent tendon injury repaired using appropriate sutures and techniques. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain management initiated. Follow-up scheduled for tendon healing evaluation and wound assessment.

9. Operative Note: Syphilitic Bursitis Endoscopic Bursectomy

Procedure: Aseptic technique followed. Small endoscopic portals established over the syphilitic bursa. Endoscope inserted for visualization. Bursectomy performed using endoscopic instruments, ensuring complete removal. Hemostasis achieved. Portals closed, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and pain control initiated. Postoperative instructions given for wound care and follow-up evaluation.

10. Operative Note: Syphilitic Bursitis Partial Bursectomy

Procedure: Aseptic measures adhered to. A transverse incision made over the syphilitic bursa. Partial bursectomy performed to remove the infected portion while preserving healthy tissue. Hemostasis ensured. Wound irrigated and closed primarily. Postoperative dressing applied. The patient recovered well without complications. Antibiotics and pain management initiated. Follow-up scheduled for wound healing evaluation and further management.

1. Operative Note: Syphilitic Bursitis Excision under General Anesthesia

Procedure: Aseptic precautions followed. Patient induced with general anesthesia using propofol and maintained with sevoflurane. A linear incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Hemostasis achieved using electrocautery. Wound irrigated and closed in layers. Postoperative dressing applied. Patient transferred to recovery in stable condition. Antibiotics and analgesics administered. Instructions given for follow-up and wound care.

2. Operative Note: Syphilitic Bursitis Drainage under Local Anesthesia

Procedure: Aseptic technique employed. Local anesthesia administered using lidocaine with epinephrine. An elliptical incision made over the infected syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly with saline solution. A Penrose drain inserted for continuous drainage. Wound closed primarily, and sterile dressing applied. Patient tolerated the procedure well. Postoperative instructions given, including antibiotic therapy and wound care.

3. Operative Note: Syphilitic Bursitis Debridement under Regional Anesthesia

Procedure: Aseptic measures adhered to. Regional anesthesia achieved with a brachial plexus block using ropivacaine. A curvilinear incision made over the syphilitic bursa. Necrotic tissue and debris meticulously debrided using sharp and blunt dissection. Hemostasis ensured. Bursa irrigated copiously with saline. Wound closed in layers. Postoperatively, the patient remained stable. Antibiotics and pain management initiated. Detailed instructions provided for wound care and follow-up.

4. Operative Note: Syphilitic Bursitis Arthroscopy under Moderate Sedation

Procedure: Aseptic precautions followed. Patient placed under moderate sedation with intravenous midazolam and fentanyl. Arthroscopic portals established. Syphilitic bursa visualized using a 30-degree arthroscope. Synovectomy performed to excise the infected bursa. Copious irrigation with saline ensured thorough cleaning. Hemostasis achieved using electrocautery. Portals closed, and sterile dressing applied. Patient recovered well and given postoperative instructions for wound care and rehabilitation.

5. Operative Note: Syphilitic Bursitis Bursectomy under Spinal Anesthesia

Procedure: Sterile technique maintained. Spinal anesthesia administered using hyperbaric bupivacaine. A curvilinear incision made over the syphilitic bursa. The bursa dissected meticulously and excised en bloc, ensuring complete removal. Hemostasis secured using electrocautery. Closure performed in layers, and sterile dressing applied. The patient tolerated the procedure without complications. Antibiotics and pain management initiated postoperatively. Follow-up scheduled for wound evaluation and suture removal.

6. Operative Note: Syphilitic Bursitis Curettage under General Anesthesia with Reduced Dosage

Procedure: Aseptic measures adhered to. Patient induced with general anesthesia using reduced dosage of propofol and maintained with sevoflurane at lower concentration. A small incision made over the syphilitic bursa. Curettes used to scrape and remove the diseased tissue and granulation material. Thorough irrigation performed with saline. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered well and transferred to recovery. Antibiotics and anal

gesics administered. Instructions given for wound care and follow-up.

7. Operative Note: Syphilitic Bursitis Synovectomy under Local Anesthesia with Sedation

Procedure: Aseptic precautions maintained. Local anesthesia administered using lidocaine with epinephrine. Sedation provided with intravenous midazolam and fentanyl. A longitudinal incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Hemostasis achieved using electrocautery. Thorough irrigation performed with saline. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation.

8. Operative Note: Syphilitic Bursitis Arthrotomy under General Anesthesia with Increased Dosage

Procedure: Aseptic technique observed. Patient induced with general anesthesia using increased dosage of propofol and maintained with sevoflurane at higher concentration. A medial incision made over the syphilitic bursa. The bursa accessed by careful dissection of surrounding tissues. Infected bursa excised completely. Hemostasis ensured. Wound irrigated and closed in layers. Postoperatively, the patient remained stable. Antibiotics and pain management initiated. Instructions provided for wound care and follow-up evaluation.

9. Operative Note: Syphilitic Bursitis Needle Aspiration under Local Anesthesia with Sedation

Procedure: Aseptic measures followed. Local anesthesia administered using lidocaine with epinephrine. Sedation provided with intravenous midazolam and fentanyl. A 21-gauge needle inserted into the syphilitic bursa under ultrasound guidance. Pus aspirated and sent for culture and sensitivity analysis. Bursa irrigated with saline. Sterile dressing applied. Patient tolerated the procedure well. Antibiotics initiated based on culture results. Instructions given for wound care and follow-up evaluation.

10. Operative Note: Syphilitic Bursitis Biopsy under Regional Anesthesia with Sedation

Procedure: Aseptic precautions maintained. Regional anesthesia achieved with a brachial plexus block using ropivacaine. Sedation provided with intravenous midazolam and fentanyl. An elliptical incision made over the syphilitic bursa. Multiple tissue samples obtained for histopathological analysis. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered without complications. Antibiotics and pain management initiated. Postoperative instructions provided for wound care and follow-up evaluation of biopsy results.

1. Operative Note: Syphilitic Bursitis Debridement with Bone Curettage

Procedure: Aseptic precautions followed. A longitudinal incision made over the syphilitic bursa. Debridement performed to remove infected tissue and granulation material. Bone erosion noted and addressed with thorough curettage. Hemostasis achieved using electrocautery. Wound irrigated and closed in layers. Postoperative dressing applied. Patient transferred to recovery in stable condition. Antibiotics and analgesics administered. Instructions given for follow-up and wound care.

2. Operative Note: Syphilitic Bursitis Excision with Bone Grafting

Procedure: Aseptic technique observed. A transverse incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Extensive bone erosion noted and addressed with debridement. Bone defect reconstructed using a bone graft harvested from the iliac crest. Graft secured with screws. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. Postoperative instructions provided for wound care and follow-up evaluation.

3. Operative Note: Syphilitic Bursitis Arthrodesis with Bone Fusion

Procedure: Sterile technique maintained. Arthrodesis approached using a dorsal incision over the syphilitic bursa. Diseased bursa excised, and extensive bone erosion noted. Adjacent joint surfaces prepared for fusion. Bone graft inserted, and fixation achieved using plates and screws. Wound closed in layers. Postoperatively, the patient remained stable. Antibiotics and pain management initiated. Instructions provided for weight-bearing restrictions and follow-up evaluation.

4. Operative Note: Syphilitic Bursitis Bursectomy with Bone Augmentation

Procedure: Aseptic precautions followed. An elliptical incision made over the syphilitic bursa. The bursa excised completely, preserving healthy tissue. Extensive bone erosion noted and addressed with bone augmentation using synthetic bone substitutes. Hemostasis secured. Wound irrigated and closed in layers. Postoperative dressing applied. The patient tolerated the procedure without complications. Antibiotics and analgesics initiated. Follow-up scheduled for wound healing evaluation and further management.

5. Operative Note: Syphilitic Bursitis Drainage with Bone Debridement

Procedure: Aseptic technique employed. A curvilinear incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Bone erosion noted and addressed with meticulous debridement using sharp and blunt dissection. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics initiated. Detailed instructions provided for wound care and follow-up evaluation.

6. Operative Note: Syphilitic Bursitis Excision with Bone Resection

Procedure: Aseptic measures adhered to. A transverse incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Extensive bone erosion noted and addressed with partial bone resection. Hemostasis achieved using electrocautery. Wound irrigated and closed primarily. Postoperative dressing applied. The patient recovered well without complications. Antibiotics and pain management initiated. Follow-up scheduled for wound healing evaluation and further management.

7. Operative Note: Syphilitic Bursitis Synovectomy with Bone Curettage

Procedure: Aseptic precautions maintained. A linear incision made over the syphilitic

bursa. Synovium carefully excised, ensuring complete removal. Extensive bone erosion noted and addressed with meticulous bone curettage. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation.

8. Operative Note: Syphilitic Bursitis Biopsy with Bone Sampling

Procedure: Aseptic measures followed. A curvilinear incision made over the syphilitic bursa. Multiple tissue samples obtained for histopathological analysis. Bone erosion noted and addressed with bone sampling for further evaluation. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered without complications. Antibiotics and pain management initiated. Postoperative instructions provided for wound care and follow-up evaluation of biopsy and bone sampling results.

9. Operative Note: Syphilitic Bursitis Bursectomy with Bone Reconstruction

Procedure: Aseptic technique observed. A medial incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Extensive bone erosion noted and addressed with bone reconstruction using autograft or allograft. Graft secured with plates and screws. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and pain management initiated. Follow-up planned for graft assessment and wound healing evaluation.

10. Operative Note: Syphilitic Bursitis Exploration with Bone Stabilization

Procedure: Aseptic precautions maintained. An elliptical incision made over the syphilitic bursa. The bursa explored, and extensive bone erosion noted. Eroded bone stabilized using plates and screws. Debridement performed to remove infected tissue. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation of bone stabilization.

1. Operative Note: Syphilitic Bursitis Bursectomy with Bone Decompression

Procedure: Aseptic precautions followed. A longitudinal incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Severe bone pain and bone marrow involvement noted. Bone decompression performed to relieve pressure and alleviate pain. Hemostasis achieved using electrocautery. Wound irrigated and closed in layers. Postoperative dressing applied. Patient transferred to recovery in stable condition. Antibiotics, analgesics, and pain management initiated. Instructions given for follow-up and wound care.

2. Operative Note: Syphilitic Bursitis Synovectomy with Bone Biopsy

Procedure: Aseptic technique observed. A curvilinear incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Severe bone pain and suspicion of bone involvement warranted bone biopsy. Multiple bone samples obtained for histopathological analysis. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. Patient recovered without complications. Antibiotics, analgesics, and pain control initiated. Postoperative instructions provided for wound care and follow-up evaluation.

3. Operative Note: Syphilitic Bursitis Drainage with Bone Debridement and Pain Control

Procedure: Aseptic measures adhered to. A transverse incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Severe bone pain and evidence of bone erosion necessitated meticulous bone debridement. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Patient remained stable postoperatively. Antibiotics, analgesics, and pain management initiated. Detailed instructions provided for wound care and follow-up evaluation.

4. Operative Note: Syphilitic Bursitis Excision with Bone Resection and Pain Relief Measures

Procedure: Aseptic precautions maintained. A transverse incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Severe bone pain and extensive bone erosion warranted bone resection. Pain relief measures implemented, including nerve blocks and local anesthetic infiltration. Hemostasis achieved using electrocautery. Wound irrigated and closed primarily. The patient tolerated the procedure without complications. Antibiotics, analgesics, and pain management initiated. Follow-up scheduled for wound healing evaluation and further pain control assessment.

5. Operative Note: Syphilitic Bursitis Biopsy with Bone Sampling and Severe Bone Pain Management

Procedure: Aseptic measures followed. A curvilinear incision made over the syphilitic bursa. Multiple tissue samples obtained for histopathological analysis. Severe bone pain and suspicion of bone involvement necessitated bone sampling. Pain management measures implemented, including analgesics and nerve blocks. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered without complications. Antibiotics and postoperative pain management initiated. Postoperative instructions provided for wound care and follow-up evaluation of biopsy and bone sampling results.

6. Operative Note: Syphilitic Bursitis Bursectomy with Bone Stabilization and Pain Control

Procedure: Aseptic technique observed. A medial incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Severe bone pain and instability due to bone erosion required bone stabilization. Pain control measures implemented, including analgesics and regional anesthesia. Bone stabilized using

plates and screws. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and postoperative pain management initiated. Follow-up planned for stability assessment and further pain control evaluation.

7. Operative Note: Syphilitic Bursitis Excision with Bone Reconstruction and Severe Bone Pain Management

Procedure: Aseptic precautions followed. An elliptical incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Severe bone pain and significant bone erosion necessitated bone reconstruction. Pain management measures implemented, including analgesics and regional anesthesia. Bone defect reconstructed using autograft or allograft. Graft secured with plates and screws. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. The patient recovered well without complications. Antibiotics and postoperative pain management initiated. Follow-up scheduled for graft assessment and further pain control evaluation.

8. Operative Note: Syphilitic Bursitis Drainage with Bone Decompression and Severe Bone Pain Control

Procedure: Aseptic measures adhered to. A longitudinal incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Severe bone pain and evidence of bone compression necessitated bone decompression. Pain control measures implemented, including analgesics and nerve blocks. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and postoperative pain management initiated. Detailed instructions provided for wound care and follow-up evaluation.

9. Operative Note: Syphilitic Bursitis Synovectomy with Bone Curettage and Severe Bone Pain Relief

Procedure: Aseptic precautions maintained. A linear incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Severe bone pain and extensive bone erosion warranted meticulous bone curettage. Pain relief measures implemented, including analgesics and local anesthetic infiltration. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation.

10. Operative Note: Syphilitic Bursitis Biopsy with Bone Resection and Severe Bone Pain Management

Procedure: Aseptic technique observed. A curvilinear incision made over the syphilitic bursa. Multiple tissue samples obtained for histopathological analysis. Severe bone pain and extensive bone erosion necessitated bone resection. Pain management measures implemented, including analgesics and nerve blocks. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered without complications. Antibiotics and postoperative pain management initiated. Postoperative instructions provided for wound care and follow-up evaluation of biopsy and bone resection results.

1. Operative Note: Syphilitic Bursitis Arthroscopic Debridement and Joint Lavage

Procedure: Aseptic precautions maintained. Arthroscopic approach utilized for syphilitic bursitis. Joint accessed using small incisions. Infected bursa debrided arthroscopically. Extensive irrigation performed to remove debris and infected material. Hemostasis achieved. Wound closed with steri-strips. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for joint protection and follow-up evaluation.

2. Operative Note: Syphilitic Bursitis Bursectomy with Open Surgical Drainage

Procedure: Aseptic technique observed. An elliptical incision made over the syphilitic bursa. Bursa excised completely, ensuring clear margins. Infected material drained using open surgical technique. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. Postoperative instructions provided for wound care and follow-up evaluation. Antibiotics and pain management initiated. Patient tolerated the procedure well.

3. Operative Note: Syphilitic Bursitis Synovectomy with Tenosynovectomy

Procedure: Aseptic precautions followed. A linear incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Concurrent tenosynovectomy performed to address involvement of adjacent tendon sheaths. Hemostasis secured. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation.

4. Operative Note: Syphilitic Bursitis Excision with Capsulectomy

Procedure: Aseptic measures adhered to. A transverse incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent capsulectomy performed to address synovial involvement. Hemostasis achieved using electrocautery. Wound irrigated and closed in layers. Postoperative dressing applied. The patient tolerated the procedure without complications. Antibiotics and pain management initiated. Follow-up scheduled for wound healing evaluation and further management.

5. Operative Note: Syphilitic Bursitis Drainage with Fasciotomy

Procedure: Aseptic technique employed. A curvilinear incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Concurrent fasciotomy performed to release compartmental pressure. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics initiated. Detailed instructions provided for wound care and follow-up evaluation.

6. Operative Note: Syphilitic Bursitis Bursectomy with Tendon Repair

Procedure: Aseptic precautions maintained. A medial incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent tendon repair performed to address tendon involvement. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and pain management initiated. Follow-up planned for tendon healing evaluation and rehabilitation.

7. Operative Note: Syphilitic Bursitis Excision with Capsular Release

Procedure: Aseptic measures followed. An elliptical incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent capsular release performed to address joint contracture.

Hemostasis achieved using electrocautery. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation.

8. Operative Note: Syphilitic Bursitis Biopsy with Joint Irrigation

Procedure: Aseptic technique observed. A curvilinear incision made over the syphilitic bursa. Multiple tissue samples obtained for histopathological analysis. Concurrent joint irrigation performed to remove infected material. Hemostasis achieved. Wound closed primarily, and sterile dressing applied. Patient recovered without complications. Antibiotics and pain management initiated. Postoperative instructions provided for wound care and follow-up evaluation of biopsy results.

9. Operative Note: Syphilitic Bursitis Drainage with Arthrodesis

Procedure: Aseptic precautions maintained. A longitudinal incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Concurrent arthrodesis performed to address joint instability and chronic infection. Hemostasis ensured. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and pain management initiated. Detailed instructions provided for wound care and follow-up evaluation of arthrodesis.

10. Operative Note: Syphilitic Bursitis Synovectomy with Joint Reconstruction

Procedure: Aseptic measures adhered to. A transverse incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Concurrent joint reconstruction performed to address joint destruction. Hemostasis achieved using electrocautery. Wound irrigated and closed in layers. Postoperative dressing applied. The patient tolerated the procedure without complications. Antibiotics and pain management initiated. Follow-up scheduled for joint stability assessment and further management.

1. Operative Note: Syphilitic Bursitis Bursectomy with Soft Tissue Reconstruction

Procedure: Aseptic precautions maintained. A curvilinear incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent soft tissue reconstruction performed to address extensive soft tissue damage. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Follow-up planned for wound healing evaluation and further management.

2. Operative Note: Syphilitic Bursitis Drainage with Joint Debridement

Procedure: Aseptic technique observed. A transverse incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Concurrent joint debridement performed to remove infected tissue and debris. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and pain management initiated. Detailed instructions provided for wound care and follow-up evaluation.

3. Operative Note: Syphilitic Bursitis Excision with Tendon Transfer

Procedure: Aseptic precautions followed. An elliptical incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent tendon transfer performed to restore function and stability. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation.

4. Operative Note: Syphilitic Bursitis Synovectomy with Joint Arthroplasty

Procedure: Aseptic measures adhered to. A linear incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Concurrent joint arthroplasty performed to address severe joint destruction. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure without complications. Antibiotics and pain management initiated. Follow-up scheduled for joint function assessment and further management.

5. Operative Note: Syphilitic Bursitis Drainage with Flap Reconstruction

Procedure: Aseptic technique employed. A curvilinear incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Concurrent flap reconstruction performed to restore tissue integrity and coverage. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics initiated. Detailed instructions provided for wound care and follow-up evaluation.

6. Operative Note: Syphilitic Bursitis Bursectomy with Nerve Decompression

Procedure: Aseptic precautions maintained. A longitudinal incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent nerve decompression performed to relieve nerve impingement and alleviate symptoms. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and pain management initiated. Follow-up planned for nerve function assessment and further management.

7. Operative Note: Syphilitic Bursitis Excision with Skin Grafting

Procedure: Aseptic measures followed. A transverse incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent skin grafting performed to close the wound and promote healing

. Hemostasis achieved using electrocautery. Wound dressed with the skin graft and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation of graft integration.

8. Operative Note: Syphilitic Bursitis Drainage with Vacuum-Assisted Closure (VAC)

Procedure: Aseptic technique observed. A curvilinear incision made over the syphilitic bursa. Pus evacuated, and the bursa irrigated thoroughly. Concurrent application of vacuum-assisted closure (VAC) performed to promote wound healing and minimize infection. Hemostasis ensured. Wound dressed with the VAC system, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and pain management initiated. Follow-up planned for VAC dressing changes and wound assessment.

9. Operative Note: Syphilitic Bursitis Synovectomy with Cartilage Restoration

Procedure: Aseptic precautions maintained. A linear incision made over the syphilitic bursa. Synovium carefully excised, ensuring complete removal. Concurrent cartilage restoration performed to address articular cartilage damage. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and pain control initiated. Instructions given for wound care and follow-up evaluation of cartilage healing.

10. Operative Note: Syphilitic Bursitis Bursectomy with Ligament Repair

Procedure: Aseptic measures adhered to. An elliptical incision made over the syphilitic bursa. The bursa excised completely, ensuring clear margins. Concurrent ligament repair performed to restore joint stability and function. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure without complications. Antibiotics and pain management initiated. Follow-up scheduled for ligament healing assessment and rehabilitation.

1. Operative Note: Syphilitic Bursitis Drainage with Arthroscopic Debridement in Severe Joint Infection

Procedure: Aseptic precautions maintained. Arthroscopic approach utilized for syphilitic bursitis with severe joint infection. Joint accessed using small incisions. Pus evacuated, and infected bursa debrided arthroscopically. Extensive irrigation performed to remove debris and infected material. Hemostasis achieved. Wound closed with steri-strips. Postoperatively, the patient remained stable. Antibiotics and intensive wound care initiated. Follow-up planned for infection control evaluation and further management.

2. Operative Note: Syphilitic Bursitis Bursectomy with Open Surgical Drainage in Severe Joint Infection

Procedure: Aseptic technique observed. An elliptical incision made over the syphilitic bursa with severe joint infection. Bursa excised completely, ensuring clear margins. Infected material drained using open surgical technique. Extensive irrigation performed to flush out the infected joint. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. Postoperative instructions provided for wound care and follow-up evaluation. Antibiotics and intensive infection management initiated.

3. Operative Note: Syphilitic Bursitis Excision with Capsulectomy in Severe Joint Infection

Procedure: Aseptic measures adhered to. A transverse incision made over the syphilitic bursa with severe joint infection. The bursa excised completely, ensuring clear margins. Concurrent capsulectomy performed to address synovial involvement and severe joint infection. Hemostasis achieved using electrocautery. Wound irrigated and closed in layers. Postoperative dressing applied. The patient tolerated the procedure without complications. Antibiotics and intensive infection control initiated. Follow-up scheduled for wound healing evaluation and further management.

4. Operative Note: Syphilitic Bursitis Drainage with Joint Lavage in Severe Joint Infection

Procedure: Aseptic technique employed. A curvilinear incision made over the syphilitic bursa with severe joint infection. Pus evacuated, and the bursa irrigated thoroughly. Concurrent joint lavage performed to remove infected material from the joint space. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and intensive infection management initiated. Detailed instructions provided for wound care and follow-up evaluation.

5. Operative Note: Syphilitic Bursitis Excision with Tendon Transfer in Severe Joint Infection

Procedure: Aseptic precautions followed. An elliptical incision made over the syphilitic bursa with severe joint infection. The bursa excised completely, ensuring clear margins. Concurrent tendon transfer performed to address tendon involvement and severe joint infection. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and intensive infection control initiated. Instructions given for wound care and follow-up evaluation.

6. Operative Note: Syphilitic Bursitis Synovectomy with Joint Reconstruction in Severe Joint Infection

Procedure: Aseptic measures maintained. A linear incision made over the syphilitic bursa with severe joint infection. Synovium carefully excised, ensuring complete removal. Concurrent joint reconstruction performed to address joint destruction and severe infection. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. The patient

tolerated the procedure without complications. Antibiotics and intensive infection management initiated. Follow-up scheduled for joint stability assessment and further management.

7. Operative Note: Syphilitic Bursitis Bursectomy with Soft Tissue Reconstruction in Severe Joint Infection

Procedure: Aseptic precautions observed. A curvilinear incision made over the syphilitic bursa with severe joint infection. The bursa excised completely, ensuring clear margins. Concurrent soft tissue reconstruction performed to address extensive soft tissue damage and severe joint infection. Hemostasis achieved using electrocautery. Wound closed in layers, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and intensive infection control initiated. Follow-up planned for wound healing evaluation and further management.

8. Operative Note: Syphilitic Bursitis Drainage with Fasciotomy in Severe Joint Infection

Procedure: Aseptic technique maintained. A curvilinear incision made over the syphilitic bursa with severe joint infection. Pus evacuated, and the bursa irrigated thoroughly. Concurrent fasciotomy performed to release compartmental pressure and address severe joint infection. Hemostasis ensured. Wound closed primarily, and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and intensive infection management initiated. Detailed instructions provided for wound care and follow-up evaluation.

9. Operative Note: Syphilitic Bursitis Excision with Skin Grafting in Severe Joint Infection

Procedure: Aseptic measures followed. A transverse incision made over the syphilitic bursa with severe joint infection. The bursa excised completely, ensuring clear margins. Concurrent skin grafting performed to close the wound and promote healing in severe joint infection. Hemostasis achieved using electrocautery. Wound dressed with the skin graft and sterile dressing applied. Postoperatively, the patient remained stable. Antibiotics and intensive infection control initiated. Instructions given for wound care and follow-up evaluation.

10. Operative Note: Syphilitic Bursitis Bursectomy with Joint Arthrodesis in Severe Joint Infection

Procedure: Aseptic precautions maintained. A longitudinal incision made over the syphilitic bursa with severe joint infection. The bursa excised completely, ensuring clear margins. Concurrent joint arthrodesis performed to address joint instability, severe infection, and prevent further damage. Hemostasis achieved. Wound closed in layers, and sterile dressing applied. The patient tolerated the procedure well. Antibiotics and intensive infection management initiated. Follow-up scheduled for joint stability assessment and further management.

## M73.8 Other soft tissue disorders in diseases classified elsewhere

1. Operative Note - Soft Tissue Excision:

Patient underwent a soft tissue excision to remove a benign mass located on the forearm. The procedure involved a curvilinear incision, followed by careful dissection and excision of the lesion. Hemostasis was achieved, and the wound was closed in layers. The specimen was sent for histopathological examination. The patient tolerated the procedure well, and postoperative care instructions were provided.

2. Operative Note - Soft Tissue Repair:

The patient presented with a laceration on the lower leg. Under sterile conditions, the wound was explored, and any foreign bodies were removed. After thorough irrigation, the edges of the wound were debrided, and a layered closure was performed using absorbable sutures. The wound was dressed, and the patient was advised on wound care and follow-up.

3. Operative Note - Soft Tissue Biopsy:

A soft tissue biopsy was performed on a suspicious mass located in the upper arm. The lesion was identified, and local anesthesia was administered. A small incision was made, and a biopsy sample was obtained using a biopsy punch. Hemostasis was ensured, and the wound was closed with sutures. The specimen was sent for pathological analysis.

4. Operative Note - Lipoma Excision:

The patient underwent an excision of a lipoma on the back. The surgical site was marked, and local anesthesia was administered. A linear incision was made over the lipoma, and careful dissection was carried out to remove the encapsulated mass. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and appropriate postoperative instructions were given.

5. Operative Note - Soft Tissue Release:

A soft tissue release was performed on a patient with Dupuytren's contracture affecting the right hand. Under regional anesthesia, a zigzag incision was made over the affected area. The contracted bands were identified and released using meticulous dissection. The finger was extended, and appropriate splinting was applied postoperatively. The patient was counseled on hand therapy and potential complications.

6. Operative Note - Ganglion Cyst Excision:

The patient underwent an excision of a ganglion cyst on the wrist. The surgical site was prepped and draped in a sterile fashion. A transverse incision was made over the cyst, and dissection was carried out to identify and remove the cystic structure. Hemostasis was achieved, and the wound was closed in layers. The patient was advised on postoperative care and potential recurrence.

7. Operative Note - Soft Tissue Reconstruction:

A soft tissue reconstruction was performed on a patient with a large defect on the lower leg following trauma. Under general anesthesia, the wound edges were debrided, and healthy tissue was mobilized for closure. Multiple layered closures were performed using absorbable sutures. Drains were placed, and a bulky dressing was applied. The patient was referred for physical therapy and wound care.

8. Operative Note - Soft Tissue Debridement:

The patient presented with a necrotic soft tissue infection on the abdomen. After appropriate anesthesia, the necrotic tissue was excised using sharp debridement. The wound was thoroughly irrigated with antiseptic solution. A wound vacuum-assisted closure (VAC) device was applied, and the patient was started on intravenous antibiotics. The wound was planned for subsequent surgical closure.

9. Operative Note - Soft Tissue Flap:

A soft tissue flap was performed to reconstruct a defect on the face following tumor resection. The defect was assessed, and a local flap was designed. The flap was elevated with meticulous dissection and transposed to cover the defect. The flap was secured in

place and sutured. The patient was monitored postoperatively for flap viability and provided with appropriate wound care instructions.

10. Operative Note - Soft Tissue Tumor Resection:

A soft tissue tumor resection was performed on a patient with a suspected malignant mass in the thigh. Under general anesthesia, an elliptical incision was made over the tumor. The mass, along with an appropriate margin of healthy tissue, was excised. Hemostasis was achieved, and the wound was closed in layers. The specimen was sent for pathological evaluation, and the patient was referred for further oncological management.

1. Operative Note - Soft Tissue Abscess Drainage:

The patient underwent a drainage procedure for a deep soft tissue abscess in the groin. After administering local anesthesia, a vertical incision was made, and the abscess cavity was explored. Pus was evacuated, and the cavity was irrigated with antiseptic solution. A drain was inserted, and the wound was left open for secondary healing. The patient was started on appropriate antibiotics and provided with wound care instructions.

2. Operative Note - Soft Tissue Hematoma Evacuation:

A hematoma evacuation was performed on a patient with a large soft tissue hematoma in the upper arm following trauma. Under sterile conditions, an oblique incision was made over the hematoma. The clotted blood was evacuated, and active bleeding vessels were cauterized. Hemostasis was achieved, and the wound was closed in layers. The patient was advised on pain management and monitored for any signs of hematoma recurrence.

3. Operative Note - Soft Tissue Reconstruction with Skin Graft:

The patient underwent a soft tissue reconstruction using a split-thickness skin graft for a chronic non-healing wound on the lower leg. After thorough debridement, a split-thickness skin graft was harvested from the thigh and secured onto the wound bed. The graft was bolstered, and a sterile dressing was applied. The patient was referred for wound care and regular graft monitoring.

4. Operative Note - Soft Tissue Foreign Body Removal:

A soft tissue foreign body was successfully removed from the hand of the patient. The hand was prepped and draped, and local anesthesia was administered. A small incision was made, and the foreign body was carefully identified and extracted. The wound was irrigated, and a sterile dressing was applied. The patient was instructed on wound care and advised to monitor for signs of infection.

5. Operative Note - Soft Tissue Tumor Biopsy:

A biopsy was performed on a suspected soft tissue tumor located in the thigh. Under sterile conditions, a longitudinal incision was made, and the tumor was visualized. A core biopsy was obtained using a biopsy needle. Hemostasis was ensured, and the wound was closed with sutures. The biopsy specimen was sent for pathological examination, and the patient was scheduled for a follow-up consultation.

6. Operative Note - Soft Tissue Flap Reconstruction:

A soft tissue flap reconstruction was performed to repair a complex defect on the scalp following tumor resection. Under general anesthesia, a flap was designed based on the nearby vascular supply. The flap was raised, rotated, and inset into the defect. Microvascular anastomosis was performed to ensure adequate blood supply. The flap was secured, and the patient was closely monitored for flap viability.

7. Operative Note - Soft Tissue Release for Contracture:

The patient underwent a soft tissue release procedure to correct contractures in the fingers caused by burn injuries. Under regional anesthesia, zigzag incisions were made over the affected areas. The contracted bands were released, and appropriate splinting was applied postoperatively. The patient was referred for hand therapy and instructed on exercises to improve range of motion.

8. Operative Note - Soft Tissue Mass Excision:

A soft tissue mass excision was performed on the neck of the patient. After marking the surgical site, a curvilinear incision was made, and dissection was carried out to remove the mass. Careful attention was given to protect nearby vital structures. Hemostasis was achieved, and the wound was closed in layers. The excised mass was sent for histopathological examination.

9. Operative Note - Soft Tissue Reconstruction with Flap and Graft:

A combined soft tissue reconstruction with flap and graft was performed on a patient with a complex

defect on the leg. A local flap was used to cover a portion of the defect, and a split-thickness skin graft was applied to the remaining area. The flap was secured, and the graft was bolstered. The patient was instructed on postoperative wound care and follow-up.

10. Operative Note - Soft Tissue Tendon Repair:

The patient underwent a soft tissue tendon repair for a partial tear in the Achilles tendon. Under regional anesthesia, an incision was made over the tendon. The torn ends were identified and meticulously sutured together. The repair was reinforced with additional sutures, and the wound was closed. The patient was placed in a non-weight-bearing cast and referred for physical therapy.

1. Operative Note - Soft Tissue Hematoma Evacuation under Local Anesthesia:

A soft tissue hematoma in the thigh was evacuated under local anesthesia. After sterile preparation, a longitudinal incision was made, and the hematoma was explored. Active bleeding vessels were cauterized, and the clot was evacuated. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well without any complications, and postoperative wound care instructions were provided.

2. Operative Note - Soft Tissue Reconstruction with Skin Graft under General Anesthesia:

A soft tissue reconstruction using a full-thickness skin graft was performed on the lower leg under general anesthesia. Following thorough debridement, a full-thickness skin graft was harvested and meticulously secured onto the wound bed. Hemostasis was achieved, and a sterile dressing was applied. The patient's vital signs remained stable throughout the procedure, and appropriate pain management was initiated postoperatively.

3. Operative Note - Soft Tissue Tumor Resection under Spinal Anesthesia:

The patient underwent a soft tissue tumor resection in the forearm under spinal anesthesia. A curvilinear incision was made, and the tumor was meticulously dissected and excised with adequate margins. Hemostasis was achieved, and the wound was closed. The patient remained comfortable throughout the procedure, and there were no anesthesia-related complications. Postoperative care instructions were discussed with the patient and their family.

4. Operative Note - Soft Tissue Flap Reconstruction under Regional Anesthesia:

A soft tissue flap reconstruction was performed on the lower leg under regional anesthesia. A local flap was designed and elevated with meticulous dissection. The flap was transferred to the defect and secured in place. The patient remained cooperative and comfortable during the procedure, and the flap showed excellent perfusion. Postoperative wound care and monitoring instructions were given to the patient.

5. Operative Note - Soft Tissue Biopsy under Moderate Sedation:

A soft tissue biopsy was performed under moderate sedation. The patient was positioned appropriately, and the biopsy site was marked. Local anesthesia was administered, and a biopsy sample was obtained using a needle. The patient remained calm and responsive throughout the procedure, with stable vital signs. The specimen was sent for pathological analysis, and the patient was discharged after a brief recovery period.

6. Operative Note - Soft Tissue Foreign Body Removal under Deep Sedation:

The patient underwent the removal of a soft tissue foreign body under deep sedation. After administering sedation, the affected area was prepped and draped in a sterile manner. An incision was made, and the foreign body was identified and carefully extracted. The patient maintained a stable respiratory rate and blood pressure throughout the procedure, and there were no complications. Postoperative wound care instructions were provided.

7. Operative Note - Soft Tissue Release for Contracture under General Anesthesia:

A soft tissue release procedure was performed to correct contractures in the hand under general anesthesia. The patient was intubated and positioned appropriately. Zigzag incisions were made, and the contracted bands were released with meticulous dissection. The patient's vital signs remained stable throughout the procedure, and the hand was splinted postoperatively. The patient was referred for hand therapy and provided with pain management instructions.

8. Operative Note - Soft Tissue Excision under Local Anesthesia with Intravenous Sedation:

The patient underwent an excision of a soft tissue mass on the back under local anesthesia with intravenous sedation. The surgical site was marked, and local anesthesia was administered. A curvilinear incision was made, and the mass was carefully dissected and excised. The patient was comfortable and sedated throughout the procedure, and there were no complications. Postoperative wound care instructions were given, and

the patient was discharged after recovery.

9. Operative Note - Soft Tissue Debridement under General Anesthesia with Balanced Anesthetic Technique:

A soft tissue debridement procedure was performed under general anesthesia using a balanced anesthetic technique. The patient was induced and maintained with a combination of intravenous and inhaled anesthetics. The necrotic tissue was excised, and the wound was thoroughly irrigated. The patient's vital signs remained stable, and postoperative pain was effectively managed. The wound was dressed, and the patient was monitored in the recovery area.

10. Operative Note - Soft Tissue Repair under Local Anesthesia with Sedation:

The patient underwent a soft tissue repair procedure under local anesthesia with sedation. The wound was explored, and any foreign bodies were removed. After thorough irrigation, the wound edges were debrided and approximated using sutures. The patient was comfortable and relaxed throughout the procedure, with stable vital signs. Postoperative wound care instructions were provided, and the patient was discharged after a short recovery period.

1. Operative Note - Soft Tissue and Bone Erosion Repair with Bone Graft under General Anesthesia:

The patient underwent a complex soft tissue and bone erosion repair with bone graft in the ankle under general anesthesia. The eroded soft tissues and bone were carefully debrided, and a bone graft was harvested from the iliac crest. The graft was inserted into the bone defect, and the surrounding soft tissues were reconstructed. The patient's vital signs remained stable throughout the procedure, and appropriate postoperative immobilization was provided.

2. Operative Note - Soft Tissue Mass Excision with Adjacent Bone Erosion Reconstruction under Regional Anesthesia:

A soft tissue mass excision with adjacent bone erosion reconstruction was performed on the forearm under regional anesthesia. An elliptical incision was made, and the mass was excised along with the surrounding eroded bone. The bone defect was reconstructed using autologous bone graft. The patient remained comfortable during the procedure, and postoperative care instructions were given, including immobilization and follow-up radiographs.

3. Operative Note - Soft Tissue and Bone Erosion Debridement under Local Anesthesia:

The patient underwent a debridement procedure for soft tissue and bone erosion in the foot under local anesthesia. The eroded tissues and bone were carefully excised and thoroughly irrigated. The wound was left open for secondary healing. The patient tolerated the procedure well without any complications, and appropriate wound care instructions were provided.

4. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft for Bone Erosion under General Anesthesia:

A soft tissue reconstruction with flap and bone graft was performed for bone erosion in the lower leg under general anesthesia. A local flap was designed and elevated, and a bone graft was harvested from the fibula. The flap was transposed to cover the exposed bone, and the bone graft was inserted into the erosion site. The patient's vital signs were stable throughout the procedure, and postoperative immobilization was initiated.

5. Operative Note - Soft Tissue Biopsy and Bone Erosion Evaluation under Moderate Sedation:

A soft tissue biopsy and bone erosion evaluation were performed under moderate sedation. The affected area was prepped and draped, and local anesthesia was administered. A biopsy sample was obtained from the soft tissue mass, and a thorough evaluation of the bone erosion was conducted. The patient remained calm and responsive throughout the procedure, and postoperative care instructions were provided.

6. Operative Note - Soft Tissue and Bone Erosion Repair with Artificial Bone Substitute under Spinal Anesthesia:

The patient underwent soft tissue and bone erosion repair in the spine using an artificial bone substitute under spinal anesthesia. The eroded soft tissues and bone were debrided, and the bone substitute was carefully inserted into the defect. The patient remained stable throughout the procedure, and appropriate postoperative immobilization and pain management were initiated.

7. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft for Extensive Bone Erosion under General Anesthesia:

A soft tissue reconstruction with flap and bone graft was performed for extensive bone erosion in the lower limb under general anesthesia. A free flap was harvested from the thigh, and the bone graft was obtained from the iliac crest. The flap was transferred to cover the exposed bone, and the bone graft was inserted into the erosion site. The patient's vital signs remained stable throughout the procedure, and postoperative wound care instructions were given.

8. Operative Note - Soft Tissue and Bone Erosion Debridement with Antibiotic Beads under Local Anesthesia with Intravenous Sedation:

The patient underwent a debridement procedure for soft tissue and bone erosion with the placement of antibiotic beads under local anesthesia with intravenous sedation. The eroded tissues and bone

were meticulously excised, and antibiotic beads were inserted into the defect. The patient was comfortable and sedated throughout the procedure, and postoperative wound care instructions were provided.

9. Operative Note - Soft Tissue and Bone Erosion Repair with Autograft and Allograft under General Anesthesia:

A comprehensive soft tissue and bone erosion repair was performed using autograft and allograft in the upper extremity under general anesthesia. The eroded soft tissues and bone were debrided, and a combination of autograft and allograft was used to reconstruct the defect. The patient's vital signs remained stable throughout the procedure, and appropriate postoperative immobilization and rehabilitation plans were initiated.

10. Operative Note - Soft Tissue and Bone Erosion Excision and Reconstruction with Vascularized Bone Graft under Regional Anesthesia:

The patient underwent soft tissue and bone erosion excision and reconstruction with a vascularized bone graft in the jaw under regional anesthesia. The eroded tissues and bone were excised, and a vascularized bone graft from the fibula was transplanted to reconstruct the defect. The patient tolerated the procedure well, and postoperative wound care instructions were provided, including diet modifications and follow-up appointments.

1. Operative Note - Soft Tissue and Bone Erosion Debridement with Nerve Block for Severe Bone Pain:

The patient underwent a debridement procedure for soft tissue and bone erosion with severe bone pain in the hip joint. Under the guidance of imaging, a nerve block was performed to provide targeted pain relief. The eroded tissues and bone were meticulously excised, and the area was thoroughly irrigated. The patient experienced significant pain relief postoperatively, and appropriate postoperative pain management was provided.

2. Operative Note - Soft Tissue and Bone Erosion Repair with Internal Fixation for Severe Bone Pain:

A soft tissue and bone erosion repair with internal fixation was performed on the forearm for severe bone pain. After meticulous debridement of the eroded tissues and bone, an appropriate internal fixation device was inserted to stabilize the bone. The patient's severe bone pain was significantly alleviated postoperatively, and appropriate pain medications were prescribed for effective pain management.

3. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft for Severe Bone Pain:

A soft tissue reconstruction with flap and bone graft was performed for severe bone pain in the lower leg. A local flap was designed and elevated, and a bone graft was obtained from the patient's iliac crest. The flap was transposed to cover the exposed bone, and the bone graft was inserted into the area of severe bone pain. The patient reported relief from severe bone pain postoperatively.

4. Operative Note - Soft Tissue and Bone Erosion Excision with Joint Replacement for Severe Bone Pain:

The patient underwent a surgical procedure involving the excision of soft tissue and bone erosion with severe bone pain in the knee joint. After meticulous debridement, a joint replacement procedure was performed to address the underlying cause of severe bone pain. The patient experienced significant relief from severe bone pain and was provided with postoperative rehabilitation instructions.

5. Operative Note - Soft Tissue and Bone Erosion Debridement with Spinal Fusion for Severe Bone Pain:

A comprehensive debridement procedure involving soft tissue and bone erosion was performed in the lumbar spine with severe bone pain. After meticulous debridement, a spinal fusion procedure was performed to stabilize the affected area. The patient experienced relief from severe bone pain postoperatively, and appropriate pain management strategies were implemented.

6. Operative Note - Soft Tissue and Bone Erosion Repair with External Fixation for Severe Bone Pain:

The patient underwent soft tissue and bone erosion repair with external fixation for severe bone pain in the lower limb. After meticulous debridement, an external fixation device was applied to stabilize the affected bone. The patient reported significant improvement in severe bone pain following the procedure, and appropriate pain medications were prescribed.

7. Operative Note - Soft Tissue and Bone Erosion Debridement with Neurolysis for Severe Bone Pain:

A debridement procedure involving soft tissue and bone erosion with severe bone pain was performed in the upper limb. The eroded tissues and bone were meticulously excised, and neurolysis was performed to relieve pressure on the affected nerves. The patient experienced relief from severe bone pain postoperatively, and appropriate postoperative pain management was provided.

8. Operative Note - Soft Tissue and Bone Erosion Excision with Radiofrequency Ablation for Severe Bone Pain:

The patient underwent a surgical procedure involving the excision of soft tissue and bone erosion with severe bone pain in the spine. After meticulous debridement, radiofrequency ablation was performed to target and alleviate severe bone pain. The patient reported significant relief from severe bone pain following the procedure, and appropriate pain medications were prescribed.

9. Operative Note - Soft Tissue Reconstruction with Flap and Bone

Graft for Severe Bone Pain and Osteonecrosis:

A soft tissue reconstruction with flap and bone graft was performed for severe bone pain and osteonecrosis in the jaw. A local flap was designed and elevated, and a bone graft was obtained from the patient's fibula. The flap was transposed to cover the affected area, and the bone graft was inserted to address the underlying osteonecrosis. The patient experienced relief from severe bone pain postoperatively.

10. Operative Note - Soft Tissue and Bone Erosion Debridement with Total Joint Replacement for Severe Bone Pain:

The patient underwent a comprehensive debridement procedure involving soft tissue and bone erosion with severe bone pain in the hip joint. After meticulous debridement, a total joint replacement procedure was performed to address the underlying cause of severe bone pain. The patient reported significant relief from severe bone pain postoperatively and was provided with postoperative rehabilitation instructions.

1. Operative Note - Soft Tissue and Bone Erosion Repair with Arthroscopic Intervention for Severe Bone Pain:

The patient underwent a surgical intervention involving soft tissue and bone erosion repair with arthroscopic intervention for severe bone pain in the knee joint. Arthroscopic debridement and irrigation were performed to address the eroded tissues and bone. The patient reported significant improvement in severe bone pain postoperatively, and postoperative rehabilitation plans were discussed.

2. Operative Note - Soft Tissue and Bone Erosion Excision with Open Reduction and Internal Fixation for Severe Bone Pain:

A surgical intervention was performed, involving the excision of soft tissue and bone erosion with open reduction and internal fixation for severe bone pain in the forearm. The eroded tissues and bone were meticulously excised, and appropriate fixation was achieved using internal fixation devices. The patient reported relief from severe bone pain postoperatively, and immobilization was initiated for optimal healing.

3. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft, Accompanied by Nerve Decompression for Severe Bone Pain:

The patient underwent a surgical intervention that included soft tissue reconstruction with flap and bone graft, accompanied by nerve decompression for severe bone pain in the lower leg. A local flap was designed and elevated, and a bone graft was obtained from the patient's iliac crest. Nerve decompression was performed to alleviate pressure on affected nerves. The patient experienced relief from severe bone pain postoperatively.

4. Operative Note - Soft Tissue and Bone Erosion Debridement with Laminectomy and Spinal Fusion for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion debridement with laminectomy and spinal fusion for severe bone pain in the lumbar spine. The eroded tissues and bone were meticulously excised, and laminectomy was performed to decompress the affected nerves. Spinal fusion was then performed to stabilize the affected area. The patient reported relief from severe bone pain postoperatively.

5. Operative Note - Soft Tissue and Bone Erosion Repair with Osteotomy for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion repair with osteotomy for severe bone pain in the foot. The eroded tissues and bone were debrided, and an osteotomy was performed to correct the underlying structural abnormalities contributing to severe bone pain. The patient reported significant improvement in severe bone pain postoperatively.

6. Operative Note - Soft Tissue and Bone Erosion Excision with Joint Replacement and Tendon Reconstruction for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion excision with joint replacement and tendon reconstruction for severe bone pain in the shoulder joint. The eroded tissues and bone were meticulously excised, and joint replacement was performed to address the underlying cause of severe bone pain. Tendon reconstruction was also performed to restore optimal joint function. The patient reported relief from severe bone pain postoperatively.

7. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft, Accompanied by Cartilage Restoration for Severe Bone Pain:

The patient underwent a surgical intervention that included soft tissue reconstruction with flap and bone graft, accompanied by cartilage restoration for severe bone pain in the knee joint. A local flap was designed and elevated, and a bone graft was obtained from the patient's fibula. Cartilage restoration techniques were employed to address the underlying cause of severe bone pain. The patient experienced relief from severe bone pain postoperatively.

8. Operative Note - Soft Tissue and Bone Erosion Debridement with Tumor Resection for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion debridement with tumor re

section for severe bone pain in the thigh. The eroded tissues and bone were meticulously excised, and a tumor resection procedure was performed to address the underlying pathology causing severe bone pain. The patient reported relief from severe bone pain postoperatively.

9. Operative Note - Soft Tissue and Bone Erosion Repair with Osteochondral Allograft Transplantation for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion repair with osteochondral allograft transplantation for severe bone pain in the ankle joint. The eroded tissues and bone were debrided, and an osteochondral allograft was carefully transplanted to restore joint function and alleviate severe bone pain. The patient reported significant improvement in severe bone pain postoperatively.

10. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft, Accompanied by Joint Denervation for Severe Bone Pain:

The patient underwent a surgical intervention that included soft tissue reconstruction with flap and bone graft, accompanied by joint denervation for severe bone pain in the wrist joint. A local flap was designed and elevated, and a bone graft was obtained from the patient's radius. Joint denervation techniques were employed to alleviate severe bone pain. The patient experienced relief from severe bone pain postoperatively.

1. Operative Note - Soft Tissue and Bone Erosion Debridement with Percutaneous Radiofrequency Ablation for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion debridement with percutaneous radiofrequency ablation for severe bone pain in the spine. The eroded tissues and bone were meticulously excised, and percutaneous radiofrequency ablation was applied to target and alleviate severe bone pain. The patient reported relief from severe bone pain postoperatively.

2. Operative Note - Soft Tissue and Bone Erosion Repair with Tendon Transfer for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion repair with tendon transfer for severe bone pain in the hand. The eroded tissues and bone were debrided, and a tendon transfer procedure was performed to restore optimal hand function and alleviate severe bone pain. The patient reported significant improvement in severe bone pain postoperatively.

3. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft, Accompanied by Ligament Reconstruction for Severe Bone Pain:

The patient underwent a surgical intervention that included soft tissue reconstruction with flap and bone graft, accompanied by ligament reconstruction for severe bone pain in the ankle joint. A local flap was designed and elevated, and a bone graft was obtained from the patient's fibula. Ligament reconstruction techniques were employed to address the underlying cause of severe bone pain. The patient experienced relief from severe bone pain postoperatively.

4. Operative Note - Soft Tissue and Bone Erosion Debridement with Microvascular Decompression for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion debridement with microvascular decompression for severe bone pain in the facial region. The eroded tissues and bone were meticulously excised, and microvascular decompression was performed to alleviate pressure on the affected nerves. The patient reported relief from severe bone pain postoperatively.

5. Operative Note - Soft Tissue and Bone Erosion Excision with Autologous Chondrocyte Implantation for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion excision with autologous chondrocyte implantation for severe bone pain in the knee joint. The eroded tissues and bone were meticulously excised, and autologous chondrocytes were implanted to restore damaged cartilage and alleviate severe bone pain. The patient reported relief from severe bone pain postoperatively.

6. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft, Accompanied by Joint Resurfacing for Severe Bone Pain:

The patient underwent a surgical intervention that included soft tissue reconstruction with flap and bone graft, accompanied by joint resurfacing for severe bone pain in the hip joint. A local flap was designed and elevated, and a bone graft was obtained from the patient's iliac crest. Joint resurfacing techniques were employed to address the underlying cause of severe bone pain. The patient experienced relief from severe bone pain postoperatively.

7. Operative Note - Soft Tissue and Bone Erosion Debridement with Intra-articular Injection for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion debridement with intra-articular injection for severe bone pain in the shoulder joint. The eroded tissues and bone were meticulously excised, and an intra-articular injection was administered to provide targeted pain relief. The patient reported relief from severe bone pain postoperatively.

8. Operative Note - Soft Tissue and Bone Erosion Repair with Capsular Release for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion repair with capsular release for severe bone

pain in the elbow joint. The eroded tissues and bone were debrided, and a capsular release procedure was performed to alleviate joint stiffness and severe bone pain. The patient reported significant improvement in severe bone pain postoperatively.

9. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft, Accompanied by Nerve Transposition for Severe Bone Pain:

The patient underwent a surgical intervention that included soft tissue reconstruction with flap and bone graft, accompanied by nerve transposition for severe bone pain in the upper limb. A local flap was designed and elevated, and a bone graft was obtained from the patient's radius. Nerve transposition was performed to alleviate pressure on affected nerves and relieve severe bone pain. The patient experienced relief from severe bone pain postoperatively.

10. Operative Note - Soft Tissue and Bone Erosion Debridement with Percutaneous Vertebroplasty for Severe Bone Pain:

A surgical intervention was performed, involving soft tissue and bone erosion debridement with percutaneous vertebroplasty for severe bone pain in the thoracic spine. The eroded tissues and bone were meticulously excised, and percutaneous vertebroplasty was performed to stabilize the affected vertebrae and alleviate severe bone pain. The patient reported relief from severe bone pain postoperatively.

1. Operative Note - Debridement and Drainage with Arthroscopic Intervention for Severe Joint Infection:

The patient presented with a severe infection in the extreme moving joint. A surgical intervention was performed, involving debridement and drainage with arthroscopic intervention. The infected tissues were meticulously debrided, and the joint was thoroughly irrigated. The patient received appropriate antibiotic therapy postoperatively to control the infection and was provided with follow-up instructions.

2. Operative Note - Soft Tissue Reconstruction with Flap and Joint Washout for Severe Joint Infection:

A patient with severe infection on the extreme moving joint underwent a surgical intervention. Soft tissue reconstruction with flap and joint washout was performed. The infected tissues were excised, and a local flap was designed and elevated to cover the exposed area. The joint was thoroughly washed out to remove the infectious material. The patient was administered appropriate intravenous antibiotics to combat the infection.

3. Operative Note - Joint Exploration with Extensive Debridement and Antibiotic Spacer Placement for Severe Joint Infection:

In the setting of a severe infection on the extreme moving joint, a joint exploration procedure was performed. Extensive debridement was carried out to remove infected tissues, and an antibiotic spacer was placed to maintain joint space and deliver localized antibiotics. The patient received appropriate intravenous antibiotics and was closely monitored for infection control and subsequent joint reconstruction.

4. Operative Note - Joint Irrigation and Debridement with Temporary External Fixation for Severe Joint Infection:

The patient presented with severe infection on the extreme moving joint requiring surgical intervention. Joint irrigation and debridement were performed to remove infected tissues and cleanse the joint. Temporary external fixation was applied to stabilize the joint and facilitate healing. The patient received intravenous antibiotics and was scheduled for follow-up to assess the response to treatment.

5. Operative Note - Joint Washout with Synovectomy and Antibiotic Impregnated Cement Spacer for Severe Joint Infection:

A patient with severe infection on the extreme moving joint underwent a joint washout procedure. Synovectomy was performed to remove infected synovial tissue, and an antibiotic impregnated cement spacer was inserted to deliver localized antibiotics. The patient received intravenous antibiotics and was closely monitored for infection resolution and subsequent joint reconstruction.

6. Operative Note - Joint Debridement with Irrigation and Closed Suction Drain Placement for Severe Joint Infection:

The patient presented with a severe infection on the extreme moving joint, necessitating surgical intervention. Joint debridement was performed to remove infected tissues, followed by thorough irrigation. A closed suction drain was placed to promote drainage and prevent further accumulation of infectious material. The patient was started on appropriate antibiotic therapy to combat the infection.

7. Operative Note - Joint Lavage with Antimicrobial Solution and Resection of Infected Tissues for Severe Joint Infection:

A surgical intervention was performed for a patient with severe infection on the extreme moving joint. Joint lavage was performed using an antimicrobial solution to cleanse the joint thoroughly. Infected tissues were resected to eliminate the source of infection. The patient received intravenous antibiotics and was closely monitored for infection control and subsequent joint reconstruction.

8. Operative Note - Joint Explantation with Spacer Placement and Soft Tissue Reconstruction for Severe Joint Infection:

The patient presented with severe infection on the extreme moving joint, necessitating joint explantation. The infected joint prosthesis was removed, and an antibiotic spacer was placed. Soft tissue reconstruction was performed to address the damaged tissues. The patient received intravenous antibiotics and was scheduled for subsequent joint reconstruction.

9. Operative Note - Joint Arthrotomy with Debridement and Vacuum-Assisted Closure for Severe Joint Infection:

A surgical intervention was performed for a patient

with severe infection on the extreme moving joint. Joint arthrotomy was performed to gain access to the infected area, followed by meticulous debridement. Vacuum-assisted closure was applied to promote wound healing. The patient received appropriate intravenous antibiotics and was closely monitored for infection resolution.

10. Operative Note - Joint Washout with Antibiotic Irrigation and Application of Negative Pressure Wound Therapy for Severe Joint Infection:

In the setting of severe infection on the extreme moving joint, a joint washout procedure was performed. The joint was thoroughly irrigated with antibiotic solution, and negative pressure wound therapy was applied to enhance wound healing and infection control. The patient received intravenous antibiotics and was closely monitored for resolution of the joint infection.

1. Operative Note - Inflammation Control with Corticosteroid Injection for Severe Joint Inflammation:

The patient presented with severe inflammation in the extreme moving joint. A surgical intervention was performed, involving inflammation control with a corticosteroid injection. The joint was carefully accessed, and a corticosteroid solution was injected to alleviate the inflammation. The patient was provided with postoperative instructions and scheduled for follow-up to monitor the response to treatment.

2. Operative Note - Joint Debridement with Synovectomy for Severe Inflammatory Joint Disease:

In the presence of severe inflammatory joint disease, a surgical intervention was performed. Joint debridement was carried out to remove inflamed tissues and alleviate symptoms. Synovectomy was performed to excise the inflamed synovial lining. The patient received appropriate postoperative care and was scheduled for further management of the underlying inflammatory condition.

3. Operative Note - Joint Lavage with Saline Irrigation for Severe Joint Inflammation:

A patient presented with severe joint inflammation, necessitating surgical intervention. Joint lavage was performed using a saline irrigation solution to cleanse the joint and reduce inflammation. The joint was meticulously irrigated to remove inflammatory mediators and debris. The patient received postoperative care instructions and was advised to continue appropriate anti-inflammatory therapy.

4. Operative Note - Joint Arthroscopy with Intra-articular Steroid Injection for Severe Inflammatory Arthritis:

The patient underwent a surgical intervention for severe inflammatory arthritis affecting the extreme moving joint. Joint arthroscopy was performed to visualize the joint and identify the inflamed areas. An intra-articular steroid injection was administered to provide targeted anti-inflammatory treatment. The patient was given postoperative instructions and recommended to follow up for further management of the underlying condition.

5. Operative Note - Joint Synovial Biopsy for Severe Inflammatory Joint Disorder:

A patient with severe inflammatory joint disorder underwent a surgical intervention. Joint synovial biopsy was performed to obtain a tissue sample for pathological examination and accurate diagnosis of the underlying inflammatory condition. The patient was provided with postoperative care instructions and referred to a rheumatologist for further management.

6. Operative Note - Joint Irrigation and Debridement with Biologic Anti-inflammatory Agent Injection for Severe Joint Inflammation:

A surgical intervention was performed for severe joint inflammation. Joint irrigation and debridement were carried out to remove inflammatory debris and optimize joint function. A biologic anti-inflammatory agent was injected intra-articularly to provide targeted anti-inflammatory treatment. The patient received postoperative care instructions and was scheduled for follow-up to assess the response to treatment.

7. Operative Note - Joint Capsular Release for Severe Inflammatory Capsulitis:

The patient presented with severe inflammatory capsulitis affecting the extreme moving joint. A surgical intervention was performed, involving joint capsular release. The tight and inflamed joint capsule was released to improve joint mobility and alleviate symptoms. The patient was instructed on postoperative care and referred to physical therapy for rehabilitation.

8. Operative Note - Joint Arthroplasty for Severe Inflammatory Joint Disease:

A patient with severe inflammatory joint disease underwent joint arthroplasty. The inflamed joint surfaces were replaced with prosthetic components to alleviate pain and improve joint function. The patient received postoperative care instructions and was scheduled for follow-up to monitor the response to surgery and manage the underlying inflammatory condition.

9. Operative Note - Joint Synovectomy with Cryotherapy for Severe Inflammatory Joint Disorder:

A surgical intervention was performed for a patient with severe inflammatory joint disorder. Joint synovectomy was carried out to remove the inflamed synovial tissue, and cryotherapy was applied to further reduce inflammation and provide pain relief. The patient was provided with postoperative care instructions and recommended to continue appropriate anti

-inflammatory therapy.

10. Operative Note - Joint Bursectomy for Severe Inflammatory Bursitis:

In the presence of severe inflammatory bursitis affecting the extreme moving joint, a surgical intervention was performed. Joint bursectomy was carried out to excise the inflamed bursa and alleviate symptoms. The patient received appropriate postoperative care and was advised on anti-inflammatory measures to manage the condition effectively.

1. Operative Note - Soft Tissue Excision with Skin Graft for Severe Soft Tissue Disorder:

A surgical intervention was performed, involving the excision of severely affected soft tissues and subsequent skin grafting. The patient was informed that the duration and frequency of follow-up visits would depend on the severity of the diagnosis and the progress of the healing process. They were advised to schedule a follow-up appointment in 1 week for wound assessment and evaluation of graft viability.

2. Operative Note - Joint Arthroscopy with Cartilage Debridement for Severe Cartilage Disorder:

The patient underwent a joint arthroscopy procedure for severe cartilage disorder. During the procedure, cartilage debridement was performed to remove damaged tissue. The patient was informed that the postoperative follow-up visits would be scheduled based on the severity of the cartilage disorder and the rate of recovery. They were instructed to contact the clinic if there were any concerns or worsening symptoms.

3. Operative Note - Soft Tissue Repair with Tendon Reconstruction for Severe Soft Tissue Disorder:

A surgical intervention was performed, involving soft tissue repair with tendon reconstruction for a severe soft tissue disorder. The patient was advised that the frequency of follow-up appointments would be determined based on the severity of the condition and the progress of the healing process. They were instructed to schedule a follow-up visit in 2 weeks to assess the surgical outcome and discuss further rehabilitation options.

4. Operative Note - Joint Stabilization Procedure for Severe Joint Instability:

The patient underwent a joint stabilization procedure for severe joint instability. The postoperative follow-up visits would be scheduled based on the severity of the joint instability and the patient's response to the procedure. They were instructed to contact the clinic if they experienced any significant changes in symptoms or if there were concerns during the recovery period.

5. Operative Note - Soft Tissue Reconstruction with Flap and Bone Graft for Severe Soft Tissue Disorder:

A surgical intervention was performed, involving soft tissue reconstruction with flap and bone graft for a severe soft tissue disorder. The patient was informed that the frequency and duration of follow-up visits would depend on the severity of the condition and the success of the surgical reconstruction. They were advised to schedule a follow-up appointment in 3 weeks for wound evaluation and monitoring of graft integration.

6. Operative Note - Joint Fusion for Severe Joint Degeneration:

The patient underwent joint fusion surgery for severe joint degeneration. The frequency of follow-up visits would be determined based on the severity of the degeneration and the patient's recovery progress. They were instructed to schedule a follow-up appointment in 6 weeks for radiographic evaluation and assessment of fusion success.

7. Operative Note - Soft Tissue Debridement and Antibiotic Therapy for Severe Infectious Soft Tissue Disorder:

A surgical intervention was performed, involving soft tissue debridement and initiation of antibiotic therapy for a severe infectious soft tissue disorder. The patient was informed that the duration and frequency of follow-up visits would depend on the severity of the infection and the response to treatment. They were advised to schedule a follow-up appointment in 1 week for wound assessment and adjustment of antibiotic therapy if necessary.

8. Operative Note - Joint Resurfacing Procedure for Severe Joint Arthritis:

The patient underwent a joint resurfacing procedure for severe joint arthritis. The frequency and duration of follow-up visits would be determined based on the severity of the arthritis and the patient's recovery progress. They were instructed to schedule a follow-up appointment in 4 weeks for clinical assessment, pain evaluation, and monitoring of joint function.

9. Operative Note - Soft Tissue Release for Severe Contracture Disorder:

A surgical intervention was performed, involving soft tissue release for severe contracture disorder. The patient was informed that the frequency of follow-up appointments would be determined based on the severity of the contracture and the response to the release procedure. They were advised to schedule a follow-up visit in 2 weeks for range of motion assessment and evaluation of the release outcome.

10. Operative Note - Joint Reconstruction for Severe Joint Trauma:

The patient underwent joint reconstruction surgery for severe joint trauma. The postoperative follow-up visits would be scheduled based on the severity of the trauma and the patient's recovery progress. They were instructed to contact the clinic if they experienced any significant changes in symptoms or if there were concerns during the healing and rehabilitation period.

## M75.0 Adhesive capsulitis of shoulder

1. Operative Note - Arthroscopic Capsular Release: A 5mm arthroscopic incision was made, followed by capsular release using electrocautery. Adhesions were meticulously dissected, and range of motion improved. Hemostasis was ensured, and the incision closed in layers. Post-op instructions given.

2. Operative Note - Manipulation Under Anesthesia: Patient was placed under anesthesia, and shoulder joint was gently manipulated to break up adhesions. Range of motion significantly improved. No complications observed. Patient instructed on post-op care.

3. Operative Note - Hydrodilatation: Shoulder joint was injected with saline solution under fluoroscopic guidance. The fluid distended the capsule, stretching and breaking up adhesions. Patient experienced immediate improvement in range of motion. No complications encountered.

4. Operative Note - Open Capsular Release: A standard deltopectoral approach was used to expose the shoulder joint. Capsule was incised, adhesions meticulously released, and thorough hemostasis achieved. Closure performed in layers. Post-op care instructions provided.

5. Operative Note - Physical Therapy-Assisted Manipulation: Patient underwent manipulation of the shoulder joint with the assistance of a physical therapist. Adhesions were disrupted, leading to enhanced range of motion. Patient tolerated the procedure well and received post-op rehabilitation guidelines.

6. Operative Note - Closed Manipulation: Patient was placed under anesthesia, and the shoulder was manipulated to loosen adhesions. Range of motion significantly improved. No complications encountered. Patient educated on post-op care.

7. Operative Note - Tenotomy: A small incision was made, and the biceps tendon was identified. Tenotomy was performed to release adhesions. Hemostasis was secured, and the incision closed. Patient provided with post-op instructions.

8. Operative Note - Arthroscopic Debridement: Arthroscopic access was gained through two small incisions. Adhesions were meticulously removed, and joint surfaces inspected for any pathologies. Hemostasis achieved, and incisions closed. Post-op care discussed.

9. Operative Note - Manipulation Under Ultrasound Guidance: Shoulder joint was manipulated under ultrasound guidance to disrupt adhesions. Improved range of motion observed. No complications noted. Patient informed about post-op care.

10. Operative Note - Distention Arthrography: Shoulder joint was injected with a contrast agent under fluoroscopic guidance. The distention aided in breaking up adhesions. Patient experienced immediate improvement in range of motion. Post-op care instructions given.

1. Operative Note - Subacromial Decompression: A standard arthroscopic approach was used to access the subacromial space. Adhesions were released, and the subacromial bursa was decompressed. Any impinging structures were addressed. Hemostasis achieved, and incisions closed. Patient instructed on post-op care.

2. Operative Note - Heat Therapy-Assisted Manipulation: Patient received localized heat therapy to the shoulder joint before manipulation. Adhesions were disrupted, and range of motion improved. No complications observed. Post-op rehabilitation guidelines provided.

3. Operative Note - Arthroscopic Rotator Interval Release: Arthroscopic portals were established, and the rotator interval was visualized. Adhesions were meticulously released, allowing for improved mobility. Hemostasis obtained, and incisions closed. Post-op care discussed.

4. Operative Note - Acromioclavicular Joint Distraction: The acromioclavicular joint was distracted using a specialized device. Adhesions were stretched and broken, resulting in enhanced range of motion. Patient educated on post-op care.

5. Operative Note - Ultrasound-Guided Intra-articular Injection: An ultrasound-guided needle was used to inject corticosteroids into the affected shoulder joint. Adhesions were targeted and inflammation reduced. Patient instructed on post-injection care.

6. Operative Note - Manipulation with Joint Mobilization Techniques: Patient underwent manual manipulation of the shoulder joint combined with joint mobilization techniques. Adhesions were disrupted, and joint mobility improved. No complications encountered. Post-op care guidelines given.

7. Operative Note - Intra-articular Distraction with Balloon Arthroplasty: A balloon device was inserted into the shoulder joint and inflated to create intra-articular distraction. Adhesions were loosened, enhancing range of motion. Patient provided with post-op instructions.

8. Operative Note - Extra-articular Release: An extra-articular approach was employed to release adhesions. Fascial layers were dissected, and adhesions meticulously released. Hemostasis ensured, and incisions closed. Post-op care discussed.

9. Operative Note - Percutaneous Needle Tenotomy: Multiple percutaneous needle tenotomies were performed to release adhesions. Precise needle placement achieved, and adhesions disrupted. Patient informed about post-op care.

10. Operative Note - Electrotherapy-Assisted Manipulation: Patient received electrotherapy to the shoulder joint before manipulation. Adhesions were disrupted, resulting in improved range of motion. No complications noted. Post-op rehabilitation guidelines provided.

1. Operative Note - Arthroscopic Capsular Release with General Anesthesia: Under general anesthesia, a 5mm arthroscopic incision was made, followed by capsular release using electrocautery. Adhesions were meticulously dissected, and range of motion improved. Hemostasis was ensured, and the incision closed in layers. Post-op instructions given.

2. Operative Note - Manipulation Under Anesthesia with Light Sedation: Patient received light sedation, and the shoulder joint was gently manipulated to break up adhesions. Range of motion significantly improved. No complications observed. Patient instructed on post-op care.

3. Operative Note - Hydrodilatation with Local Anesthesia: Shoulder joint was injected with saline solution under fluoroscopic guidance using local anesthesia. The fluid distended the capsule, stretching and breaking up adhesions. Patient experienced immediate improvement in range of motion. No complications encountered.

4. Operative Note - Open Capsular Release with Regional Anesthesia: Using regional anesthesia, a standard deltopectoral approach was used to expose the shoulder joint. Capsule was incised, adhesions meticulously released, and thorough hemostasis achieved. Closure performed in layers. Post-op care instructions provided.

5. Operative Note - Physical Therapy-Assisted Manipulation with Moderate Sedation: Patient underwent manipulation of the shoulder joint with the assistance of a physical therapist under moderate sedation. Adhesions were disrupted, leading to enhanced range of motion. Patient tolerated the procedure well and received post-op rehabilitation guidelines.

6. Operative Note - Closed Manipulation with Deep Sedation: Patient received deep sedation, and the shoulder was manipulated to loosen adhesions. Range of motion significantly improved. No complications encountered. Patient educated on post-op care.

7. Operative Note - Tenotomy with Local Anesthesia: Under local anesthesia, a small incision was made, and the biceps tendon was identified. Tenotomy was performed to release adhesions. Hemostasis was secured, and the incision closed. Patient provided with post-op instructions.

8. Operative Note - Arthroscopic Debridement with General Anesthesia: Under general anesthesia, arthroscopic access was gained through two small incisions. Adhesions were meticulously removed, and joint surfaces inspected for any pathologies. Hemostasis achieved, and incisions closed. Post-op care discussed.

9. Operative Note - Manipulation Under Ultrasound Guidance with Moderate Sedation: Shoulder joint was manipulated under ultrasound guidance with moderate sedation to disrupt adhesions. Improved range of motion observed. No complications noted. Patient informed about post-op care.

10. Operative Note - Distention Arthrography with Local Anesthesia: Shoulder joint was injected with a contrast agent under fluoroscopic guidance using local anesthesia. The distention aided in breaking up adhesions. Patient experienced immediate improvement in range of motion. Post-op care instructions given.

1. Operative Note - Arthroscopic Capsular Release with Bone Erosion: Under general anesthesia, a 5mm arthroscopic incision was made. Intraoperatively, bone erosion was noted. Capsular release was performed using electrocautery, and adhesions meticulously dissected. Bone erosion areas were addressed, and thorough hemostasis achieved. Incision closed in layers. Post-op instructions given.

2. Operative Note - Manipulation Under Anesthesia with Severe Bone Erosion: Patient received general anesthesia, and the shoulder joint was manipulated. Severe bone erosion was observed intraoperatively. Adhesions were disrupted, and range of motion improved. Bone erosion areas addressed. No complications observed. Post-op care discussed.

3. Operative Note - Open Capsular Release with Bone Erosion: Under regional anesthesia, a standard deltopectoral approach was used. Intraoperatively, bone erosion was noted. Capsule incised, adhesions released, and bone erosion areas addressed. Thorough hemostasis achieved. Closure performed in layers. Post-op care instructions provided.

4. Operative Note - Arthroscopic Debridement with Bone Erosion: Under general anesthesia, arthroscopic access gained through small incisions. Adhesions meticulously removed, and bone erosion areas identified. Debridement performed, addressing both adhesions and bone erosion. Hemostasis achieved, and incisions closed. Post-op care discussed.

5. Operative Note - Manipulation with Joint Mobilization Techniques and Bone Erosion: Patient underwent manual manipulation of the shoulder joint combined with joint mobilization techniques. Intraoperatively, bone erosion was noted. Adhesions disrupted, and range of motion improved. Bone erosion areas addressed. No complications encountered. Post-op care guidelines given.

6. Operative Note - Arthroscopic Rotator Interval Release with Bone Erosion: Arthroscopic portals established, and the rotator interval visualized. Adhesions meticulously released, addressing bone erosion areas. Improved mobility observed. Hemostasis obtained, and incisions closed. Post-op care discussed.

7. Operative Note - Physical Therapy-Assisted Manipulation with Moderate Sedation and Bone Erosion: Patient underwent manipulation with the assistance of a physical therapist under moderate sedation. Intraoperatively, bone erosion was observed. Adhesions disrupted, and range of motion improved. Bone erosion areas addressed. Patient tolerated the procedure well and received post-op rehabilitation guidelines.

8. Operative Note - Tenotomy with Bone Erosion: Under local anesthesia, a small incision made, and the biceps tendon identified. Tenotomy performed to release adhesions, addressing bone erosion areas. Hemostasis secured, and the incision closed. Patient provided with post-op instructions.

9. Operative Note - Distention Arthrography with Bone Erosion: Shoulder joint injected with a contrast agent under fluoroscopic guidance. Bone erosion observed. The distention aided in breaking up adhesions and addressed bone erosion areas. Immediate improvement in range of motion noted. Post-op care instructions given.

10. Operative Note - Hydrodilatation with Local Anesthesia and Bone Erosion: Shoulder joint injected with saline solution under fluoroscopic guidance using local anesthesia. Bone erosion areas identified. The fluid distended the capsule, stretching adhesions, and addressed bone erosion. Patient experienced immediate improvement in range of motion. No complications encountered.

1. Operative Note - Arthroscopic Capsular Release with Severe Bone Pain: Under general anesthesia, a 5mm arthroscopic incision was made. Intraoperatively, severe bone pain was noted. Capsular release was performed using electrocautery, meticulously dissecting adhesions. Bone pain areas were addressed and explored. Thorough hemostasis achieved, and incision closed. Post-op instructions given.

2. Operative Note - Manipulation Under Anesthesia with Severe Bone Pain: Patient received general anesthesia, and the shoulder joint was gently manipulated. Severe bone pain was observed intraoperatively. Adhesions were disrupted, and range of motion improved. Bone pain areas addressed and explored. No complications observed. Post-op care discussed.

3. Operative Note - Open Capsular Release with Severe Bone Pain: Under regional anesthesia, a standard deltopectoral approach was used. Intraoperatively, severe bone pain was noted. Capsule incised, adhesions released, and bone pain areas addressed and explored. Thorough hemostasis achieved. Closure performed in layers. Post-op care instructions provided.

4. Operative Note - Arthroscopic Debridement with Severe Bone Pain: Under general anesthesia, arthroscopic access gained through small incisions. Adhesions meticulously removed, and severe bone pain areas identified. Debridement performed, addressing both adhesions and bone pain. Hemostasis achieved, and incisions closed. Post-op care discussed.

5. Operative Note - Manipulation with Joint Mobilization Techniques and Severe Bone Pain: Patient underwent manual manipulation of the shoulder joint combined with joint mobilization techniques. Intraoperatively, severe bone pain was noted. Adhesions disrupted, and range of motion improved. Bone pain areas addressed and explored. No complications encountered. Post-op care guidelines given.

6. Operative Note - Arthroscopic Rotator Interval Release with Severe Bone Pain: Arthroscopic portals established, and the rotator interval visualized. Adhesions meticulously released, addressing severe bone pain areas. Improved mobility observed. Hemostasis obtained, and incisions closed. Post-op care discussed.

7. Operative Note - Physical Therapy-Assisted Manipulation with Moderate Sedation and Severe Bone Pain: Patient underwent manipulation with the assistance of a physical therapist under moderate sedation. Intraoperatively, severe bone pain was observed. Adhesions disrupted, and range of motion improved. Bone pain areas addressed and explored. Patient tolerated the procedure well and received post-op rehabilitation guidelines.

8. Operative Note - Tenotomy with Severe Bone Pain: Under local anesthesia, a small incision made, and the biceps tendon identified. Tenotomy performed to release adhesions, addressing severe bone pain areas. Hemostasis secured, and the incision closed. Patient provided with post-op instructions.

9. Operative Note - Distention Arthrography with Severe Bone Pain: Shoulder joint injected with a contrast agent under fluoroscopic guidance. Severe bone pain observed. The distention aided in breaking up adhesions and addressed severe bone pain areas. Immediate improvement in range of motion noted. Post-op care instructions given.

10. Operative Note - Hydrodilatation with Local Anesthesia and Severe Bone Pain: Shoulder joint injected with saline solution under fluoroscopic guidance using local anesthesia. Severe bone pain areas identified. The fluid distended the capsule, stretching adhesions, and addressed severe bone pain. Patient experienced immediate improvement in range of motion. No complications encountered.

1. Operative Note - Arthroscopic Capsular Release with Surgical Intervention: Under general anesthesia, a 5mm arthroscopic incision was made. Intraoperatively, severe adhesive capsulitis was observed, necessitating a surgical intervention. Capsular release was performed using electrocautery, meticulously dissecting adhesions. Surgical intervention involved excision of fibrotic tissue. Thorough hemostasis achieved, and incision closed. Post-op instructions given.

2. Operative Note - Manipulation Under Anesthesia with Surgical Intervention: Patient received general anesthesia, and the shoulder joint was gently manipulated. Intraoperatively, extensive adhesions were encountered, requiring a surgical intervention. Adhesions were disrupted, and range of motion improved. Surgical intervention involved the removal of fibrotic tissue and scar release. No complications observed. Post-op care discussed.

3. Operative Note - Open Capsular Release with Surgical Intervention: Under regional anesthesia, a standard deltopectoral approach was used. Intraoperatively, severe adhesive capsulitis with contracture was identified, necessitating a surgical intervention. Capsule incised, adhesions released, and surgical intervention involved capsular reconstruction and repair. Thorough hemostasis achieved. Closure performed in layers. Post-op care instructions provided.

4. Operative Note - Arthroscopic Debridement with Surgical Intervention: Under general anesthesia, arthroscopic access gained through small incisions. Intraoperatively, extensive adhesions and fibrotic tissue were encountered, requiring a surgical intervention. Adhesions meticulously removed, and surgical intervention involved thorough debridement of fibrotic tissue and joint surface smoothing. Hemostasis achieved, and incisions closed. Post-op care discussed.

5. Operative Note - Manipulation with Joint Mobilization Techniques and Surgical Intervention: Patient underwent manual manipulation of the shoulder joint combined with joint mobilization techniques. Intraoperatively, severe adhesive capsulitis with joint contracture was observed, necessitating a surgical intervention. Adhesions disrupted, and range of motion improved. Surgical intervention involved the release of scar tissue and joint capsule reconstruction. No complications encountered. Post-op care guidelines given.

6. Operative Note - Arthroscopic Rotator Interval Release with Surgical Intervention: Arthroscopic portals established, and the rotator interval visualized. Intraoperatively, extensive adhesions and fibrosis were identified, requiring a surgical intervention. Adhesions meticulously released, and surgical intervention involved the removal of fibrotic tissue and joint capsule reconstruction. Improved mobility observed. Hemostasis obtained, and incisions closed. Post-op care discussed.

7. Operative Note - Physical Therapy-Assisted Manipulation with Moderate Sedation and Surgical Intervention: Patient underwent manipulation with the assistance of a physical therapist under moderate sedation. Intraoperatively, severe adhesive capsulitis with fibrotic contracture was observed, necessitating a surgical intervention. Adhesions disrupted, and range of motion improved. Surgical intervention involved fibrotomy and scar tissue release. Patient tolerated the procedure well and received post-op rehabilitation guidelines.

8. Operative Note - Tenotomy with Surgical Intervention: Under local anesthesia, a small incision made, and the biceps tendon identified. Tenotomy performed to release adhesions, but extensive fibrotic tissue was encountered, requiring a surgical intervention. Surgical intervention involved meticulous fibrotomy and tendon repair. Hemostasis secured, and the incision closed. Patient provided with post-op instructions.

9. Operative Note - Distention Arthrography with Surgical Intervention: Shoulder joint injected with a contrast agent under fluoroscopic guidance. Severe adhesive capsulitis with fibrotic contracture and joint surface irregularities identified, necessitating a surgical intervention. The dist

ention aided in breaking up adhesions, and surgical intervention involved capsular reconstruction and joint surface smoothing. Immediate improvement in range of motion noted. Post-op care instructions given.

10. Operative Note - Hydrodilatation with Local Anesthesia and Surgical Intervention: Shoulder joint injected with saline solution under fluoroscopic guidance using local anesthesia. Extensive adhesions and fibrotic tissue encountered, requiring a surgical intervention. The fluid distended the capsule, facilitating the surgical intervention involving meticulous adhesiolysis and joint capsule reconstruction. Patient experienced immediate improvement in range of motion. No complications encountered.

1. Operative Note - Arthroscopic Release and Capsular Reconstruction with Surgical Intervention: Under general anesthesia, arthroscopic access was gained through small incisions. Intraoperatively, severe adhesive capsulitis with joint instability was observed, necessitating a surgical intervention. Adhesions were meticulously released, and surgical intervention involved capsular reconstruction using graft material. Hemostasis achieved, and incisions closed. Post-op care instructions provided.

2. Operative Note - Manipulation Under Anesthesia with Surgical Intervention and Capsular Plication: Patient received general anesthesia, and the shoulder joint was manipulated. Intraoperatively, significant capsular laxity and adhesions were encountered, requiring a surgical intervention. Adhesions disrupted, and range of motion improved. Surgical intervention involved capsular plication to address laxity. No complications observed. Post-op care discussed.

3. Operative Note - Open Capsular Release with Surgical Intervention and Rotator Cuff Repair: Under regional anesthesia, a standard deltopectoral approach was used. Intraoperatively, severe adhesive capsulitis with rotator cuff tear was identified, necessitating a surgical intervention. Capsule incised, adhesions released, and surgical intervention involved both capsular reconstruction and rotator cuff repair. Thorough hemostasis achieved. Closure performed in layers. Post-op care instructions provided.

4. Operative Note - Arthroscopic Debridement and Subacromial Decompression with Surgical Intervention: Under general anesthesia, arthroscopic access gained through small incisions. Intraoperatively, severe adhesive capsulitis with subacromial impingement was observed, necessitating a surgical intervention. Adhesions meticulously removed, and surgical intervention involved debridement of fibrotic tissue and subacromial decompression. Hemostasis achieved, and incisions closed. Post-op care discussed.

5. Operative Note - Manipulation with Superior Capsular Reconstruction and Surgical Intervention: Patient underwent manual manipulation of the shoulder joint combined with joint mobilization techniques. Intraoperatively, severe adhesive capsulitis with massive rotator cuff tear and superior capsule deficiency was observed, necessitating a surgical intervention. Adhesions disrupted, and range of motion improved. Surgical intervention involved superior capsular reconstruction and rotator cuff repair. No complications encountered. Post-op care guidelines given.

6. Operative Note - Arthroscopic Rotator Interval Release and Bankart Repair with Surgical Intervention: Arthroscopic portals established, and the rotator interval visualized. Intraoperatively, severe adhesive capsulitis with anterior instability was identified, necessitating a surgical intervention. Adhesions meticulously released, and surgical intervention involved rotator interval release and Bankart repair. Improved mobility observed. Hemostasis obtained, and incisions closed. Post-op care discussed.

7. Operative Note - Physical Therapy-Assisted Manipulation with Moderate Sedation, Surgical Intervention, and Labral Repair: Patient underwent manipulation with the assistance of a physical therapist under moderate sedation. Intraoperatively, severe adhesive capsulitis with labral tear was observed, necessitating a surgical intervention. Adhesions disrupted, and range of motion improved. Surgical intervention involved labral repair and capsular reconstruction. Patient tolerated the procedure well and received post-op rehabilitation guidelines.

8. Operative Note - Tenotomy with Surgical Intervention and Tendon Transfer: Under local anesthesia, a small incision made, and the biceps tendon identified. Tenotomy performed to release adhesions, but extensive fibrotic tissue and tendon rupture were encountered, necessitating a surgical intervention. Surgical intervention involved tendon transfer and meticulous adhesiolysis. Hemostasis secured, and the incision closed. Patient provided with post-op instructions.

9. Operative Note - Distention Arthro

graphy with Surgical Intervention and Joint Resurfacing: Shoulder joint injected with a contrast agent under fluoroscopic guidance. Severe adhesive capsulitis with extensive joint surface erosion was identified, necessitating a surgical intervention. The distention aided in breaking up adhesions, and surgical intervention involved joint resurfacing and capsular reconstruction. Immediate improvement in range of motion noted. Post-op care instructions given.

10. Operative Note - Hydrodilatation with Local Anesthesia and Surgical Intervention with Joint Stabilization: Shoulder joint injected with saline solution under fluoroscopic guidance using local anesthesia. Extensive adhesions and joint instability encountered, requiring a surgical intervention. The fluid distended the capsule, facilitating the surgical intervention involving capsular reconstruction and joint stabilization. Patient experienced immediate improvement in range of motion. No complications encountered.

1. Operative Note - Arthroscopic Debridement with Surgical Intervention for Severe Infection: Under general anesthesia, arthroscopic access was gained through small incisions. Intraoperatively, a severe infection was observed on the extreme moving joint. Adhesions and infected tissue were meticulously removed. Surgical intervention involved thorough debridement, irrigation, and placement of antibiotic beads. Hemostasis achieved, and incisions closed. Post-op care included intravenous antibiotics.

2. Operative Note - Open Joint Exploration and Debridement with Surgical Intervention for Severe Infection: Under general anesthesia, a standard surgical approach was used to access the extreme moving joint. Intraoperatively, a severe infection was encountered. Joint exploration and debridement were performed, addressing infected tissue and purulent material. Surgical intervention involved extensive irrigation and placement of a drainage system. Thorough hemostasis achieved. Post-op care included intravenous antibiotics and wound care.

3. Operative Note - Joint Aspiration with Surgical Intervention for Severe Infection: Under local anesthesia, the extreme moving joint was aspirated. Intraoperatively, a severe infection was noted. Aspiration was performed to obtain fluid samples for culture and sensitivity. Surgical intervention involved thorough irrigation, debridement, and placement of a drainage system. Hemostasis secured, and incision closed. Post-op care included intravenous antibiotics and regular follow-up.

4. Operative Note - Joint Lavage and Irrigation with Surgical Intervention for Severe Infection: Under general anesthesia, the extreme moving joint was lavaged and irrigated. Intraoperatively, a severe infection was identified. Lavage and irrigation were performed using a sterile saline solution. Surgical intervention involved debridement of infected tissue and placement of a drainage system. Thorough hemostasis achieved. Post-op care included intravenous antibiotics and wound care.

5. Operative Note - Joint Reconstruction with Surgical Intervention for Severe Infection: Under general anesthesia, surgical reconstruction of the extreme moving joint was performed. Intraoperatively, a severe infection was observed. Surgical intervention involved removal of infected tissue, reconstruction of damaged structures, and placement of antibiotic-impregnated material. Thorough hemostasis achieved, and incisions closed. Post-op care included intravenous antibiotics and close monitoring for signs of infection.

6. Operative Note - Joint Fusion with Surgical Intervention for Severe Infection: Under general anesthesia, joint fusion of the extreme moving joint was performed. Intraoperatively, a severe infection was encountered. Surgical intervention involved removal of infected tissue, fusion of the joint, and placement of antibiotic-impregnated material. Thorough hemostasis achieved, and incisions closed. Post-op care included intravenous antibiotics and immobilization of the joint.

7. Operative Note - Joint Resection and Arthroplasty with Surgical Intervention for Severe Infection: Under general anesthesia, joint resection and arthroplasty of the extreme moving joint were performed. Intraoperatively, a severe infection was noted. Surgical intervention involved resection of infected tissue, placement of a prosthetic joint, and antibiotic-impregnated material. Thorough hemostasis achieved, and incisions closed. Post-op care included intravenous antibiotics and rehabilitation.

8. Operative Note - Joint Stabilization with Surgical Intervention for Severe Infection: Under general anesthesia, joint stabilization of the extreme moving joint was performed. Intraoperatively, a severe infection was identified. Surgical intervention involved removal of infected tissue, repair of damaged ligaments, and placement of antibiotic-impregnated material. Thorough hemostasis achieved, and incisions closed. Post-op care included intravenous antibiotics and immobilization of the joint.

9. Operative Note - Joint Salvage Procedure with

Surgical Intervention for Severe Infection: Under general anesthesia, a joint salvage procedure was performed on the extreme moving joint. Intraoperatively, a severe infection was encountered. Surgical intervention involved extensive debridement of infected tissue, irrigation, and placement of antibiotic-impregnated material. Thorough hemostasis achieved, and incisions closed. Post-op care included intravenous antibiotics and wound care.

10. Operative Note - Joint Amputation with Surgical Intervention for Severe Infection: Under general anesthesia, joint amputation of the extreme moving joint was performed. Intraoperatively, a severe infection was observed. Surgical intervention involved removal of infected tissue, bone resection, and closure of the incision. Thorough hemostasis achieved. Post-op care included intravenous antibiotics, pain management, and rehabilitation planning.

1. Operative Note - Arthroscopic Synovectomy with Surgical Intervention for Severe Inflammation: Under general anesthesia, arthroscopic access was gained through small incisions. Intraoperatively, severe inflammation of the joint was observed. Synovectomy was performed, meticulously removing inflamed synovial tissue. Surgical intervention involved thorough irrigation and placement of anti-inflammatory agents. Hemostasis achieved, and incisions closed. Post-op care included anti-inflammatory medication and rehabilitation.

2. Operative Note - Open Joint Debridement with Surgical Intervention for Severe Inflammation: Under general anesthesia, a standard surgical approach was used to access the joint. Intraoperatively, severe inflammation was encountered. Debridement was performed to remove inflamed and necrotic tissue. Surgical intervention involved irrigation, application of anti-inflammatory agents, and drainage placement. Thorough hemostasis achieved. Post-op care included anti-inflammatory medication and wound care.

3. Operative Note - Joint Aspiration with Surgical Intervention for Severe Inflammation: Under local anesthesia, the joint was aspirated. Intraoperatively, severe inflammation was noted. Aspiration was performed to obtain fluid samples for analysis and relieve intra-articular pressure. Surgical intervention involved irrigation, application of anti-inflammatory agents, and placement of a drainage system. Hemostasis secured, and incision closed. Post-op care included anti-inflammatory medication and regular follow-up.

4. Operative Note - Joint Lavage and Irrigation with Surgical Intervention for Severe Inflammation: Under general anesthesia, the joint was lavaged and irrigated. Intraoperatively, severe inflammation was identified. Lavage and irrigation were performed using a sterile solution to remove inflammatory mediators and debris. Surgical intervention involved debridement of inflamed tissue and placement of anti-inflammatory agents. Thorough hemostasis achieved. Post-op care included anti-inflammatory medication and wound care.

5. Operative Note - Joint Resurfacing with Surgical Intervention for Severe Inflammation: Under general anesthesia, joint resurfacing of the affected joint was performed. Intraoperatively, severe inflammation and cartilage damage were observed. Surgical intervention involved the removal of damaged tissue, joint surface smoothing, and application of anti-inflammatory agents. Thorough hemostasis achieved, and incisions closed. Post-op care included anti-inflammatory medication and rehabilitation.

6. Operative Note - Joint Reconstruction with Surgical Intervention for Severe Inflammation: Under general anesthesia, surgical reconstruction of the joint was performed. Intraoperatively, severe inflammation and ligament instability were noted. Surgical intervention involved removal of inflamed tissue, ligament repair or reconstruction, and application of anti-inflammatory agents. Thorough hemostasis achieved, and incisions closed. Post-op care included anti-inflammatory medication and rehabilitation.

7. Operative Note - Joint Fusion with Surgical Intervention for Severe Inflammation: Under general anesthesia, joint fusion of the affected joint was performed. Intraoperatively, severe inflammation and joint instability were encountered. Surgical intervention involved removal of inflamed tissue, joint fusion, and application of anti-inflammatory agents. Thorough hemostasis achieved, and incisions closed. Post-op care included anti-inflammatory medication and immobilization of the joint.

8. Operative Note - Joint Resection and Arthroplasty with Surgical Intervention for Severe Inflammation: Under general anesthesia, joint resection and arthroplasty were performed. Intraoperatively, severe inflammation and joint surface erosion were observed. Surgical intervention involved removal of inflamed tissue, joint resurfacing with prosthetic components, and application of anti-inflammatory agents. Thorough hemostasis achieved, and incisions closed. Post-op care included anti-inflammatory medication and rehabilitation.

9. Operative Note - Joint Stabilization with Surgical Intervention for

Severe Inflammation: Under general anesthesia, joint stabilization of the affected joint was performed. Intraoperatively, severe inflammation and ligament laxity were identified. Surgical intervention involved removal of inflamed tissue, ligament repair or reconstruction, and application of anti-inflammatory agents. Thorough hemostasis achieved, and incisions closed. Post-op care included anti-inflammatory medication and immobilization of the joint.

10. Operative Note - Joint Salvage Procedure with Surgical Intervention for Severe Inflammation: Under general anesthesia, a joint salvage procedure was performed on the affected joint. Intraoperatively, severe inflammation and joint damage were encountered. Surgical intervention involved removal of inflamed tissue, joint debridement, and application of anti-inflammatory agents. Thorough hemostasis achieved, and incisions closed. Post-op care included anti-inflammatory medication and rehabilitation planning.

1. Operative Note - Arthroscopic Debridement with Surgical Intervention: Under general anesthesia, arthroscopic access was gained through small incisions. Intraoperatively, extensive adhesive capsulitis and fibrotic tissue were observed. Surgical intervention involved meticulous debridement and removal of adhesions. Thorough irrigation performed. Post-op care instructions provided, with follow-up appointments scheduled based on the severity of the diagnosis.

2. Operative Note - Open Capsular Release with Surgical Intervention: Under regional anesthesia, a standard deltopectoral approach was used. Intraoperatively, severe adhesive capsulitis with limited range of motion was identified. Surgical intervention involved capsular release and joint mobilization. Hemostasis achieved, and incisions closed. Post-op care discussed, with the frequency of follow-up appointments determined based on the severity of the diagnosis.

3. Operative Note - Manipulation Under Anesthesia with Surgical Intervention: Patient received general anesthesia, and the shoulder joint was manipulated. Intraoperatively, significant capsular tightness and restricted range of motion were encountered. Surgical intervention involved capsular release and joint mobilization. Patient provided post-op care instructions, with follow-up appointments scheduled based on the severity of the diagnosis.

4. Operative Note - Joint Lavage and Synovectomy with Surgical Intervention: Under general anesthesia, the affected joint was lavaged and synovectomy performed. Intraoperatively, severe inflammation and synovial hypertrophy were observed. Surgical intervention involved thorough irrigation and removal of inflamed synovial tissue. Hemostasis achieved, and incisions closed. Post-op care discussed, with follow-up appointments determined based on the severity of the diagnosis.

5. Operative Note - Joint Fusion with Surgical Intervention: Under general anesthesia, joint fusion of the affected joint was performed. Intraoperatively, severe joint instability and pain were encountered. Surgical intervention involved joint preparation, fixation, and fusion. Post-op care instructions provided, with follow-up appointments scheduled based on the severity of the diagnosis.

6. Operative Note - Joint Resurfacing and Cartilage Repair with Surgical Intervention: Under general anesthesia, joint resurfacing and cartilage repair were performed. Intraoperatively, severe cartilage damage and joint inflammation were observed. Surgical intervention involved debridement, cartilage restoration procedures, and application of regenerative therapies. Post-op care discussed, with follow-up appointments determined based on the severity of the diagnosis.

7. Operative Note - Tendon Transfer with Surgical Intervention: Under regional anesthesia, a small incision was made, and the affected tendon identified. Intraoperatively, severe tendon degeneration and dysfunction were encountered. Surgical intervention involved tendon transfer and repair. Hemostasis secured, and the incision closed. Post-op care instructions provided, with follow-up appointments scheduled based on the severity of the diagnosis.

8. Operative Note - Joint Reconstruction with Surgical Intervention: Under general anesthesia, surgical reconstruction of the affected joint was performed. Intraoperatively, severe joint instability and functional impairment were noted. Surgical intervention involved removal of damaged tissue, ligament repair or reconstruction, and joint stabilization. Post-op care discussed, with follow-up appointments determined based on the severity of the diagnosis.

9. Operative Note - Joint Salvage Procedure with Surgical Intervention: Under general anesthesia, a joint salvage procedure was performed on the affected joint. Intraoperatively, severe joint damage and functional limitations were encountered. Surgical intervention involved debridement, joint preservation techniques, and application of regenerative therapies. Post-op care instructions provided, with follow-up appointments scheduled based on the severity of the diagnosis.

10. Operative Note - Joint Replacement with Surgical Intervention: Under general anesthesia, joint replacement surgery was performed. Intraoperatively, severe joint degeneration and chronic pain

were observed. Surgical intervention involved removal of the damaged joint surfaces and placement of a prosthetic joint. Post-op care discussed, with follow-up appointments determined based on the severity of the diagnosis.

## M75.1 Rotator cuff syndrome

1. Patient presented with symptoms consistent with rotator cuff syndrome, including shoulder pain, weakness, and limited range of motion. Physical examination revealed positive impingement signs and weakness in abduction and external rotation. Diagnosis confirmed by MRI, which demonstrated partial-thickness tear in supraspinatus tendon. Patient scheduled for arthroscopic rotator cuff repair.

2. Operative note: Arthroscopic rotator cuff repair performed on patient with chronic rotator cuff syndrome. Subacromial decompression performed to alleviate impingement. Torn supraspinatus tendon identified and repaired using suture anchors. Acromioplasty performed to ensure proper subacromial space. Postoperatively, patient was placed in a sling for comfort and instructed to begin physical therapy after a two-week period.

3. Operative note: Patient underwent open rotator cuff repair for symptomatic rotator cuff syndrome. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon. Tendon edges were mobilized and repaired using transosseous sutures. Subacromial decompression performed to eliminate impingement. Closure completed with absorbable sutures. Patient's arm immobilized in a shoulder abduction brace for six weeks postoperatively.

4. Operative note: Mini-open rotator cuff repair performed on patient with chronic rotator cuff syndrome. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon. Torn edges were debrided and repaired using double-row suture anchor technique. Acromioplasty performed to address subacromial impingement. Closure achieved with absorbable sutures. Patient initiated passive range of motion exercises immediately postoperatively.

5. Operative note: Arthroscopic subacromial decompression performed on patient with rotator cuff syndrome and impingement. Acromioplasty performed to enlarge the subacromial space. Acromial spur identified and resected using a burr. Bursal tissue debrided to improve tendon mobility. Closure achieved with absorbable sutures. Postoperatively, patient advised to begin a guided rehabilitation program to restore shoulder function.

6. Operative note: Patient with recurrent rotator cuff syndrome underwent revision arthroscopic rotator cuff repair. Intraoperatively, a retear of the supraspinatus tendon was identified. Previous anchors removed, and freshened tendon edges were repaired using a double-row suture anchor technique. Adhesions and scar tissue were carefully excised. Postoperatively, patient was placed in a shoulder immobilizer and referred for aggressive rehabilitation.

7. Operative note: Patient presented with acute rotator cuff syndrome following trauma. Open rotator cuff repair performed due to significant full-thickness tear in the teres minor tendon. Tendon edges mobilized and repaired with non-absorbable sutures. Subacromial decompression and acromioplasty performed to address impingement. Patient's arm immobilized in a shoulder abduction brace postoperatively. Rehabilitation initiated after six weeks.

8. Operative note: Patient underwent arthroscopic rotator cuff repair for chronic rotator cuff syndrome. Intraoperatively, multiple partial-thickness tears were identified in the supraspinatus and infraspinatus tendons. Tears were debrided and repaired using suture anchors. Acromioplasty performed to eliminate subacromial impingement. Closure achieved with absorbable sutures. Patient advised to commence physical therapy after a brief immobilization period.

9. Operative note: Mini-open rotator cuff repair performed on patient with symptomatic rotator cuff syndrome. Intraoperatively, a large full-thickness tear was identified in the subscapularis tendon. T

endon edges mobilized and repaired using suture anchors. Subacromial decompression and acromioplasty performed to alleviate impingement. Closure completed with absorbable sutures. Patient placed in a shoulder sling and started passive range of motion exercises.

10. Operative note: Patient presented with chronic rotator cuff syndrome and underwent arthroscopic rotator cuff repair. Intraoperatively, a massive tear involving all four rotator cuff tendons was identified. Tendon edges debrided and repaired using double-row suture anchor technique. Acromioplasty performed to address impingement. Closure achieved with absorbable sutures. Patient placed in an abduction brace postoperatively and referred for a prolonged rehabilitation program.

1. Operative note: Patient with rotator cuff syndrome underwent mini-open rotator cuff repair. Intraoperatively, a small tear was identified in the supraspinatus tendon. Torn edges were debrided and repaired using single-row suture anchors. Subacromial decompression performed to alleviate impingement. Closure achieved with absorbable sutures. Patient advised to initiate a progressive rehabilitation program after a brief period of immobilization.

2. Operative note: Arthroscopic subacromial decompression performed on patient with rotator cuff syndrome and associated biceps tendinitis. Acromioplasty performed to address subacromial impingement. Biceps tenotomy performed to relieve tension on the tendon. Bursal tissue debrided, and closure achieved with absorbable sutures. Postoperatively, patient prescribed pain management and instructed to begin gentle range of motion exercises.

3. Operative note: Revision arthroscopic rotator cuff repair performed on patient with recurrent rotator cuff syndrome. Intraoperatively, a retear of the supraspinatus tendon was identified. Tendon edges carefully debrided and repaired using a modified Mason-Allen technique. Adhesions and scar tissue meticulously excised. Postoperatively, patient immobilized in a shoulder sling and scheduled for aggressive physical therapy.

4. Operative note: Patient with rotator cuff syndrome underwent arthroscopic partial repair. Intraoperatively, a large tear involving the anterior portion of the supraspinatus tendon was identified. Torn edges debrided, and partial repair performed using suture anchors. Acromioplasty performed to address subacromial impingement. Closure achieved with absorbable sutures. Postoperatively, patient advised to initiate a progressive rehabilitation program.

5. Operative note: Open rotator cuff repair performed on patient with massive rotator cuff syndrome. Intraoperatively, full-thickness tears were observed in all rotator cuff tendons. Tendon edges mobilized and repaired using double-row suture anchor technique. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient's arm immobilized in a shoulder brace postoperatively.

6. Operative note: Arthroscopic rotator cuff repair performed on patient with degenerative rotator cuff syndrome. Intraoperatively, a small-to-medium-sized tear was identified in the supraspinatus tendon. Torn edges debrided and repaired using single-row suture anchor technique. Subacromial decompression performed to alleviate impingement. Closure achieved with absorbable sutures. Patient instructed to start a guided rehabilitation program after a period of immobilization.

7. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff repair. Intraoperatively, a medium-sized tear was identified in the subscapularis tendon. Tendon edges mobilized and repaired using suture anchors. Acromioplasty performed to address subacromial impingement. Closure achieved with absorbable sutures. Patient placed in a shoulder immobilizer for six weeks postoperatively.

8. Operative note: Arthroscopic subacromial decompression and distal clavicle excision performed on patient with rotator cuff syndrome and associated AC joint arthritis. Acromioplasty performed to alleviate subacromial impingement. Distal clavicle resected to relieve AC joint pain. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient prescribed pain medication and advised to commence range of motion exercises.

9. Operative note: Patient underwent arthro

scopic rotator cuff repair for acute traumatic rotator cuff syndrome. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon. Tendon edges mobilized and repaired using suture anchors. Subacromial decompression performed to address impingement. Closure achieved with absorbable sutures. Patient's arm immobilized in a shoulder sling for a period of six weeks.

10. Operative note: Mini-open rotator cuff repair performed on patient with rotator cuff syndrome and associated adhesive capsulitis. Intraoperatively, a moderate-sized tear was identified in the infraspinatus tendon. Torn edges debrided and repaired using suture anchors. Manipulation under anesthesia performed to address the adhesive capsulitis. Closure achieved with absorbable sutures. Postoperatively, patient referred for intensive physical therapy.

1. Operative note: Arthroscopic rotator cuff repair performed under general anesthesia on patient with chronic rotator cuff syndrome. Intraoperatively, a small tear was identified in the supraspinatus tendon. Tendon edges debrided and repaired using suture anchors. Subacromial decompression performed. Closure achieved with absorbable sutures. Patient tolerated the procedure well with 1% lidocaine used for local anesthesia during the subacromial injection.

2. Operative note: Patient underwent mini-open rotator cuff repair under regional anesthesia for rotator cuff syndrome. Intraoperatively, a moderate-sized tear was identified in the infraspinatus tendon. Torn edges repaired using suture anchors. Acromioplasty performed to address subacromial impingement. Closure achieved with absorbable sutures. Patient remained comfortable throughout the procedure with the administration of 20 ml of 0.5% bupivacaine for regional anesthesia.

3. Operative note: Revision arthroscopic rotator cuff repair performed on patient under combined spinal-epidural anesthesia for recurrent rotator cuff syndrome. Intraoperatively, a retear of the supraspinatus tendon was identified. Tendon edges debrided and repaired using a modified Mason-Allen technique. Acromioplasty performed. Closure achieved with absorbable sutures. Patient remained sedated throughout the procedure with continuous infusion of 0.2% ropivacaine via epidural catheter.

4. Operative note: Arthroscopic subacromial decompression performed on patient with rotator cuff syndrome under local anesthesia with sedation. Acromioplasty performed to alleviate subacromial impingement. Closure achieved with absorbable sutures. Patient received 30 ml of 1% lidocaine for local anesthesia in the subacromial space and remained calm and comfortable with the administration of intravenous midazolam and fentanyl for sedation.

5. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff repair under general anesthesia. Intraoperatively, a large tear involving the anterior portion of the supraspinatus tendon was identified. Torn edges debrided and repaired using suture anchors. Acromioplasty performed. Closure achieved with absorbable sutures. Patient received 1.5 mg/kg of propofol and 100 mcg of fentanyl for induction and was maintained on sevoflurane and remifentanil during the procedure.

6. Operative note: Open rotator cuff repair performed on patient with massive rotator cuff syndrome under general anesthesia. Intraoperatively, full-thickness tears were observed in all rotator cuff tendons. Tendon edges mobilized and repaired using double-row suture anchor technique. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient received a total intravenous anesthesia (TIVA) technique with propofol and remifentanil infusion throughout the procedure.

7. Operative note: Patient underwent arthroscopic rotator cuff repair under regional anesthesia with intravenous sedation for chronic rotator cuff syndrome. Intraoperatively, a medium-sized tear was identified in the subscapularis tendon. Tendon edges mobilized and repaired using suture anchors. Acromioplasty performed. Closure achieved with absorbable sutures. Patient received an interscalene nerve block with 20 ml of 0.5% bupivacaine for regional anesthesia and remained relaxed with intermittent doses of intravenous midazolam

.

8. Operative note: Arthroscopic subacromial decompression and distal clavicle excision performed on patient with rotator cuff syndrome under general anesthesia. Acromioplasty performed to address subacromial impingement. Distal clavicle resected. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient received 1 mcg/kg of fentanyl and 2 mg/kg of propofol for induction followed by maintenance with sevoflurane and remifentanil infusion.

9. Operative note: Patient with acute traumatic rotator cuff syndrome underwent arthroscopic rotator cuff repair under local anesthesia with intravenous sedation. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon. Tendon edges mobilized and repaired using suture anchors. Subacromial decompression performed. Closure achieved with absorbable sutures. Patient received 40 ml of 1% lidocaine for local anesthesia and remained relaxed and pain-free with intravenous midazolam and fentanyl.

10. Operative note: Mini-open rotator cuff repair performed on patient with rotator cuff syndrome under general anesthesia. Intraoperatively, a small-to-medium-sized tear was identified in the infraspinatus tendon. Torn edges debrided and repaired using suture anchors. Acromioplasty performed. Closure achieved with absorbable sutures. Patient received 1 mcg/kg of fentanyl and 1.5 mg/kg of propofol for induction and was maintained on sevoflurane and remifentanil infusion throughout the procedure.

1. Operative note: Arthroscopic rotator cuff repair performed on patient with rotator cuff syndrome and significant bone erosion. Intraoperatively, a large tear involving the supraspinatus tendon was identified, accompanied by erosion of the greater tuberosity. Tendon edges debrided and repaired using suture anchors. Bone grafting performed to address the bone defect. Closure achieved with absorbable sutures. Patient advised to follow an extended rehabilitation program.

2. Operative note: Patient with chronic rotator cuff syndrome and extensive bone erosion underwent mini-open rotator cuff repair. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon, associated with erosion of the humeral head. Tendon edges mobilized and repaired using suture anchors. Bone grafting performed to reconstruct the humeral head defect. Closure achieved with absorbable sutures. Patient immobilized in a shoulder brace postoperatively.

3. Operative note: Revision arthroscopic rotator cuff repair performed on patient with recurrent rotator cuff syndrome and severe bone erosion. Intraoperatively, retears were observed in multiple tendons, accompanied by significant erosion of the greater tuberosity. Tendon edges debrided and repaired using suture anchors. Bone augmentation performed using allograft material to reconstruct the eroded bone. Closure achieved with absorbable sutures. Patient referred for intensive postoperative rehabilitation.

4. Operative note: Arthroscopic subacromial decompression performed on patient with rotator cuff syndrome and bone erosion. Erosion of the acromion and subacromial space was identified on imaging. Acromioplasty performed to address subacromial impingement and restore the subacromial anatomy. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient advised to initiate a guided rehabilitation program to manage the underlying bone erosion.

5. Operative note: Patient with chronic rotator cuff syndrome and extensive bone erosion underwent open rotator cuff repair. Intraoperatively, full-thickness tears were identified in multiple tendons, accompanied by substantial erosion of the humeral head. Tendon edges mobilized and repaired using suture anchors. Bone grafting performed to reconstruct the humeral head defect. Closure achieved with absorbable sutures. Patient's arm immobilized in a shoulder brace for a prolonged period.

6. Operative note: Arthroscopic rotator cuff repair performed on patient with rotator cuff syndrome and bone erosion at the insertion site. Intraoperatively, a small-to-medium-sized tear was identified in the subscapularis tendon, associated with erosion of the lesser tuberosity. Torn edges debrided and repaired using suture anchors. Bone grafting performed to reconstruct the eroded area. Closure achieved with absorbable sutures. Patient instructed to follow an extended rehabilitation program.

7. Operative note: Patient with acute traumatic rotator cuff syndrome and bone erosion underwent mini-open rotator cuff repair. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon, accompanied by erosion of the greater tuberosity. Tendon edges debrided and repaired using suture anchors. Bone grafting performed to reconstruct the eroded area. Closure achieved with absorbable sutures. Patient immobilized in a shoulder sling and referred for comprehensive rehabilitation.

8. Operative note: Arthroscopic subacromial decompression performed on patient with rotator cuff syndrome and significant bone erosion. Erosion of the acromion and subacromial space observed on imaging. Acromioplasty performed to address impingement and restore normal

anatomy. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient prescribed pain management and initiated gentle range of motion exercises, considering the underlying bone erosion.

9. Operative note: Patient with chronic rotator cuff syndrome and bone erosion underwent mini-open rotator cuff repair. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon, accompanied by erosion of the greater tuberosity. Tendon edges mobilized and repaired using suture anchors. Bone grafting performed to reconstruct the eroded bone. Closure achieved with absorbable sutures. Patient placed in a shoulder immobilizer for an extended period postoperatively.

10. Operative note: Revision arthroscopic rotator cuff repair performed on patient with recurrent rotator cuff syndrome and bone erosion. Intraoperatively, retears were observed in multiple tendons, accompanied by significant erosion of the humeral head. Tendon edges debrided and repaired using suture anchors. Bone grafting performed to reconstruct the eroded bone and enhance the repair. Closure achieved with absorbable sutures. Patient referred for intensive postoperative rehabilitation, considering the bone erosion.

1. Operative note: Arthroscopic rotator cuff repair performed on patient with rotator cuff syndrome and severe bone pain. Intraoperatively, a large tear involving the supraspinatus tendon was identified, accompanied by significant bone spurs and subacromial bursitis. Tendon edges debrided and repaired using suture anchors. Subacromial decompression and acromioplasty performed to address impingement. Closure achieved with absorbable sutures. Patient prescribed postoperative analgesics to manage severe bone pain.

2. Operative note: Patient with chronic rotator cuff syndrome and severe bone pain underwent mini-open rotator cuff repair. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon, associated with extensive bone spurs and acromioclavicular joint arthritis. Tendon edges mobilized and repaired using suture anchors. Subacromial decompression and distal clavicle excision performed to alleviate pain. Closure achieved with absorbable sutures. Patient advised to follow a comprehensive rehabilitation program for pain management.

3. Operative note: Revision arthroscopic rotator cuff repair performed on patient with recurrent rotator cuff syndrome and severe bone pain. Intraoperatively, retears were observed in multiple tendons, accompanied by significant bone erosion and subacromial bursitis. Tendon edges debrided and repaired using a double-row suture anchor technique. Bone grafting performed to address the bone defects. Closure achieved with absorbable sutures. Patient referred for intensive postoperative pain management and rehabilitation.

4. Operative note: Arthroscopic subacromial decompression performed on patient with rotator cuff syndrome and severe bone pain. Erosion of the acromion and subacromial space was identified on imaging, contributing to the pain. Acromioplasty performed to alleviate impingement and restore the subacromial anatomy. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient prescribed postoperative analgesics and instructed to initiate a guided rehabilitation program for pain relief.

5. Operative note: Patient with chronic rotator cuff syndrome and severe bone pain underwent open rotator cuff repair. Intraoperatively, full-thickness tears were identified in multiple tendons, accompanied by substantial bone spurs and acromioclavicular joint degeneration. Tendon edges mobilized and repaired using suture anchors. Subacromial decompression, acromioplasty, and distal clavicle excision performed to address the underlying pathology. Closure achieved with absorbable sutures. Patient's arm immobilized and prescribed strong analgesics for severe bone pain management.

6. Operative note: Arthroscopic rotator cuff repair performed on patient with rotator cuff syndrome and severe bone pain at the insertion site. Intraoperatively, a small-to-medium-sized tear was identified in the subscapularis tendon, associated with significant bone spurs and subcoracoid impingement. Torn edges debrided and repaired using suture anchors. Subcoracoid decompression performed to alleviate impingement. Closure achieved with absorbable sutures. Patient advised to follow a comprehensive rehabilitation program for pain relief.

7. Operative note: Patient with acute traumatic rotator cuff syndrome and severe bone pain underwent mini-open rotator cuff repair. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon, accompanied by extensive bone spurs and subacromial bursitis. Tendon edges debrided and repaired using suture anchors. Subacromial

decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient prescribed postoperative analgesics and referred for intensive pain management and rehabilitation.

8. Operative note: Arthroscopic subacromial decompression performed on patient with rotator cuff syndrome and severe bone pain. Erosion of the acromion and subacromial space observed on imaging, contributing to the pain. Acromioplasty performed to address impingement and alleviate bone-related pain. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient instructed to initiate a guided rehabilitation program and prescribed appropriate analgesics for severe bone pain management.

9. Operative note: Patient with chronic rotator cuff syndrome and severe bone pain underwent mini-open rotator cuff repair. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon, accompanied by significant bone spurs and acromioclavicular joint arthrosis. Tendon edges mobilized and repaired using suture anchors. Subacromial decompression and distal clavicle excision performed to alleviate pain. Closure achieved with absorbable sutures. Patient referred for specialized pain management and rehabilitation.

10. Operative note: Revision arthroscopic rotator cuff repair performed on patient with recurrent rotator cuff syndrome and severe bone pain. Intraoperatively, retears were observed in multiple tendons, accompanied by extensive bone erosion, subacromial bursitis, and acromioclavicular joint degeneration. Tendon edges debrided and repaired using suture anchors. Bone grafting performed to address the bone defects. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for intensive postoperative pain management and comprehensive rehabilitation.

1. Operative note: Arthroscopic rotator cuff repair with augmentation performed on patient with rotator cuff syndrome. Intraoperatively, a large tear involving the supraspinatus tendon was identified. Tendon edges debrided and repaired using suture anchors, and augmentation performed using a dermal allograft patch. Subacromial decompression and acromioplasty performed to address impingement. Closure achieved with absorbable sutures. Patient advised to follow a guided rehabilitation program for optimal recovery.

2. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff repair with biceps tenodesis. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon. Tendon edges mobilized and repaired using suture anchors, and biceps tenodesis performed to stabilize the long head of the biceps tendon. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient instructed to follow a comprehensive rehabilitation program.

3. Operative note: Revision arthroscopic rotator cuff repair with biological augmentation performed on patient with recurrent rotator cuff syndrome. Intraoperatively, retears were observed in multiple tendons. Tendon edges debrided and repaired using suture anchors, and augmentation performed using a platelet-rich plasma injection. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for intensive postoperative rehabilitation to optimize the surgical outcome.

4. Operative note: Arthroscopic subacromial decompression with debridement and repair performed on patient with rotator cuff syndrome. Intraoperatively, subacromial impingement and bursal tissue inflammation were observed. Subacromial decompression performed to address impingement, and debridement and repair of the torn tendon performed using suture anchors. Closure achieved with absorbable sutures. Patient advised to initiate a guided rehabilitation program for optimal recovery.

5. Operative note: Patient with chronic rotator cuff syndrome underwent open rotator cuff repair with superior capsular reconstruction. Intraoperatively, full-thickness tears were identified in multiple tendons. Tendon edges mobilized and repaired using suture anchors, and superior capsular reconstruction performed using an autograft. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient immobilized in a shoulder brace postoperatively.

6. Operative note: Arthroscopic rotator cuff repair with tendon transfer performed on patient with rotator cuff syndrome. Intraoperatively, a small-to-medium-sized tear was identified in the subscapularis tendon. Torn edges debrided and repaired using suture anchors, and a tendon transfer from the teres minor was performed to reinforce the repair. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient instructed to follow a comprehensive rehabilitation program.

7. Operative note: Patient with acute traumatic rotator cuff syndrome underwent mini-open rotator cuff repair with Latarjet procedure. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon. Tendon edges debrided and repaired using suture anchors, and a Latarjet procedure performed to stabilize the shoulder joint. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for specialized postoperative rehabilitation.

8. Operative note: Arthroscopic subacromial decompression with distal clavicle excision performed

on patient with rotator cuff syndrome. Erosion of the acromion and subacromial space observed on imaging. Subacromial decompression performed to address impingement, and distal clavicle excision performed to alleviate pain. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient prescribed postoperative pain management and initiated a guided rehabilitation program.

9. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff repair with deltoid flap augmentation. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon. Tendon edges mobilized and repaired using suture anchors, and deltoid flap augmentation performed to reinforce the repair. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for specialized rehabilitation for optimal recovery.

10. Operative note: Revision arthroscopic rotator cuff repair with allograft augmentation performed on patient with recurrent rotator cuff syndrome. Intraoperatively, retears were observed in multiple tendons. Tendon edges debrided and repaired using suture anchors, and augmentation performed using an allograft patch. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for intensive postoperative rehabilitation to optimize the surgical outcome.

1. Operative note: Arthroscopic rotator cuff repair with superior labral repair performed on patient with rotator cuff syndrome and concomitant labral tear. Intraoperatively, a large tear involving the supraspinatus tendon was identified. Tendon edges debrided and repaired using suture anchors, and superior labral repair performed to address the labral pathology. Closure achieved with absorbable sutures. Patient advised to follow a comprehensive rehabilitation program for optimal recovery.

2. Operative note: Patient with chronic rotator cuff syndrome underwent open rotator cuff repair with tenotomy and tenodesis of the long head of the biceps tendon. Intraoperatively, full-thickness tears were identified in multiple tendons. Tendon edges mobilized and repaired using suture anchors, and tenotomy and tenodesis of the biceps tendon performed to alleviate pain and improve function. Closure achieved with absorbable sutures. Patient immobilized in a shoulder brace postoperatively.

3. Operative note: Revision arthroscopic rotator cuff repair with patch augmentation performed on patient with recurrent rotator cuff syndrome and compromised tissue quality. Intraoperatively, retears were observed in multiple tendons. Tendon edges debrided and repaired using suture anchors, and patch augmentation performed using a dermal allograft. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for specialized postoperative rehabilitation.

4. Operative note: Arthroscopic subacromial decompression with distal clavicle resection performed on patient with rotator cuff syndrome and acromioclavicular joint osteoarthritis. Erosion of the acromion and subacromial space observed on imaging. Subacromial decompression performed to address impingement, and distal clavicle resection performed to alleviate pain and improve joint mobility. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient prescribed postoperative pain management and initiated a guided rehabilitation program.

5. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff repair with allograft augmentation. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon. Tendon edges mobilized and repaired using suture anchors, and augmentation performed using an allograft to reinforce the repair. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for specialized rehabilitation for optimal recovery.

6. Operative note: Arthroscopic rotator cuff repair with arthroscopic capsular release performed on patient with rotator cuff syndrome and associated adhesive capsulitis. Intraoperatively, a small-to-medium-sized tear was identified in the subscapularis tendon. Torn edges debrided and repaired using suture anchors, and arthroscopic capsular release performed to address the capsular tightness. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient instructed to follow a comprehensive rehabilitation program.

7. Operative note: Patient with acute traumatic rotator cuff syndrome underwent open rotator cuff repair with allograft reconstruction. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon. Tendon edges debrided and repaired using suture anchors, and allograft reconstruction performed to bridge the tissue defect. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for specialized postoperative rehabilitation.

8. Operative note: Arthro

scopic subacromial decompression with biceps tenodesis performed on patient with rotator cuff syndrome and concomitant long head of the biceps tendon pathology. Erosion of the acromion observed on imaging. Subacromial decompression performed to address impingement, and biceps tenodesis performed to alleviate pain and improve function. Bursal tissue debrided, and closure achieved with absorbable sutures. Patient prescribed postoperative pain management and initiated a guided rehabilitation program.

9. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff repair with acromioclavicular joint resection. Intraoperatively, a medium-sized tear was identified in the infraspinatus tendon. Tendon edges mobilized and repaired using suture anchors, and acromioclavicular joint resection performed to address joint degeneration and alleviate pain. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for specialized rehabilitation.

10. Operative note: Revision arthroscopic rotator cuff repair with tendon transfer performed on patient with recurrent rotator cuff syndrome and compromised tendon quality. Intraoperatively, retears were observed in multiple tendons. Tendon edges debrided and repaired using suture anchors, and a tendon transfer from the latissimus dorsi performed to reinforce the repair. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for intensive postoperative rehabilitation.

1. Operative note: Surgical debridement and irrigation performed on a patient with rotator cuff syndrome and severe infection in the extreme moving joint. Intraoperatively, purulent fluid and necrotic tissue were encountered. Thorough debridement and irrigation performed to remove infected material. Cultures obtained for pathogen identification. Wound left open for secondary intention healing. Intravenous antibiotics initiated, and patient referred to infectious disease specialist for further management.

2. Operative note: Emergency arthroscopic lavage and drainage performed on a patient with rotator cuff syndrome and severe infection in the extreme moving joint. Intraoperatively, pus accumulation and synovial inflammation observed. Joint washed out using sterile saline, and copious irrigation performed to remove infected material. Antibiotic solution instilled intra-articularly. Wound closed with sutures, and patient started on a course of intravenous antibiotics.

3. Operative note: Open surgical exploration and debridement performed on a patient with rotator cuff syndrome and severe infection in the extreme moving joint. Intraoperatively, purulent material and necrotic tissue encountered within the joint space. Extensive debridement performed, removing infected tissue and foreign bodies. Copious irrigation with antibiotic solution performed. Wound left open, and patient initiated on broad-spectrum intravenous antibiotics.

4. Operative note: Arthroscopic debridement and synovectomy performed on a patient with rotator cuff syndrome and severe infection in the extreme moving joint. Intraoperatively, synovial hypertrophy and pus accumulation noted. Synovium extensively debrided and removed. Joint washed out with antibiotic solution. Wound closed with sutures, and patient started on a targeted intravenous antibiotic regimen.

5. Operative note: Open joint irrigation and implant removal performed on a patient with rotator cuff syndrome and severe infection in the extreme moving joint. Intraoperatively, infected joint fluid and loosening of previous implants observed. Implants removed, joint thoroughly irrigated, and infected tissues debrided. Wound left open for secondary intention healing. Patient started on a combination of intravenous and oral antibiotics.

6. Operative note: Repeat open surgical debridement and washout performed on a patient with rotator cuff syndrome and recurrent severe infection in the extreme moving joint. Intraoperatively, pus accumulation and necrotic tissue encountered. Extensive debridement performed, and joint irrigated with antibiotic solution. Implantable antibiotic beads placed for local delivery. Wound closed with sutures, and patient initiated on a prolonged course of intravenous antibiotics.

7. Operative note: Emergency arthroscopic lavage and debridement performed on a patient with rotator cuff syndrome and acute severe infection in the extreme moving joint. Intraoperatively, purulent joint fluid and synovial inflammation noted. Joint extensively irrigated, and infected tissues debrided. Antibiotic solution instilled intra-articularly. Wound closed with sutures, and patient commenced on intravenous antibiotics.

8. Operative note: Open surgical exploration and joint washout performed on a patient with rotator cuff syndrome and severe infection in the extreme moving joint. Intraoperatively, presence of pus and necrotic tissue within the joint cavity observed. Joint washed out with sterile saline and antibiotic solution. Infected tissues debrided. Wound left open, and patient started on intravenous antibiotics targeting the identified pathogens.

9. Operative note: Arthroscopic debridement and synovectomy performed on a patient with rotator cuff syndrome and chronic severe infection in the extreme moving joint. Intraoperatively, hypertrophic syn

ovium and purulent material encountered. Synovium extensively debrided and removed. Copious irrigation with antibiotic solution performed. Wound closed with sutures, and patient initiated on a prolonged course of intravenous antibiotics.

10. Operative note: Repeat open surgical debridement and joint washout performed on a patient with rotator cuff syndrome and persistent severe infection in the extreme moving joint. Intraoperatively, presence of purulent material and necrotic tissue observed. Thorough debridement performed, and joint irrigated with antibiotic solution. Implantable antibiotic beads placed. Wound left open, and patient referred to an infectious disease specialist for further management.

1. Operative note: Arthroscopic rotator cuff repair performed on a patient with rotator cuff syndrome and mild inflammatory changes. Intraoperatively, minimal synovial inflammation observed. Tendon edges mobilized and repaired using suture anchors. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient instructed to follow a guided rehabilitation program for optimal recovery.

2. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff repair with subacromial bursectomy. Intraoperatively, significant bursal tissue inflammation observed. Bursal tissue debrided and removed, and tendon edges repaired using suture anchors. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for specialized rehabilitation.

3. Operative note: Revision arthroscopic rotator cuff repair performed on a patient with recurrent rotator cuff syndrome and moderate inflammatory changes. Intraoperatively, mild synovial inflammation and focal bursal tissue inflammation encountered. Tendon edges debrided and repaired using suture anchors. Subacromial decompression and acromioplasty performed. Closure achieved with absorbable sutures. Patient referred for intensive postoperative rehabilitation.

4. Operative note: Arthroscopic subacromial decompression with debridement performed on a patient with rotator cuff syndrome and severe inflammatory changes. Intraoperatively, significant synovial inflammation and thickened bursal tissue observed. Subacromial decompression performed to address impingement, and extensive debridement performed to remove inflamed tissues. Closure achieved with absorbable sutures. Patient prescribed postoperative pain management and initiated a guided rehabilitation program.

5. Operative note: Patient with chronic rotator cuff syndrome underwent open rotator cuff repair with tenotomy and synovectomy. Intraoperatively, moderate synovial inflammation and adhesions observed. Tendon edges mobilized and repaired using suture anchors, and synovectomy performed to address the inflammatory changes. Closure achieved with absorbable sutures. Patient immobilized in a shoulder brace postoperatively.

6. Operative note: Arthroscopic rotator cuff repair with acromioclavicular joint debridement performed on a patient with rotator cuff syndrome and mild inflammatory changes. Intraoperatively, minimal synovial inflammation and degenerative changes in the acromioclavicular joint observed. Tendon edges repaired using suture anchors, and acromioclavicular joint debridement performed. Closure achieved with absorbable sutures. Patient advised to follow a comprehensive rehabilitation program.

7. Operative note: Patient with acute traumatic rotator cuff syndrome underwent mini-open rotator cuff repair with bursal tissue debridement. Intraoperatively, significant bursal tissue inflammation and adhesions encountered. Tendon edges mobilized and repaired using suture anchors, and bursal tissue debrided to alleviate the inflammatory changes. Closure achieved with absorbable sutures. Patient referred for specialized postoperative rehabilitation.

8. Operative note: Arthroscopic subacromial decompression with partial synovectomy performed on a patient with rotator cuff syndrome and moderate inflammatory changes. Intraoperatively, synovial inflammation and hypertrophy observed. Subacromial decompression performed to address impingement, and partial synovectomy performed to remove inflamed synovium. Closure achieved with absorbable sutures. Patient prescribed postoperative pain management and initiated a guided rehabilitation program.

9. Operative note: Patient with chronic rotator cuff syndrome underwent mini-open rotator cuff

repair with subacromial bursectomy and synovial debridement. Intraoperatively, significant synovial inflammation and bursal tissue inflammation encountered. Tendon edges repaired using suture anchors, and extensive debridement performed to alleviate the inflammatory changes. Closure achieved with absorbable sutures. Patient referred for specialized rehabilitation.

10. Operative note: Revision arthroscopic rotator cuff repair with subacromial bursectomy performed on a patient with recurrent rotator cuff syndrome and mild inflammatory changes. Intraoperatively, minimal synovial inflammation and bursal tissue inflammation noted. Tendon edges debrided and repaired using suture anchors. Subacromial bursectomy performed to address the inflammatory changes. Closure achieved with absorbable sutures. Patient referred for intensive postoperative rehabilitation.

1. Operative note: Arthroscopic rotator cuff repair performed on a patient with moderate rotator cuff syndrome. Intraoperatively, a partial-thickness tear was identified in the supraspinatus tendon. Tendon edges mobilized and repaired using suture anchors. Subacromial decompression performed. Closure achieved with absorbable sutures. Patient scheduled for a follow-up examination in 6 weeks to assess healing progress and determine the need for further rehabilitation.

2. Operative note: Patient with chronic rotator cuff syndrome underwent open rotator cuff repair with acromioplasty. Intraoperatively, full-thickness tears were observed in multiple tendons. Tendon edges mobilized and repaired using suture anchors. Extensive acromioplasty performed to address impingement. Closure achieved with absorbable sutures. Patient advised to follow a comprehensive rehabilitation program and scheduled for follow-up visits at 4, 8, and 12 weeks postoperatively to monitor recovery progress.

3. Operative note: Arthroscopic subacromial decompression with debridement performed on a patient with mild rotator cuff syndrome. Intraoperatively, minimal tears and bursal tissue inflammation were observed. Subacromial decompression performed to address impingement, and debridement performed to remove inflamed tissues. Closure achieved with absorbable sutures. Patient instructed to start physical therapy immediately and scheduled for a follow-up visit in 2 weeks to assess response to conservative treatment.

4. Operative note: Patient with acute traumatic rotator cuff syndrome underwent arthroscopic rotator cuff repair with biceps tenodesis. Intraoperatively, a full-thickness tear was identified in the supraspinatus tendon. Tendon edges debrided and repaired using suture anchors, and biceps tenodesis performed to alleviate pain and stabilize the joint. Closure achieved with absorbable sutures. Patient scheduled for follow-up visits at 2, 6, and 12 weeks postoperatively to monitor healing and progress.

5. Operative note: Revision arthroscopic rotator cuff repair performed on a patient with recurrent severe rotator cuff syndrome. Intraoperatively, extensive retears were observed in multiple tendons. Tendon edges debrided and repaired using suture anchors. Substantial bursal tissue debridement performed. Closure achieved with absorbable sutures. Patient referred to an experienced rehabilitation specialist for intensive postoperative care and scheduled for frequent follow-up visits at 2, 4, 8, and 12 weeks to closely monitor healing and response.

6. Operative note: Open surgical exploration and debridement performed on a patient with chronic rotator cuff syndrome and suspected infection. Intraoperatively, moderate tears and signs of infection were encountered. Tendon edges debrided and repaired using suture anchors, and extensive debridement performed to remove infected tissues. Wound left open for secondary intention healing. Patient referred to an infectious disease specialist and scheduled for frequent follow-up visits to monitor wound healing and infection control.

7. Operative note: Arthroscopic subacromial decompression with acromioclavicular joint debridement performed on a patient with moderate rotator cuff syndrome and acromioclavicular joint osteoarthritis. Intraoperatively, partial-thickness tears and degenerative changes in the joint were observed. Subacromial decompression performed to address impingement, and acromioclavicular joint debridement performed to alleviate pain and improve joint mobility. Closure achieved with absorbable sutures. Patient scheduled for follow-up visits

at 4, 8, and 12 weeks postoperatively to assess joint function and determine the need for further intervention.

8. Operative note: Patient with severe rotator cuff syndrome underwent open rotator cuff repair with tendon transfer. Intraoperatively, extensive full-thickness tears and compromised tendon quality were encountered. Tendon edges debrided and repaired using suture anchors, and a tendon transfer from the latissimus dorsi performed to reinforce the repair. Closure achieved with absorbable sutures. Patient referred for specialized rehabilitation and scheduled for regular follow-up visits at 6, 12, and 24 weeks to monitor tendon healing and functional outcome.

9. Operative note: Revision arthroscopic rotator cuff repair performed on a patient with recurrent rotator cuff syndrome and moderate tears. Intraoperatively, persistent tears and adhesions were observed. Tendon edges debrided and repaired using suture anchors, and extensive adhesion release performed to improve tendon mobility. Closure achieved with absorbable sutures. Patient referred to a dedicated shoulder therapist for specialized rehabilitation and scheduled for frequent follow-up visits to monitor progress.

10. Operative note: Arthroscopic subacromial decompression with debridement performed on a patient with severe rotator cuff syndrome and extensive bursal tissue inflammation. Intraoperatively, massive tears and hypertrophic bursa were observed. Subacromial decompression performed to address impingement, and bursal tissue debridement performed to alleviate inflammation. Closure achieved with absorbable sutures. Patient prescribed postoperative pain management and initiated a guided rehabilitation program. Follow-up visits scheduled at 4, 8, and 12 weeks postoperatively to evaluate healing and response to treatment.

## M75.2 Bicipital tendinitis

Operative Note 1:

Patient presented with bicipital tendinitis. A small incision was made over the affected area. The biceps tendon was visualized and found to be inflamed. Debridement of the tendon was performed, removing any damaged tissue. The tendon was then reattached to the humerus using sutures. Closure was done in layers, and the patient tolerated the procedure well. Postoperative instructions and rehabilitation were provided.

Operative Note 2:

The patient underwent surgery for bicipital tendinitis. A standard arthroscopic technique was employed. The inflamed biceps tendon was identified and debrided using a shaver and radiofrequency ablation. Careful inspection of the surrounding structures revealed no additional abnormalities. The procedure was completed successfully, and the patient was transferred to the recovery room in stable condition.

Operative Note 3:

Bicipital tendinitis was diagnosed in the patient. An open surgical approach was chosen. A longitudinal incision was made along the course of the biceps tendon. The inflamed tendon was visualized and carefully released from any adhesions. After confirming the absence of any tears, the tendon was repositioned and sutured back to its original attachment site. Hemostasis was achieved, and the wound was closed in layers.

Operative Note 4:

Surgery was performed on the patient with bicipital tendinitis. The procedure involved an arthroscopic technique. A small incision was made, and the arthroscope was inserted into the joint. The inflamed biceps tendon was located and debrided using a combination of mechanical and radiofrequency instruments. The joint was thoroughly irrigated, and the instruments were removed. The patient was transferred to the recovery area in stable condition.

Operative Note 5:

The patient underwent a surgical procedure for bicipital tendinitis. A mini-open approach was employed. A small skin incision was made, and a retractor was inserted to expose the underlying structures. The inflamed biceps tendon was identified and carefully released from any surrounding adhesions. Following debridement, the tendon was reattached to its original insertion site using sutures. The wound was closed in layers, and the patient's postoperative recovery was uneventful.

Operative Note 6:

Bicipital tendinitis was confirmed in the patient. An arthroscopic procedure was performed. A small incision was made, and the arthroscope was introduced into the joint. The inflamed biceps tendon was visualized and treated using a combination of electrocautery and shaver. The procedure was successful in removing the diseased tissue, and the patient tolerated the surgery well. Postoperative care instructions were provided.

Operative Note 7:

Surgery was performed on the patient with bicipital tendinitis. A diagnostic arthroscopy was initially carried out, confirming the presence of inflammation in the biceps tendon. Subsequently, a biceps tenodesis procedure was performed. The diseased tendon was excised, and the remaining healthy tendon was reattached to the bone using anchors. The surgical site was closed meticulously, and the patient was discharged with appropriate postoperative guidelines.

Operative Note 8:

The patient underwent an open surgical procedure for bicipital tendinitis. A curvilinear incision was made over the bicipital groove. The inflamed tendon was identified and released from any adhesions. The tendon was thoroughly debrided to remove damaged tissue. Repair was achieved by reattaching the tendon to its anatomical insertion site using non-absorbable sutures. Hemostasis was obtained, and the wound was closed in layers.

Operative Note 9:

Arthroscopic surgery was performed on the patient with

bicipital tendinitis. The affected biceps tendon was visualized and assessed for any tears or fraying. Subsequently, the tendon was debrided using a combination of mechanical shaver and radiofrequency ablation. The surgical area was irrigated and inspected for any residual debris. The procedure was concluded without complications, and the patient was sent for postoperative rehabilitation.

Operative Note 10:

The patient underwent an open surgical intervention for bicipital tendinitis. An incision was made along the long axis of the biceps tendon. The inflamed tendon was carefully inspected and released from any adhesions. Debridement was performed to remove any diseased tissue. The tendon was then reattached to its insertion site using sutures. Hemostasis was achieved, and the wound was closed in layers. The patient was transferred to the recovery unit in stable condition.

Operative Note 11:

Bicipital tendinitis was diagnosed in the patient. An ultrasound-guided percutaneous procedure was performed. Under local anesthesia, a needle was inserted into the inflamed tendon, and a corticosteroid injection was administered to reduce inflammation. The needle was then removed, and the patient was provided with post-procedural instructions. The patient tolerated the procedure well and was advised for follow-up evaluation.

Operative Note 12:

Surgery was performed on the patient with bicipital tendinitis. A minimally invasive endoscopic technique was utilized. Two small incisions were made, allowing for the insertion of an arthroscope and surgical instruments. The inflamed biceps tendon was visualized and treated using a combination of debridement and thermal ablation. The surgical sites were closed, and the patient was discharged with postoperative care guidelines.

Operative Note 13:

The patient underwent a biceps tenotomy procedure for bicipital tendinitis. A small incision was made over the bicipital groove. The tendon was identified, and a portion of it was surgically released from its attachment to the bone. The remaining tendon was then sutured to the surrounding soft tissues, creating a tension-free environment. The incision was closed, and the patient was referred for postoperative rehabilitation.

Operative Note 14:

An open surgical procedure was performed on the patient with bicipital tendinitis. After exposing the biceps tendon, it was found to be partially torn. The torn portion was excised, and the remaining healthy tendon was anchored back to the bone using specialized sutures. The integrity of the repair was confirmed, and the wound was closed in layers. The patient was advised on postoperative care and follow-up appointments.

Operative Note 15:

Bicipital tendinitis was confirmed in the patient. A needle was inserted into the inflamed tendon under ultrasound guidance, allowing for accurate placement. A combination of local anesthetic and corticosteroid was injected to provide pain relief and reduce inflammation. The needle was carefully withdrawn, and the patient was monitored for any adverse reactions. Post-procedural instructions were given, and the patient was scheduled for a follow-up visit.

Operative Note 16:

The patient underwent a subacromial decompression procedure for bicipital tendinitis. After arthroscopic visualization of the subacromial space, the inflamed bursa and any bone spurs were meticulously removed. The biceps tendon was assessed for any pathology and treated accordingly. The procedure was completed successfully, and the patient's range of motion was assessed before being transferred to the recovery area.

Operative Note 17:

Surgery was performed on the patient with bicipital tendinitis. A mini-open approach was chosen. A small incision was made, and the biceps tendon was visualized. Debridement of the diseased tendon was performed, followed by repair using suture anchors. The repaired tendon was secured to the bone, restoring its stability. The incision was closed, and the patient was provided with postoperative care instructions.

Operative Note 18:

Bicipital tendinitis was diagnosed in the patient. A platelet-rich plasma (PRP) injection was performed for therapeutic purposes. PRP was prepared by extracting the patient's blood, processing it to isolate the platelets, and then injecting the concentrated platelets into the affected area. The patient tolerated the procedure well, and post-injection instructions were provided for optimal recovery.

Operative Note 19:

The patient underwent an ultrasound-guided needle tenotomy for bicipital tendinitis. Using real-time imaging, a needle was precisely inserted into the inflamed tendon. The needle was then manipulated to create controlled

micro-injuries in the tendon tissue, promoting healing. The procedure was completed without complications, and the patient was discharged with appropriate post-procedural care recommendations.

Operative Note 20:

Bicipital tendinitis was confirmed in the patient. A minimally invasive extracorporeal shockwave therapy (ESWT) procedure was performed. High-energy shockwaves were delivered to the affected area using a specialized device, promoting tissue regeneration and reducing inflammation. The treatment was well-tolerated by the patient, and post-procedure instructions were given. The patient was scheduled for follow-up evaluation to monitor treatment efficacy.

Operative Note 21:

The patient underwent a surgical procedure for bicipital tendinitis under local anesthesia. A small incision was made over the affected area. The inflamed biceps tendon was identified and carefully debrided. Following the debridement, the tendon was reattached using sutures. The wound was closed, and the patient remained comfortable throughout the procedure. Postoperative instructions and follow-up were provided.

Operative Note 22:

Surgery was performed on the patient with bicipital tendinitis under regional anesthesia. A regional nerve block was administered, providing effective pain control and immobility of the upper limb. The procedure involved arthroscopic visualization and debridement of the inflamed biceps tendon. The tendon was then repaired using sutures, and the incisions were closed. The patient's vital signs remained stable throughout the surgery.

Operative Note 23:

Bicipital tendinitis was confirmed in the patient, who underwent surgery under general anesthesia. The patient was intubated and maintained on a general anesthetic. The affected biceps tendon was visualized arthroscopically and treated accordingly. Debridement and repair of the tendon were performed successfully. The patient was extubated at the end of the procedure and transferred to the recovery area in stable condition.

Operative Note 24:

The patient underwent a surgical intervention for bicipital tendinitis under monitored anesthesia care (MAC). The patient received a combination of intravenous sedation and local anesthesia. The procedure involved the debridement and repair of the inflamed biceps tendon. The patient remained responsive and comfortable throughout the surgery. Vital signs were closely monitored, and the patient was discharged with appropriate postoperative instructions.

Operative Note 25:

Surgery was performed on the patient with bicipital tendinitis under spinal anesthesia. A spinal block was administered, providing effective anesthesia for the upper limb. The procedure involved an open approach with debridement and repair of the inflamed biceps tendon. The patient remained hemodynamically stable throughout the surgery, and postoperative pain control was achieved using analgesics. The patient was transferred to the post-anesthesia care unit for monitoring.

Operative Note 26:

The patient underwent arthroscopic surgery for bicipital tendinitis under local anesthesia with sedation. The affected biceps tendon was visualized and treated accordingly. Debridement of the inflamed tissue and repair of the tendon were performed successfully. The patient remained calm and comfortable throughout the procedure. Postoperative pain control was managed with oral analgesics, and the patient was discharged with appropriate instructions.

Operative Note 27:

Bicipital tendinitis was diagnosed in the patient, who underwent surgery under general anesthesia with balanced anesthesia technique. The patient received inhalation anesthesia and intravenous medications for sedation and pain control. Arthroscopic debridement and repair of the inflamed biceps tendon were performed successfully. The patient's vital signs were stable throughout the procedure, and postoperative pain was managed with a multimodal approach.

Operative Note 28:

The patient underwent an open surgical procedure for bicipital tendinitis under local anesthesia with epinephrine. A field block was administered to provide anesthesia and hemostasis. The inflamed biceps tendon was visualized, debrided, and repaired using sutures. The patient remained comfortable and responsive during the surgery. Local infiltration of analgesics was utilized for postoperative pain management, and the patient was discharged with appropriate instructions.

Operative Note 29:

Surgery was performed on the patient with bicipital tendinitis under monitored anesthesia care (MAC) with deep sedation. The patient received intravenous sedatives and analgesics for optimal comfort. The procedure involved arthroscopic treatment of the inflamed biceps tendon, including debridement and repair. The patient's vital signs were closely monitored throughout the surgery, and postoperative pain control was achieved using a combination of analgesics.

Operative Note 30:

Bicipital tendinitis was confirmed in the patient, who underwent surgery under general anesthesia with intravenous propofol. The patient was intubated and maintained on general anesthesia throughout the procedure. Arthroscopic debridement and repair of the inflamed biceps tendon were successfully performed. The patient's airway and vital signs were closely monitored, and postoperative pain control was managed using a patient-controlled analgesia pump.

Operative Note 31:

The patient presented with bicipital tendinitis and significant bone erosion. A surgical procedure was performed under general anesthesia. An arthroscopic approach was utilized to visualize the extent of the erosion and assess the condition of the biceps tendon. Debridement of the diseased tendon and bone was performed, followed by the application of bone grafting material to promote healing and restoration of the affected area. The patient tolerated the procedure well, and postoperative care instructions were provided.

Operative Note 32:

Surgery was performed on the patient with bicipital tendinitis and bone erosion. The procedure involved an open surgical approach. The inflamed biceps tendon was visualized, and extensive bone erosion was observed. Debridement of the diseased tissue was performed, and bone grafting was done to fill the erosive defects. The tendon was reattached using sutures. The wound was closed, and the patient was provided with postoperative guidelines.

Operative Note 33:

The patient underwent surgery for bicipital tendinitis and accompanying bone erosion. An arthroscopic technique was employed. The erosion site was identified, and careful debridement of the diseased tissue was performed. Additionally, bone grafting was conducted to address the erosive defects. The biceps tendon was repaired and reattached using specialized suture anchors. The procedure was successfully completed, and the patient was discharged with postoperative care instructions.

Operative Note 34:

Bicipital tendinitis with significant bone erosion was diagnosed in the patient. Surgery was performed under general anesthesia. An open approach was chosen, allowing visualization of the erosion site. Debridement of the affected tendon and erosion area was meticulously performed. The defect was reconstructed using bone grafting material. The biceps tendon was then repaired and reattached to the anatomical insertion site. The patient's postoperative recovery was uneventful.

Operative Note 35:

The patient presented with bicipital tendinitis and notable bone erosion. Surgery was performed under regional anesthesia. An arthroscopic technique was employed to address the erosion. The diseased tissue and eroded bone were meticulously debrided. Bone grafting was performed to restore the integrity of the affected area. The biceps tendon was repaired using sutures. The patient's vital signs remained stable throughout the procedure, and postoperative instructions were provided.

Operative Note 36:

Surgery was performed on the patient with bicipital tendinitis and significant bone erosion. The procedure was conducted under general anesthesia. An open surgical approach was utilized to access the erosion site. Debridement of the diseased tendon and bone was performed, followed by bone grafting to fill the erosive defects. The biceps tendon was repaired and reattached to its insertion site. The patient tolerated the procedure well, and postoperative care instructions were given.

Operative Note 37:

The patient underwent surgical intervention for bicipital tendinitis and associated bone erosion. Under general anesthesia, an arthroscopic technique was employed. Extensive debridement of the affected tendon and bone erosion was performed. Bone grafting was executed to restore the damaged bone structure. The biceps tendon was then repaired using sutures and anchored back into position. The patient was transferred to the recovery unit in stable condition.

Operative Note 38:

Bicipital tendinitis with significant bone erosion was diagnosed in the patient. Surgery was performed under monitored anesthesia care (MAC). An open surgical approach was used to address the erosion. Debridement of the diseased tissue and bone was conducted meticulously. Bone grafting was performed to restore the structural integrity. The biceps tendon was repaired and reattached using specialized sutures. The patient remained comfortable throughout the procedure, and postoperative instructions were

provided.

Operative Note 39:

The patient presented with bicipital tendinitis and evident bone erosion. Surgery was performed under general anesthesia. An open surgical technique was employed, allowing for direct visualization of the erosion. Debridement of the affected tendon and bone erosion was performed meticulously. Bone grafting was conducted to fill the erosive defects and promote healing. The biceps tendon was repaired and reattached using sutures. The patient's recovery was uneventful.

Operative Note 40:

Surgery was performed on the patient with bicipital tendinitis and significant bone erosion. The procedure was conducted under regional anesthesia. An open approach was used to address the erosion. Debridement of the diseased tendon and bone was performed meticulously. Bone grafting was conducted to restore the structural integrity of the affected area. The biceps tendon was repaired using specialized sutures. The patient's vital signs remained stable, and postoperative care instructions were provided.

Operative Note 41:

The patient presented with severe bone pain in the context of bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was utilized to address the underlying pathology. The inflamed biceps tendon was debrided, and careful attention was given to the surrounding bone. Bone spurs were removed, and the bone surface was smoothed to alleviate the pain. The tendon was repaired, and the patient's postoperative course was uneventful.

Operative Note 42:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain. The procedure was conducted under regional anesthesia. An open surgical technique was employed to directly access the affected area. Debridement of the diseased tendon and bone was performed meticulously. The bone surface was carefully inspected and treated to alleviate pain. The tendon was repaired, and the patient's postoperative pain was effectively managed.

Operative Note 43:

The patient presented with bicipital tendinitis and severe bone pain. Surgery was performed under general anesthesia. An arthroscopic approach was chosen to address the pathology. The inflamed biceps tendon was debrided, and particular attention was given to the eroded bone. Bone recontouring and smoothing were performed to relieve pain. The tendon was repaired, and the patient's postoperative pain was well-controlled.

Operative Note 44:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain. The procedure was conducted under monitored anesthesia care (MAC). An open surgical approach was utilized to directly visualize the pathology. Debridement of the diseased tendon and bone was performed meticulously. Bone contouring and smoothing were carried out to alleviate severe bone pain. The tendon was repaired, and the patient's postoperative pain was effectively managed.

Operative Note 45:

The patient presented with bicipital tendinitis and debilitating bone pain. Surgery was performed under general anesthesia. An open surgical technique was employed to directly address the underlying cause. The inflamed biceps tendon was debrided, and meticulous attention was given to the bone surfaces. Bone recontouring and smoothing were performed to alleviate severe pain. The tendon was repaired, and the patient experienced relief from postoperative pain.

Operative Note 46:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain. The procedure was conducted under regional anesthesia. An open surgical approach was chosen to directly address the pathology. Debridement of the diseased tendon and bone was performed meticulously. Special attention was given to the eroded bone, which was contoured and smoothed to alleviate severe pain. The tendon was repaired, and the patient's postoperative pain was effectively managed.

Operative Note 47:

The patient presented with bicipital tendinitis and severe bone pain. Surgery was performed under general anesthesia. An arthroscopic approach was utilized to address the underlying pathology. The inflamed biceps tendon was debrided, and meticulous attention was given to the eroded bone. Bone recontouring and smoothing were performed to alleviate severe pain. The tendon was repaired, and the patient's postoperative pain was effectively managed.

Operative Note 48:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain. The procedure was conducted under monitored anesthesia care (MAC). An open surgical approach was utilized to directly visualize and address the pathology. Debridement of the diseased tendon and bone was performed meticulously. Bone recontouring and smoothing were carried out to alleviate severe bone pain. The tendon was repaired, and the patient's postoperative pain was effectively managed.

Operative Note 49:

The patient presented with bicipital tendinitis and severe bone pain.

Surgery was performed under general anesthesia. An arthroscopic approach was chosen to address the underlying pathology. The inflamed biceps tendon was debrided, and careful attention was given to the eroded bone. Bone recontouring and smoothing were performed to alleviate severe pain. The tendon was repaired, and the patient experienced relief from postoperative pain.

Operative Note 50:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain. The procedure was conducted under regional anesthesia. An open surgical approach was employed to directly visualize and address the pathology. Debridement of the diseased tendon and bone was performed meticulously. Special attention was given to the eroded bone, which was contoured and smoothed to alleviate severe pain. The tendon was repaired, and the patient's postoperative pain was effectively managed.

Operative Note 51:

The patient underwent a surgical intervention for bicipital tendinitis with severe bone pain. Under general anesthesia, an arthroscopic approach was used to address the pathology. Debridement of the inflamed tendon and meticulous bone contouring were performed to alleviate pain. The tendon was repaired using sutures, and the patient's postoperative pain was managed with a combination of analgesics. The procedure was successful, and the patient was discharged with appropriate instructions.

Operative Note 52:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain. The procedure involved an open surgical intervention under regional anesthesia. The inflamed biceps tendon was identified, debrided, and repaired. Extensive bone contouring and smoothing were conducted to alleviate severe pain. The patient tolerated the procedure well, and postoperative pain control was achieved with analgesics.

Operative Note 53:

The patient presented with bicipital tendinitis and severe bone pain, necessitating surgical intervention. Under general anesthesia, an arthroscopic approach was employed. The inflamed biceps tendon was debrided and repaired, while special attention was given to the eroded bone. Bone recontouring and smoothing were performed to alleviate pain. The patient's postoperative recovery was uneventful, and appropriate pain management was provided.

Operative Note 54:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain. The surgical intervention was conducted under general anesthesia. An open approach was employed to directly address the pathology. The inflamed tendon was debrided and repaired, and extensive bone contouring and smoothing were performed to alleviate severe pain. The patient's postoperative course was uneventful, and pain control was achieved with analgesic medication.

Operative Note 55:

The patient underwent a surgical intervention for bicipital tendinitis and severe bone pain. Under regional anesthesia, an open surgical approach was used to address the pathology. The inflamed tendon was meticulously debrided and repaired, with particular attention given to the eroded bone. Bone contouring and smoothing were performed to alleviate severe pain. The patient's postoperative pain was effectively managed, and they were discharged with appropriate instructions.

Operative Note 56:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain, necessitating a surgical intervention. The procedure was conducted under general anesthesia. An arthroscopic approach was utilized to address the underlying pathology. The inflamed biceps tendon was debrided and repaired, and meticulous bone contouring was performed to alleviate severe pain. The patient's postoperative pain was effectively managed with a multimodal approach.

Operative Note 57:

The patient presented with bicipital tendinitis and severe bone pain, requiring a surgical intervention. The procedure was performed under regional anesthesia. An open surgical approach was employed to directly address the pathology. The inflamed tendon was debrided and repaired, and extensive bone contouring and smoothing were conducted to alleviate severe pain. The patient's postoperative pain was effectively managed, and they were discharged with appropriate instructions.

Operative Note 58:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain, necessitating a surgical intervention. The procedure was conducted under general anesthesia. An arthroscopic approach was utilized to address the underlying pathology. The inflamed biceps tendon was debrided and repaired, and meticulous bone contouring was performed to alleviate severe pain. The patient's postoperative pain was effectively managed, and appropriate rehabilitation was initiated.

Operative Note 59:

The patient underwent a surgical intervention for bicipital tendinitis and severe bone pain. Under regional anesthesia, an open surgical approach was used

to address the pathology. The inflamed tendon was meticulously debrided and repaired, with particular attention given to the eroded bone. Bone contouring and smoothing were performed to alleviate severe pain. The patient's postoperative pain was effectively managed, and appropriate rehabilitation protocols were initiated.

Operative Note 60:

Surgery was performed on the patient with bicipital tendinitis and severe bone pain, necessitating a surgical intervention. The procedure was conducted under general anesthesia. An arthroscopic approach was employed to directly address the pathology. The inflamed biceps tendon was debrided and repaired, and extensive bone contouring and smoothing were conducted to alleviate severe pain. The patient's postoperative pain was effectively managed, and they were provided with comprehensive rehabilitation guidelines.

Operative Note 61:

The patient underwent surgical intervention for severe bicipital tendinitis and associated bone pain. Under general anesthesia, an open surgical approach was employed. The inflamed biceps tendon was meticulously debrided, and careful attention was given to the eroded bone. Bone recontouring and smoothing were performed to alleviate pain. The tendon was repaired using sutures, and the patient's postoperative pain was effectively managed with a combination of analgesics and physical therapy.

Operative Note 62:

Surgery was performed on the patient with severe bicipital tendinitis and bone pain. The procedure involved an open surgical intervention under general anesthesia. The inflamed biceps tendon was debrided, and extensive bone recontouring and smoothing were conducted to alleviate pain. The tendon was repaired using specialized sutures. Postoperative pain control was achieved with a multimodal analgesic regimen, and the patient was provided with postoperative rehabilitation instructions.

Operative Note 63:

The patient presented with severe bone pain associated with bicipital tendinitis, requiring surgical intervention. Under general anesthesia, an arthroscopic approach was employed. The inflamed biceps tendon was debrided, and meticulous attention was given to the eroded bone. Bone contouring and smoothing were performed to alleviate severe pain. The tendon was repaired, and the patient's postoperative pain was effectively managed through a tailored analgesic regimen.

Operative Note 64:

Surgery was performed on the patient with severe bicipital tendinitis and bone pain. The surgical intervention was conducted under regional anesthesia. An open surgical approach was utilized to directly address the pathology. The inflamed tendon was debrided and repaired, and extensive bone contouring and smoothing were performed to alleviate severe pain. The patient's postoperative pain was effectively managed with a combination of analgesics and physical therapy.

Operative Note 65:

The patient underwent surgical intervention for severe bicipital tendinitis and bone pain. Under general anesthesia, an arthroscopic approach was used to address the underlying pathology. The inflamed biceps tendon was debrided, and meticulous attention was given to the eroded bone. Bone contouring and smoothing were performed to alleviate severe pain. The tendon was repaired using specialized sutures, and the patient's postoperative pain was effectively managed through a multimodal analgesic approach.

Operative Note 66:

Surgery was performed on the patient with severe bicipital tendinitis and bone pain, necessitating a surgical intervention. The procedure was conducted under regional anesthesia. An open surgical approach was employed to directly visualize and address the pathology. The inflamed tendon was debrided and repaired, and extensive bone contouring and smoothing were conducted to alleviate severe pain. The patient's postoperative pain was effectively managed with a combination of analgesics and physical therapy.

Operative Note 67:

The patient presented with severe bone pain associated with bicipital tendinitis, necessitating surgical intervention. Under general anesthesia, an arthroscopic approach was utilized. The inflamed biceps tendon was meticulously debrided, and careful attention was given to the eroded bone. Bone recontouring and smoothing were performed to alleviate pain. The tendon was repaired using specialized sutures, and the patient's postoperative pain was effectively managed through a multimodal analgesic regimen.

Operative Note 68:

Surgery was performed on the patient with severe bicipital tendinitis and bone pain. The procedure involved an open surgical intervention under general anesthesia. The inflamed biceps tendon was debrided, and extensive bone recontouring and smoothing were conducted to alleviate pain. The tendon was repaired using specialized sutures. Postoperative pain control was achieved with a combination of

analgesics, and the patient was instructed on postoperative rehabilitation protocols.

Operative Note 69:

The patient underwent surgical intervention for severe bicipital tendinitis and associated bone pain. Under regional anesthesia, an open surgical approach was employed. The inflamed biceps tendon was meticulously debrided, and careful attention was given to the eroded bone. Bone recontouring and smoothing were performed to alleviate pain. The tendon was repaired using sutures, and the patient's postoperative pain was effectively managed with a combination of analgesics and physical therapy.

Operative Note 70:

Surgery was performed on the patient with severe bicipital tendinitis and bone pain, necessitating a surgical intervention. The procedure was conducted under general anesthesia. An arthroscopic approach was employed to directly visualize and address the pathology. The inflamed tendon was debrided and repaired, and extensive bone recontouring and smoothing were conducted to alleviate severe pain. The patient's postoperative pain was effectively managed through a multimodal analgesic approach, and they were provided with comprehensive postoperative care instructions.

Operative Note 71:

The patient presented with severe infection on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An open surgical approach was employed to address the infection. The infected tissue was meticulously debrided, and thorough irrigation was performed. Antibiotic-impregnated cement was used for local delivery of antibiotics. The biceps tendon was repaired, and appropriate postoperative antibiotic therapy was initiated to manage the infection.

Operative Note 72:

Surgery was performed on the patient with severe infection on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was chosen to directly address the infected joint. Debridement of the infected tissue was performed meticulously, and extensive irrigation was carried out to eliminate the infection. The biceps tendon was repaired, and appropriate postoperative antibiotic therapy was initiated to control the infection.

Operative Note 73:

The patient presented with severe infection on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was utilized to address the infection. The infected tissue was thoroughly debrided, and careful irrigation was performed. Intraoperative antibiotics were administered, and the biceps tendon was repaired. Postoperatively, the patient was started on a course of systemic antibiotics to treat the infection.

Operative Note 74:

Surgery was performed on the patient with severe infection on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was employed to directly address the infected joint. Debridement of the infected tissue was performed meticulously, and thorough irrigation was carried out to eliminate the infection. The biceps tendon was repaired, and appropriate postoperative antibiotic therapy was initiated to manage the infection.

Operative Note 75:

The patient presented with severe infection on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was chosen to address the infection. The infected tissue was meticulously debrided, and thorough irrigation with antibiotic solution was performed. The biceps tendon was repaired, and systemic antibiotics were initiated postoperatively to control the infection.

Operative Note 76:

Surgery was performed on the patient with severe infection on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was utilized to directly address the infected joint. Debridement of the infected tissue was performed meticulously, and extensive irrigation with antibiotic solution was carried out. The biceps tendon was repaired, and appropriate postoperative antibiotic therapy was initiated to manage the infection.

Operative Note 77:

The patient presented with severe infection on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was employed to address the infection. The infected tissue was thoroughly debrided, and meticulous irrigation with antibiotic solution was performed. The biceps tendon was repaired, and appropriate postoperative antibiotic therapy was initiated to control the infection.

Operative Note 78:

Surgery was performed on the patient with severe infection on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was chosen to directly address the infected joint. Debridement of the infected tissue was performed meticulously, and thorough irrigation with antibiotic solution was carried out. The biceps tendon was repaired, and appropriate postoperative antibiotic therapy was initiated to manage the infection.

Operative Note 79:

The patient presented with severe infection on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was utilized to address the

infection. The infected tissue was meticulously debrided, and thorough irrigation with antibiotic solution was performed. The biceps tendon was repaired, and systemic antibiotics were initiated postoperatively to control the infection.

Operative Note 80:

Surgery was performed on the patient with severe infection on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was employed to directly address the infected joint. Debridement of the infected tissue was performed meticulously, and extensive irrigation with antibiotic solution was carried out. The biceps tendon was repaired, and appropriate postoperative antibiotic therapy was initiated to manage the infection.

Operative Note 81:

The patient presented with severe inflammation on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was employed to address the inflamed joint. The inflamed tissues were carefully debrided, and irrigation was performed. Anti-inflammatory medications were administered locally. The biceps tendon was repaired, and postoperative anti-inflammatory treatment was initiated to manage the inflammation.

Operative Note 82:

Surgery was performed on the patient with moderate inflammation on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was utilized to directly address the inflamed joint. Debridement of the inflamed tissues was performed meticulously, and irrigation was carried out. Corticosteroid injection was administered locally. The biceps tendon was repaired, and appropriate postoperative anti-inflammatory therapy was initiated.

Operative Note 83:

The patient presented with severe inflammation on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was employed to address the inflamed joint. The inflamed tissues were meticulously debrided, and thorough irrigation was performed. Local cryotherapy was applied to reduce inflammation. The biceps tendon was repaired, and postoperative anti-inflammatory medication was prescribed.

Operative Note 84:

Surgery was performed on the patient with moderate inflammation on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was chosen to directly address the inflamed joint. Debridement of the inflamed tissues was performed meticulously, and thorough irrigation was carried out. Nonsteroidal anti-inflammatory drugs (NSAIDs) were administered systemically. The biceps tendon was repaired, and appropriate postoperative anti-inflammatory therapy was initiated.

Operative Note 85:

The patient presented with severe inflammation on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was utilized to address the inflamed joint. The inflamed tissues were carefully debrided, and irrigation with saline solution was performed. Intraoperative corticosteroid injection was administered. The biceps tendon was repaired, and postoperative anti-inflammatory medication was prescribed to manage the inflammation.

Operative Note 86:

Surgery was performed on the patient with moderate inflammation on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was employed to directly address the inflamed joint. Debridement of the inflamed tissues was performed meticulously, and thorough irrigation was carried out. Topical anti-inflammatory gel was applied. The biceps tendon was repaired, and appropriate postoperative anti-inflammatory therapy was initiated.

Operative Note 87:

The patient presented with severe inflammation on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was employed to address the inflamed joint. The inflamed tissues were meticulously debrided, and thorough irrigation with sterile saline was performed. Intraoperative corticosteroid injection was administered. The biceps tendon was repaired, and postoperative anti-inflammatory medication was prescribed to manage the inflammation.

Operative Note 88:

Surgery was performed on the patient with moderate inflammation on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was chosen to directly address the inflamed joint. Debridement of the inflamed tissues was performed meticulously, and thorough irrigation with sterile saline was carried out. Nonsteroidal anti-inflammatory drugs (NSAIDs) were administered systemically. The biceps tendon was repaired, and appropriate postoperative

anti-inflammatory therapy was initiated.

Operative Note 89:

The patient presented with severe inflammation on the extreme moving joint associated with bicipital tendinitis. Surgery was performed under general anesthesia. An arthroscopic approach was utilized to address the inflamed joint. The inflamed tissues were carefully debrided, and thorough irrigation with saline solution was performed. Local cryotherapy was applied intraoperatively. The biceps tendon was repaired, and postoperative anti-inflammatory medication was prescribed to manage the inflammation.

Operative Note 90:

Surgery was performed on the patient with moderate inflammation on the extreme moving joint due to bicipital tendinitis. The procedure was conducted under regional anesthesia. An open surgical approach was employed to directly address the inflamed joint. Debridement of the inflamed tissues was performed meticulously, and thorough irrigation was carried out. Topical anti-inflammatory gel was applied. The biceps tendon was repaired, and appropriate postoperative anti-inflammatory therapy was initiated.

Operative Note 91:

The patient presented with a diagnosis of mild bicipital tendinitis. Surgery was not warranted in this case, and the patient was advised conservative management. They were prescribed nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy, and activity modification. Follow-up appointments were scheduled at regular intervals to monitor the patient's progress and adjust the treatment plan as needed.

Operative Note 92:

The patient was diagnosed with moderate bicipital tendinitis. Surgery was not initially recommended, and the patient was advised a comprehensive conservative management approach. This included NSAIDs, physical therapy, and a modification of activities. Follow-up appointments were scheduled to assess the patient's response to the treatment plan. If symptoms persisted or worsened, surgical intervention would be reconsidered.

Operative Note 93:

Severe bicipital tendinitis was diagnosed in the patient, warranting a surgical intervention. The procedure was performed under general anesthesia. An arthroscopic approach was employed to directly address the pathology. The inflamed tendon was debrided and repaired. Postoperatively, the patient was instructed to follow a structured rehabilitation program. Regular follow-up appointments were scheduled to monitor their progress and adjust the rehabilitation plan as necessary.

Operative Note 94:

The patient's diagnosis indicated mild bicipital tendinitis. Conservative management was recommended, including activity modification, physical therapy, and the use of NSAIDs. Follow-up appointments were scheduled to assess the patient's response to the conservative measures and adjust the treatment plan accordingly.

Operative Note 95:

Moderate bicipital tendinitis was diagnosed in the patient. A conservative treatment approach was initially pursued, involving the use of NSAIDs, activity modification, and physical therapy. Follow-up appointments were scheduled to evaluate the patient's response to the conservative measures. If symptoms persisted or worsened, further interventions, including possible surgical options, would be considered.

Operative Note 96:

The patient's diagnosis indicated severe bicipital tendinitis, necessitating surgical intervention. Under general anesthesia, an open surgical approach was chosen to address the pathology. The inflamed tendon was meticulously debrided and repaired. Postoperatively, the patient was advised to follow a structured rehabilitation program. Regular follow-up appointments were scheduled to monitor their progress and ensure proper healing.

Operative Note 97:

Mild bicipital tendinitis was diagnosed in the patient. Conservative management was recommended, including NSAIDs, rest, and physical therapy. Follow-up appointments were scheduled to assess the patient's response to the conservative measures and make any necessary adjustments to the treatment plan.

Operative Note 98:

The patient's diagnosis indicated moderate bicipital tendinitis. Conservative treatment measures, including NSAIDs, physical therapy, and activity modification, were prescribed. Regular follow-up appointments were scheduled to evaluate the patient's response to the treatment plan. If symptoms persisted or worsened, further interventions would be considered.

Operative Note 99:

Severe bicipital tendinitis was diagnosed in the patient, warranting a surgical intervention. The procedure was performed under regional anesthesia. An open surgical approach was employed to directly address the pathology. The inflamed tendon was debrided and repaired. The patient was advised on a tailored postoperative rehabilitation program. Follow-up appointments were scheduled to monitor the patient's progress and ensure optimal healing.

Operative Note 100:

The patient's diagnosis indicated mild bicipital tendinitis. Conservative management was recommended, including rest, NSAIDs, and physical therapy. Follow-up appointments were scheduled to evaluate the patient's response to the conservative measures and make any necessary adjustments to the treatment plan based on their progress.

## M75.3 Calcific tendinitis of shoulder

1. Operative Note - Calcific Tendinitis Excision: A 2 cm incision was made over the shoulder joint. The calcific deposit was identified within the supraspinatus tendon and carefully excised. Hemostasis was achieved, and the incision was closed in layers.

2. Operative Note - Arthroscopic Debridement: Arthroscopic portals were established, allowing access to the shoulder joint. The calcific deposits within the subscapularis tendon were visualized and meticulously debrided. The joint was irrigated, and portals were closed.

3. Operative Note - Mini-Open Calcific Tendinitis Decompression: A mini-open approach was utilized. The affected area of the infraspinatus tendon was exposed, and the calcific deposit was meticulously decompressed and removed. Closure was performed in layers.

4. Operative Note - Extracorporeal Shockwave Therapy (ESWT): The patient received ESWT for calcific tendinitis. Focused shockwaves were applied to the affected shoulder area, targeting the calcific deposits. Treatment was well-tolerated, and the patient was discharged with post-procedure instructions.

5. Operative Note - Ultrasound-Guided Needle Aspiration: Under ultrasound guidance, a needle was inserted into the calcific deposit within the supraspinatus tendon. Aspiration was performed, evacuating the calcific material. Post-procedure, the patient was instructed regarding shoulder immobilization.

6. Operative Note - Needle Lavage and Injection: After administering local anesthesia, a needle was inserted into the calcific deposit. Lavage was performed with sterile saline, followed by injection of corticosteroids for pain relief. The procedure was uneventful, and the patient was discharged.

7. Operative Note - Arthroscopic Subacromial Decompression with Calcific Tendinitis: Arthroscopic portals were established, providing access to the subacromial space. Subacromial decompression was performed, and calcific deposits within the rotator cuff tendons were meticulously removed. The procedure was completed without complications.

8. Operative Note - Open Subacromial Bursectomy and Calcific Tendinitis Excision: An open approach was used to access the subacromial space. The inflamed bursa was excised, and the calcific deposits within the rotator cuff tendons were identified and meticulously excised. Closure was performed in layers.

9. Operative Note - Corticosteroid Injection: A needle was inserted into the affected shoulder joint, targeting the calcific deposit. Corticosteroid suspension was injected to alleviate pain and inflammation. The patient tolerated the procedure well, and post-injection instructions were provided.

10. Operative Note - Tenotomy and Repair: A tenotomy was performed on the affected tendon to release tension and access the calcific deposit. The deposit was carefully removed, and the tendon was repaired with sutures. Closure was performed in layers, and postoperative care instructions were provided.

1. Operative Note - Mini-Open Subacromial Decompression and Calcific Tendinitis Excision: A mini-open approach was used to access the subacromial space. The inflamed bursa was excised, and the calcific deposits within the rotator cuff tendons were meticulously identified and removed. The area was irrigated, and the incision was closed in layers.

2. Operative Note - Arthroscopic Rotator Cuff Repair with Calcific Tendinitis: Arthroscopic portals were established, providing access to the rotator cuff tear. The calcific deposit within the tendon was identified and carefully excised. The rotator cuff tear was repaired using sutures and anchors. The procedure was completed successfully, and the patient was given postoperative instructions.

3. Operative Note - Acromioplasty and Calcific Tendinitis Decompression: An open approach was used to expose the acromion. Acromioplasty was performed to remove any impingement on the rotator cuff. The calcific deposit within the supraspinatus tendon was meticulously decompressed and removed. The incision was closed after confirming hemostasis.

4. Operative Note - Percutaneous Needle Fragmentation: Under fluoroscopic guidance, a needle was inserted into the calcific deposit. Fragmentation of the calcific material was performed using ultrasound or electromechanical energy. The procedure was well-tolerated, and the patient was discharged with post-procedure care instructions.

5. Operative Note - Tenodesis and Calcific Tendinitis Excision: A tenodesis procedure was performed to address the chronic calcific tendinitis. The affected tendon was released from its attachment and reattached in a new position. The calcific deposit was meticulously excised, and the tenodesis site was secured. The incision was closed in layers.

6. Operative Note - Open Rotator Cuff Repair with Calcific Tendinitis Excision: An open approach was used to expose the rotator cuff tear. The calcific deposit within the tendon was identified and meticulously excised. The rotator cuff tear was repaired using sutures and anchors. The wound was closed after confirming hemostasis.

7. Operative Note - Subacromial Bursectomy and Needle Aspiration: An incision was made over the subacromial space, allowing access to the inflamed bursa. The bursa was excised, and a needle was inserted into the calcific deposit for aspiration. The procedure was successful, and the wound was closed.

8. Operative Note - Arthroscopic Capsular Release and Calcific Tendinitis Excision: Arthroscopic portals were established, providing access to the shoulder joint. Capsular release was performed to address adhesive capsulitis. The calcific deposit within the tendon was meticulously excised. The joint was irrigated, and the portals were closed.

9. Operative Note - Open Tendon Transfer and Calcific Tendinitis Decompression: An open approach was used to access the affected tendon. Tendon transfer was performed to restore function and relieve stress on the calcific deposit. The deposit was meticulously decompressed and removed. The incision was closed after confirming hemostasis.

10. Operative Note - Arthroscopic Resection and Chondroplasty: Arthroscopic portals were established, providing access to the shoulder joint. The calcific deposit was visualized and resected using specialized instruments. Chondroplasty was performed to address any associated cartilage damage. The joint was thoroughly irrigated, and the portals were closed.

1. Operative Note - Calcific Tendinitis Excision with Local Anesthesia: The patient was placed under local anesthesia. A 2 cm incision was made over the shoulder joint. The calcific deposit within the supraspinatus tendon was identified and meticulously excised. Hemostasis was achieved, and the incision was closed in layers. The patient remained stable throughout the procedure.

2. Operative Note - Arthroscopic Debridement with Regional Anesthesia: Regional anesthesia was administered to the patient. Arthroscopic portals were established, allowing access to the shoulder joint. The calcific deposits within the subscapularis tendon were visualized and meticulously debrided. The joint was irrigated, and portals were closed. The patient tolerated the procedure well without any complications.

3. Operative Note - Mini-Open Calcific Tendinitis Decompression with General Anesthesia: The patient received general anesthesia. A mini-open approach was utilized. The affected area of the infraspinatus tendon was exposed, and the calcific deposit was meticulously decompressed and removed. Closure was performed in layers. The patient's vital signs remained stable throughout the procedure.

4. Operative Note - Extracorporeal Shockwave Therapy (ESWT) with Conscious Sedation: Conscious sedation was administered to the patient. Focused shockwaves were applied to the affected shoulder area, targeting the calcific deposits. Treatment was well-tolerated, and the patient remained conscious and comfortable throughout the procedure. Post-procedure, the patient was discharged with post-procedure instructions.

5. Operative Note - Ultrasound-Guided Needle Aspiration with Local Anesthesia: Local anesthesia was administered to the patient. Under ultrasound guidance, a needle was inserted into the calcific deposit within the supraspinatus tendon. Aspiration was performed, evacuating the calcific material. Post-procedure, the patient was instructed regarding shoulder immobilization. The patient had no adverse reactions to the anesthesia.

6. Operative Note - Needle Lavage and Injection with Sedation: The patient received sedation for the procedure. After administering local anesthesia, a needle was inserted into the calcific deposit. Lavage was performed with sterile saline, followed by injection of corticosteroids for pain relief. The procedure was uneventful, and the patient remained sedated throughout.

7. Operative Note - Arthroscopic Subacromial Decompression with Calcific Tendinitis under Spinal Anesthesia: The patient underwent spinal anesthesia. Arthroscopic portals were established, providing access to the subacromial space. Subacromial decompression was performed, and calcific deposits within the rotator cuff tendons were meticulously removed. The procedure was completed without complications. The patient remained comfortable under spinal anesthesia.

8. Operative Note - Open Subacromial Bursectomy and Calcific Tendinitis Excision with General Anesthesia: General anesthesia was administered to the patient. An open approach was used to access the subacromial space. The inflamed bursa was excised, and the calcific deposits within the rotator cuff tendons were meticulously identified and excised. Closure was performed in layers. The patient's vital signs remained stable throughout the procedure.

9. Operative Note - Corticosteroid Injection with Topical Anesthesia: Topical anesthesia was applied to the injection site. A needle was inserted into the affected shoulder joint, targeting the calcific deposit. Corticosteroid suspension was injected to alleviate pain and inflammation. The patient tolerated the procedure well, and post-injection instructions were provided. No complications were observed.

10. Operative Note - Tenotomy and Repair with Combined Spinal-Epidural Anesthesia: The patient underwent combined spinal-epidural anesthesia. A tenotomy was performed on the affected tendon to release tension and access the calcific deposit. The deposit was carefully removed, and the tendon was repaired with sutures. Closure was performed in layers, and postoperative care instructions were provided. The patient remained comfortable throughout the procedure.

1. Operative Note - Arthroscopic Subacromial Decompression and Calcific Tendinitis Excision with Bone Erosion: Arthroscopic portals were established, providing access to the subacromial space. Bone erosion due to calcific tendinitis was noted. Subacromial decompression was performed, and the calcific deposits within the rotator cuff tendons were meticulously removed. The eroded bone surfaces were smoothed and debrided. The joint was irrigated, and portals were closed. The patient tolerated the procedure well.

2. Operative Note - Mini-Open Calcific Tendinitis Decompression with Bone Erosion: A mini-open approach was utilized. Bone erosion was identified in the affected area of the infraspinatus tendon. The calcific deposit was meticulously decompressed and removed. The eroded bone surfaces were addressed and treated. Closure was performed in layers. The patient remained stable throughout the procedure.

3. Operative Note - Open Subacromial Bursectomy, Calcific Tendinitis Excision, and Bone Erosion Repair: An open approach was used to access the subacromial space. Bone erosion associated with calcific tendinitis was observed. The inflamed bursa was excised, and the calcific deposits within the rotator cuff tendons were meticulously identified and excised. The eroded bone surfaces were reconstructed and repaired. Closure was performed in layers.

4. Operative Note - Arthroscopic Rotator Cuff Repair with Calcific Tendinitis and Bone Erosion: Arthroscopic portals were established, providing access to the rotator cuff tear. Calcific tendinitis with bone erosion was observed. The calcific deposit within the tendon was meticulously excised. The rotator cuff tear was repaired using sutures and anchors, and the eroded bone surfaces were addressed. The procedure was completed successfully.

5. Operative Note - Open Tendon Transfer, Calcific Tendinitis Excision, and Bone Erosion Repair: An open approach was used to access the affected tendon. Tendon transfer was performed to address the chronic calcific tendinitis. The calcific deposit was meticulously excised, and the eroded bone surfaces were reconstructed and repaired. The incision was closed in layers. The patient remained stable throughout the procedure.

6. Operative Note - Arthroscopic Resection, Chondroplasty, and Bone Erosion Repair: Arthroscopic portals were established, providing access to the shoulder joint. The calcific deposit was visualized and resected using specialized instruments. Chondroplasty was performed to address any associated cartilage damage. The eroded bone surfaces were treated and repaired. The joint was thoroughly irrigated, and the portals were closed.

7. Operative Note - Open Subacromial Decompression, Calcific Tendinitis Excision, and Bone Erosion Repair with Bone Grafting: An open approach was used to access the subacromial space. Calcific tendinitis with bone erosion was observed. Subacromial decompression was performed, and the calcific deposits within the rotator cuff tendons were meticulously removed. The eroded bone surfaces were reconstructed using bone grafts. Closure was performed in layers.

8. Operative Note - Arthroscopic Capsular Release, Calcific Tendinitis Excision, and Bone Erosion Repair: Arthroscopic portals were established, providing access to the shoulder joint. Capsular release was performed to address adhesive capsulitis. The calcific deposit within the tendon was meticulously excised. The eroded bone surfaces were addressed and repaired. The joint was irrigated, and the portals were closed.

9. Operative Note - Open Rotator Cuff Repair, Calcific Tendinitis Excision, and Bone Erosion Repair: An open approach was used to expose the rotator cuff tear. Calcific tendinitis with bone erosion was observed. The calcific deposit within the tendon was meticulously excised. The rotator cuff tear was repaired using sutures and anchors, and the eroded bone surfaces were treated and repaired. The wound was closed after confirming hemostasis.

10. Operative Note - Mini-Open Calcific Tendinitis Decompression, Bone Erosion Repair, and Platelet-Rich Plasma Injection: A mini-open approach was utilized. Bone erosion associated with calcific tendinitis was noted. The calcific deposit was meticulously decompressed and removed. The eroded bone surfaces were addressed and repaired. Platelet-rich plasma injection was performed to promote healing. Closure was performed in layers, and the patient's postoperative recovery was monitored.

1. Operative Note - Arthroscopic Subacromial Decompression and Calcific Tendinitis Excision with Severe Bone Pain: Arthroscopic portals were established, providing access to the subacromial space. The patient presented with severe bone pain due to calcific tendinitis. Subacromial decompression was performed, and the calcific deposits within the rotator cuff tendons were meticulously removed. The patient's severe bone pain was addressed intraoperatively. The procedure was completed successfully, and postoperative pain management was initiated.

2. Operative Note - Open Subacromial Bursectomy, Calcific Tendinitis Excision, and Bone Erosion Repair with Severe Bone Pain: An open approach was used to access the subacromial space. The patient experienced severe bone pain associated with calcific tendinitis and bone erosion. The inflamed bursa was excised, and the calcific deposits within the rotator cuff tendons were meticulously identified and excised. The eroded bone surfaces were reconstructed and repaired, targeting the source of severe bone pain.

3. Operative Note - Mini-Open Calcific Tendinitis Decompression with Severe Bone Pain: A mini-open approach was utilized. The patient presented with severe bone pain due to calcific tendinitis. The affected area of the infraspinatus tendon was exposed, and the calcific deposit was meticulously decompressed and removed. The patient's severe bone pain was managed intraoperatively. Closure was performed in layers.

4. Operative Note - Arthroscopic Rotator Cuff Repair with Calcific Tendinitis and Severe Bone Pain: Arthroscopic portals were established, providing access to the rotator cuff tear. The patient had severe bone pain associated with calcific tendinitis. The calcific deposit within the tendon was meticulously excised. The rotator cuff tear was repaired using sutures and anchors, targeting the source of severe bone pain. The procedure was completed successfully.

5. Operative Note - Open Tendon Transfer, Calcific Tendinitis Excision, and Bone Erosion Repair with Severe Bone Pain: An open approach was used to access the affected tendon. The patient experienced severe bone pain due to calcific tendinitis. Tendon transfer was performed to address the chronic condition. The calcific deposit was meticulously excised, and the eroded bone surfaces were reconstructed and repaired, targeting the source of severe bone pain. The patient's postoperative pain was effectively managed.

6. Operative Note - Arthroscopic Resection, Chondroplasty, and Bone Erosion Repair with Severe Bone Pain: Arthroscopic portals were established, providing access to the shoulder joint. The patient presented with severe bone pain associated with calcific tendinitis. The calcific deposit was visualized and resected using specialized instruments. Chondroplasty was performed to address any associated cartilage damage. The eroded bone surfaces were treated and repaired, aiming to alleviate severe bone pain.

7. Operative Note - Open Subacromial Decompression, Calcific Tendinitis Excision, and Bone Erosion Repair with Severe Bone Pain: An open approach was used to access the subacromial space. The patient had severe bone pain due to calcific tendinitis and bone erosion. Subacromial decompression was performed, and the calcific deposits within the rotator cuff tendons were meticulously removed. The eroded bone surfaces were reconstructed and repaired, targeting the source of severe bone pain. The patient's pain was effectively managed.

8. Operative Note - Arthroscopic Capsular Release, Calcific Tendinitis Excision, and Bone Erosion

Repair with Severe Bone Pain: Arthroscopic portals were established, providing access to the shoulder joint. The patient experienced severe bone pain due to calcific tendinitis. Capsular release was performed to address adhesive capsulitis. The calcific deposit within the tendon was meticulously excised. The eroded bone surfaces were addressed and repaired, targeting the source of severe bone pain.

9. Operative Note - Open Rotator Cuff Repair, Calcific Tendinitis Excision, and Bone Erosion Repair with Severe Bone Pain: An open approach was used to expose the rotator cuff tear. The patient presented with severe bone pain associated with calcific tendinitis. The calcific deposit within the tendon was meticulously excised. The rotator cuff tear was repaired using sutures and anchors, and the eroded bone surfaces were treated and repaired, targeting the source of severe bone pain.

10. Operative Note - Mini-Open Calcific Tendinitis Decompression, Bone Erosion Repair, and Platelet-Rich Plasma Injection with Severe Bone Pain: A mini-open approach was utilized. The patient had severe bone pain due to calcific tendinitis. The calcific deposit was meticulously decompressed and removed. The eroded bone surfaces were addressed and repaired. Platelet-rich plasma injection was performed to promote healing and alleviate severe bone pain. The patient's postoperative pain was effectively managed.

1. Operative Note - Calcific Tendinitis Excision with Arthroscopic Intervention: The patient underwent arthroscopic surgery for calcific tendinitis. Multiple portals were established, providing access to the affected tendon. The calcific deposit was meticulously excised using specialized instruments. The joint was thoroughly irrigated, and the portals were closed. The patient's postoperative recovery was monitored, and appropriate pain management was initiated.

2. Operative Note - Open Surgical Intervention for Severe Calcific Tendinitis: The patient underwent open surgery for severe calcific tendinitis. A longitudinal incision was made over the affected area, exposing the tendon and calcific deposit. Careful dissection and excision of the calcification were performed. The eroded bone surfaces were addressed and repaired. The wound was closed in layers, and postoperative instructions were provided.

3. Operative Note - Arthroscopic Decompression and Removal of Calcific Deposit: The patient underwent arthroscopic intervention to address calcific tendinitis. Arthroscopic portals were established, allowing visualization of the affected tendon. Subacromial decompression was performed, followed by meticulous removal of the calcific deposit. The joint was irrigated, and the portals were closed. The patient was advised regarding postoperative care and rehabilitation.

4. Operative Note - Mini-Open Surgical Intervention for Calcific Tendinitis: The patient underwent a mini-open surgical intervention for calcific tendinitis. A small incision was made over the affected area, providing access to the tendon. The calcific deposit was meticulously excised, and the surrounding tissues were examined for any associated damage. Closure was performed in layers, and appropriate postoperative pain management was initiated.

5. Operative Note - Endoscopic Surgical Intervention for Calcific Tendinitis: The patient underwent endoscopic surgery for calcific tendinitis. Endoscopic portals were established, allowing visualization of the affected tendon. The calcific deposit was meticulously removed using specialized instruments. The joint was irrigated, and the portals were closed. The patient's postoperative recovery and pain management were closely monitored.

6. Operative Note - Open Surgical Excision and Repair for Chronic Calcific Tendinitis: The patient underwent open surgical excision and repair for chronic calcific tendinitis. An incision was made over the affected area, exposing the calcific deposit and the eroded bone surfaces. The deposit was meticulously excised, and the bone surfaces were reconstructed and repaired. Closure was performed in layers, and appropriate postoperative care was initiated.

7. Operative Note - Arthroscopic Intervention with Calcific Tendinitis Debridement: The patient underwent arthroscopic intervention for calcific tendinitis debridement. Arthroscopic portals were established, providing access to the affected tendon. The calcific deposit and any associated debris were meticulously debrided using specialized instruments. The joint was irrigated, and the portals were closed. The patient's postoperative recovery and pain management were closely monitored.

8. Operative Note - Surgical Intervention for Recurrent Calcific Tendinitis: The patient underwent surgical intervention for recurrent calcific tendinitis. A surgical approach was chosen based on the specific requirements of the case. The calcific deposit was meticulously excised, and any underlying bone erosion was addressed and repaired. Closure was performed, and appropriate postoperative measures were taken to prevent recurrence.

9. Operative Note - Open Surgical Intervention for Calcific Tendinitis and Subacromial Impingement: The patient underwent open surgical intervention to address calcific tendinitis and subacromial impingement. An incision was made over the affected area, providing access to the tendon and subacromial space. The calcific deposit

was excised, and subacromial decompression was performed to alleviate impingement. The wound was closed, and postoperative care was initiated.

10. Operative Note - Arthroscopic Intervention with Tenotomy for Calcific Tendinitis: The patient underwent arthroscopic intervention with tenotomy for calcific tendinitis. Arthroscopic portals were established, allowing visualization of the affected tendon. A tenotomy was performed to release tension and access the calcific deposit. The deposit was meticulously removed, and the tendon was repaired. Closure was performed, and the patient's postoperative recovery was closely monitored.

1. Operative Note - Open Surgical Intervention with Subacromial Bursectomy for Calcific Tendinitis: The patient underwent open surgical intervention for calcific tendinitis. An incision was made over the affected area, exposing the tendon and calcific deposit. In addition to excising the deposit, a subacromial bursectomy was performed to alleviate inflammation. The eroded bone surfaces were addressed and repaired. Closure was performed in layers, and postoperative instructions were provided.

2. Operative Note - Arthroscopic Intervention with Rotator Cuff Repair for Calcific Tendinitis: The patient underwent arthroscopic intervention for calcific tendinitis with associated rotator cuff tear. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and the rotator cuff tear was repaired using sutures and anchors. The joint was irrigated, and the portals were closed. Postoperative care and rehabilitation were initiated.

3. Operative Note - Mini-Open Surgical Intervention with Tendon Transfer for Calcific Tendinitis: The patient underwent a mini-open surgical intervention for calcific tendinitis with tendon transfer. A small incision was made to access the affected tendon. The calcific deposit was meticulously excised, and a tendon transfer was performed to address the chronic condition. Closure was performed, and appropriate postoperative pain management was initiated.

4. Operative Note - Open Surgical Intervention with Capsular Release for Calcific Tendinitis: The patient underwent open surgical intervention for calcific tendinitis with associated adhesive capsulitis. An incision was made to expose the affected area, allowing access to the tendon and joint capsule. The calcific deposit was meticulously excised, and a capsular release was performed to address the adhesive capsulitis. The wound was closed, and postoperative care was provided.

5. Operative Note - Arthroscopic Intervention with Chondroplasty for Calcific Tendinitis: The patient underwent arthroscopic intervention for calcific tendinitis with associated cartilage damage. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and chondroplasty was performed to address the cartilage damage. The joint was irrigated, and the portals were closed. Postoperative rehabilitation was initiated.

6. Operative Note - Open Surgical Intervention with Bone Grafting for Calcific Tendinitis and Bone Erosion: The patient underwent open surgical intervention for calcific tendinitis with severe bone erosion. An incision was made over the affected area, exposing the tendon and eroded bone surfaces. The calcific deposit was meticulously excised, and bone grafting was performed to reconstruct and repair the eroded bone. Closure was performed, and appropriate postoperative measures were taken.

7. Operative Note - Arthroscopic Intervention with Platelet-Rich Plasma Injection for Calcific Tendinitis: The patient underwent arthroscopic intervention for calcific tendinitis. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and platelet-rich plasma injection was administered to promote healing and alleviate symptoms. The joint was irrigated, and the portals were closed. Postoperative care and rehabilitation were initiated.

8. Operative Note - Open Surgical Intervention with Tendon Release for Calcific Tendinitis: The patient underwent open surgical intervention for calcific tendinitis with associated tendon contracture. An incision was made to access the affected tendon. The calcific deposit was meticulously excised, and a tendon release was performed to address the contracture. Closure was performed, and appropriate postoperative measures were taken.

9. Operative

Note - Arthroscopic Intervention with Tenodesis for Calcific Tendinitis: The patient underwent arthroscopic intervention for calcific tendinitis. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and a tenodesis procedure was performed to stabilize the tendon. The joint was irrigated, and the portals were closed. Postoperative care and rehabilitation were initiated.

10. Operative Note - Open Surgical Intervention with Joint Resurfacing for Calcific Tendinitis: The patient underwent open surgical intervention for calcific tendinitis with associated joint surface damage. An incision was made to access the affected area, exposing the tendon and joint surfaces. The calcific deposit was meticulously excised, and joint resurfacing was performed to address the damaged joint surfaces. Closure was performed, and postoperative care was provided.

1. Operative Note - Emergency Surgical Intervention for Calcific Tendinitis with Severe Joint Infection: The patient presented with severe infection on the extreme moving joint due to calcific tendinitis. An emergency surgical intervention was performed to address the infection. The affected area was thoroughly debrided, and the calcific deposit was excised. The joint was irrigated with antimicrobial solution, and appropriate antibiotic therapy was initiated. The wound was closed, and close monitoring of the patient's postoperative recovery was ensured.

2. Operative Note - Arthroscopic Lavage and Debridement for Calcific Tendinitis with Severe Joint Infection: The patient underwent arthroscopic intervention to address calcific tendinitis with severe joint infection. Arthroscopic portals were established, providing access to the affected joint. Lavage was performed to clean the infected joint, followed by meticulous debridement of the calcific deposit. The joint was irrigated with antimicrobial solution, and appropriate postoperative antibiotics were administered.

3. Operative Note - Open Surgical Intervention with Extensive Debridement and Joint Washout for Calcific Tendinitis with Severe Joint Infection: The patient underwent open surgical intervention to address calcific tendinitis with severe infection of the extreme moving joint. An extensive debridement was performed to remove infected tissues, including the calcific deposit. The joint was thoroughly washed out with antimicrobial solution, and drainage was established. Appropriate antibiotic therapy and wound care were initiated.

4. Operative Note - Mini-Open Surgical Intervention with Joint Exploration and Abscess Drainage for Calcific Tendinitis with Severe Joint Infection: The patient underwent a mini-open surgical intervention to address calcific tendinitis with severe joint infection. A small incision was made to access the infected joint, allowing for exploration and identification of abscess formation. The abscess was drained, and the calcific deposit was meticulously excised. The wound was irrigated and closed, and appropriate antibiotic treatment was initiated.

5. Operative Note - Arthroscopic Intervention with Joint Flushing and Infectious Tissue Debridement for Calcific Tendinitis with Severe Joint Infection: The patient underwent arthroscopic intervention to address calcific tendinitis with severe infection of the extreme moving joint. Arthroscopic portals were established, providing access to the joint. Flushing of the joint with antimicrobial solution was performed, followed by meticulous debridement of infected tissues, including the calcific deposit. Postoperative antibiotic therapy and close monitoring were initiated.

6. Operative Note - Open Surgical Intervention with Excisional Debridement and Infected Tissue Removal for Calcific Tendinitis with Severe Joint Infection: The patient underwent open surgical intervention for calcific tendinitis with severe joint infection. An incision was made to access the infected joint, and excisional debridement was performed to remove infected tissues, including the calcific deposit. Thorough irrigation with antimicrobial solution was done, and appropriate wound care was provided postoperatively.

7. Operative Note - Arthroscopic Lavage, Debridement, and Antibiotic Bead Placement for Calcific Tendinitis with Severe Joint Infection: The patient underwent arthroscopic intervention to address calcific tendinitis with severe joint infection. Arthroscopic portals were established, allowing access to the affected joint. Lavage with antimicrobial solution was performed, and meticulous debridement of infected tissues and calcific deposit was carried out. Antibiotic-impregnated beads were placed in the joint for targeted antimicrobial therapy.

8. Operative Note - Open Surgical Intervention with Extensive Debridement, Joint Washout, and Irrigation for Calcific Tend

initis with Severe Joint Infection: The patient underwent open surgical intervention to address calcific tendinitis with severe infection of the extreme moving joint. An extensive debridement was performed to remove infected tissues, including the calcific deposit. The joint was thoroughly washed out and irrigated with antimicrobial solution. Appropriate antibiotic therapy and wound closure were provided.

9. Operative Note - Mini-Open Surgical Intervention with Joint Exploration, Abscess Drainage, and Antibiotic Spacer Placement for Calcific Tendinitis with Severe Joint Infection: The patient underwent a mini-open surgical intervention to address calcific tendinitis with severe joint infection. A small incision was made to access the infected joint, allowing for exploration and identification of abscess formation. The abscess was drained, and an antibiotic spacer was placed to facilitate targeted antibiotic therapy. The wound was closed, and postoperative care was initiated.

10. Operative Note - Arthroscopic Intervention with Joint Flushing, Infectious Tissue Debridement, and Antibiotic Irrigation for Calcific Tendinitis with Severe Joint Infection: The patient underwent arthroscopic intervention to address calcific tendinitis with severe infection of the extreme moving joint. Arthroscopic portals were established, providing access to the joint. Flushing of the joint with antimicrobial solution was performed, followed by meticulous debridement of infected tissues, including the calcific deposit. Antibiotic irrigation was administered, and the portals were closed. Postoperative antibiotic therapy and close monitoring were initiated.

1. Operative Note - Arthroscopic Intervention for Calcific Tendinitis with Acute Inflammatory Response: The patient underwent arthroscopic intervention for calcific tendinitis with an acute inflammatory response. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and the inflamed tissues were carefully debrided. The joint was irrigated, and anti-inflammatory measures were taken intraoperatively. The portals were closed, and appropriate postoperative care was provided.

2. Operative Note - Open Surgical Intervention for Calcific Tendinitis with Chronic Inflammatory Changes: The patient underwent open surgical intervention for calcific tendinitis with chronic inflammatory changes. An incision was made over the affected area, exposing the tendon and calcific deposit. The deposit was meticulously excised, and the chronically inflamed tissues were addressed and debrided. Closure was performed in layers, and postoperative anti-inflammatory measures were initiated.

3. Operative Note - Arthroscopic Intervention with Corticosteroid Injection for Calcific Tendinitis and Moderate Inflammation: The patient underwent arthroscopic intervention for calcific tendinitis with moderate inflammation. Arthroscopic portals were established, allowing access to the affected area. The calcific deposit was meticulously excised, and a corticosteroid injection was administered to reduce inflammation. The joint was irrigated, and the portals were closed. Postoperative care and anti-inflammatory medication were prescribed.

4. Operative Note - Open Surgical Intervention with Tenosynovectomy for Calcific Tendinitis and Severe Inflammation: The patient underwent open surgical intervention for calcific tendinitis with severe inflammation. An incision was made to access the affected area, exposing the tendon and surrounding tissues. The calcific deposit was meticulously excised, and a tenosynovectomy was performed to remove inflamed synovial tissue. Closure was performed, and postoperative anti-inflammatory measures were initiated.

5. Operative Note - Arthroscopic Intervention with Synovectomy for Calcific Tendinitis and Synovial Inflammation: The patient underwent arthroscopic intervention for calcific tendinitis with synovial inflammation. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and a synovectomy was performed to address the inflamed synovial tissue. The joint was irrigated, and postoperative anti-inflammatory measures were implemented.

6. Operative Note - Open Surgical Intervention with Inflammatory Tissue Debridement for Calcific Tendinitis and Focal Inflammation: The patient underwent open surgical intervention for calcific tendinitis with focal inflammation. An incision was made over the affected area, exposing the tendon and surrounding inflamed tissues. The calcific deposit was meticulously excised, and the inflamed tissues were debrided. Closure was performed, and appropriate postoperative anti-inflammatory measures were taken.

7. Operative Note - Arthroscopic Intervention with Biologic Scaffold Placement for Calcific Tendinitis and Chronic Inflammation: The patient underwent arthroscopic intervention for calcific tendinitis with chronic inflammation. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and a biologic scaffold was placed to promote tissue healing and reduce inflammation. The joint was irrigated, and the portals were closed. Postoperative care and anti-inflammatory measures were prescribed.

8. Operative Note - Open Surgical Intervention with Fasciotomy for Calcific Tendinitis and Compartmental Inflammation: The patient underwent open surgical intervention for calcific tendinitis with compartmental inflammation. An incision was made to access the affected

area, allowing for fasciotomy to relieve pressure and address the inflamed compartments. The calcific deposit was meticulously excised, and closure was performed. Postoperative anti-inflammatory measures and monitoring were initiated.

9. Operative Note - Arthroscopic Intervention with Inflammation Control Measures for Calcific Tendinitis and Diffuse Inflammation: The patient underwent arthroscopic intervention for calcific tendinitis with diffuse inflammation. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and inflammation control measures such as irrigation with anti-inflammatory solutions and application of cryotherapy were employed. The portals were closed, and postoperative anti-inflammatory medication was prescribed.

10. Operative Note - Open Surgical Intervention with Bursectomy for Calcific Tendinitis and Bursal Inflammation: The patient underwent open surgical intervention for calcific tendinitis with bursal inflammation. An incision was made to access the affected area, allowing for bursectomy to address the inflamed bursa. The calcific deposit was meticulously excised, and closure was performed. Postoperative anti-inflammatory measures and wound care were initiated.

1. Operative Note - Arthroscopic Intervention for Mild Calcific Tendinitis: The patient underwent arthroscopic intervention for mild calcific tendinitis. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and the tendon was examined for any additional pathology. The joint was irrigated, and the portals were closed. Postoperative follow-up was scheduled in four weeks to assess the patient's response to treatment and determine the need for further intervention.

2. Operative Note - Open Surgical Intervention for Moderate Calcific Tendinitis: The patient underwent open surgical intervention for moderate calcific tendinitis. An incision was made over the affected area, exposing the tendon and calcific deposit. The deposit was meticulously excised, and any associated tendon pathology was addressed. Closure was performed, and a postoperative follow-up was scheduled in two weeks to evaluate the patient's progress and determine the need for rehabilitation or additional treatment.

3. Operative Note - Arthroscopic Intervention for Severe Calcific Tendinitis: The patient underwent arthroscopic intervention for severe calcific tendinitis. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and extensive debridement of the inflamed tissues was performed. The joint was thoroughly irrigated, and postoperative follow-up was scheduled in one week to assess the patient's response to treatment and determine the need for further intervention or specialized rehabilitation.

4. Operative Note - Open Surgical Intervention for Recurrent Calcific Tendinitis: The patient underwent open surgical intervention for recurrent calcific tendinitis. An incision was made over the affected area, exposing the tendon and recurrent calcific deposits. The deposits were meticulously excised, and the tendon was evaluated for any underlying pathology. Closure was performed, and a postoperative follow-up was scheduled in three weeks to assess the patient's response and consider long-term management options.

5. Operative Note - Arthroscopic Intervention for Chronic Calcific Tendinitis: The patient underwent arthroscopic intervention for chronic calcific tendinitis. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and extensive debridement was performed to address chronic inflammation and damaged tissues. The joint was irrigated, and a postoperative follow-up was scheduled in four weeks to evaluate the patient's response to treatment and determine the need for additional intervention or rehabilitation.

6. Operative Note - Open Surgical Intervention for Severe and Extensive Calcific Tendinitis: The patient underwent open surgical intervention for severe and extensive calcific tendinitis. An incision was made to access the affected area, exposing the tendon and multiple calcific deposits. The deposits were meticulously excised, and thorough debridement was performed. Closure was performed, and a postoperative follow-up was scheduled in two weeks to assess the patient's response and determine the need for further management or rehabilitation.

7. Operative Note - Arthroscopic Intervention for Calcific Tendinitis with Concurrent Shoulder Pathology: The patient underwent arthroscopic intervention for calcific tendinitis with concurrent shoulder pathology. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and any additional shoulder pathology, such as rotator cuff tears or labral injuries, was addressed. The joint was irrigated, and a postoperative follow-up was scheduled in six weeks to evaluate the patient's response to treatment and determine the need for targeted rehabilitation or further intervention.

8. Operative Note - Open Surgical Intervention for Severe Calcific Tendinitis with Joint Instability: The patient underwent open surgical intervention for severe calc

ific tendinitis with joint instability. An incision was made over the affected area, exposing the tendon, calcific deposit, and addressing the underlying joint instability. The deposit was meticulously excised, and appropriate joint stabilization procedures were performed. Closure was performed, and a postoperative follow-up was scheduled in three weeks to assess the patient's response and determine the need for further stabilization or rehabilitation.

9. Operative Note - Arthroscopic Intervention for Calcific Tendinitis with Associated Nerve Impingement: The patient underwent arthroscopic intervention for calcific tendinitis with associated nerve impingement. Arthroscopic portals were established, providing access to the affected area. The calcific deposit was meticulously excised, and the nerve impingement was relieved through appropriate decompression techniques. The joint was irrigated, and a postoperative follow-up was scheduled in four weeks to evaluate the patient's response and assess nerve function.

10. Operative Note - Open Surgical Intervention for Severe Multifocal Calcific Tendinitis: The patient underwent open surgical intervention for severe multifocal calcific tendinitis. Multiple incisions were made over the affected areas, exposing the tendons and multiple calcific deposits. The deposits were meticulously excised, and extensive debridement was performed. Closure was performed, and a postoperative follow-up was scheduled in two weeks to assess the patient's response and determine the need for further management or rehabilitation.

## M75.4 Impingement syndrome of shoulder

1. Operative Note: Patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression. The subacromial space was inspected and a bursectomy was performed. Acromioplasty was done to remove any bony spurs. The rotator cuff was evaluated and found to be intact. Closure was done using absorbable sutures. Postoperative instructions were given, emphasizing early range of motion exercises.

2. Operative Note: The patient presented with shoulder impingement syndrome and underwent an arthroscopic acromioclavicular joint resection. The distal clavicle was excised using a burr, and the subacromial space was inspected. The bursa was debrided, and a partial acromioplasty was performed. The rotator cuff tendons were intact. Closure was performed, and the patient was instructed on postoperative rehabilitation.

3. Operative Note: A patient with shoulder impingement syndrome underwent an open surgical procedure. A deltoid-splitting approach was used. The acromion was inspected and found to have a type 2 morphology. A resection of the distal acromion was performed, and the bursal tissue was excised. No rotator cuff tear was found. Closure was performed, and the patient was advised on postoperative care and rehabilitation.

4. Operative Note: The patient presented with chronic impingement syndrome of the shoulder. An arthroscopic procedure was performed, involving subacromial decompression and rotator cuff repair. The subacromial space was evaluated and debrided. Partial acromioplasty was performed to alleviate impingement. A full-thickness tear of the supraspinatus tendon was identified and repaired using suture anchors. The procedure was completed, and postoperative care instructions were provided.

5. Operative Note: A patient with recurrent shoulder impingement syndrome underwent a minimally invasive procedure. Arthroscopy was performed, revealing bursal thickening and acromial spurring. Bursectomy and acromioplasty were conducted. The subacromial space was cleared, and the rotator cuff tendons were found to be intact. The incisions were closed, and postoperative guidelines were given to the patient regarding rehabilitation and follow-up appointments.

6. Operative Note: The patient with symptomatic impingement syndrome of the shoulder underwent an arthroscopic procedure. Subacromial decompression was performed, removing the inflamed bursa and subacromial spurs. The acromion was shaped to provide more space. The rotator cuff tendons were examined and found to be intact. The surgical sites were closed, and the patient was instructed on postoperative care and rehabilitation exercises.

7. Operative Note: A patient with chronic shoulder impingement syndrome underwent an open procedure. An incision was made over the anterior aspect of the shoulder, and the subacromial space was exposed. A bursectomy was performed, followed by an acromioplasty to address the impingement. The integrity of the rotator cuff was assessed and found to be intact. The incision was closed, and the patient was given postoperative instructions.

8. Operative Note: The patient presented with severe impingement syndrome of the shoulder. Arthroscopic surgery was performed to address the issue. Subacromial decompression was done, removing the bursa and any bone spurs. Acromioplasty was performed, ensuring sufficient space for the rotator cuff. The integrity of the rotator cuff tendons was confirmed. Closure was performed, and the patient was educated about postoperative care and rehabilitation.

9. Operative Note:

The patient with refractory shoulder impingement syndrome underwent an arthroscopic procedure. Subacromial decompression was performed using a burr, and the bursa was removed. Acromioplasty was done to eliminate impinging structures. The rotator cuff was inspected and found to be intact. Closure was performed, and the patient was advised on postoperative precautions and rehabilitation exercises.

10. Operative Note: The patient presented with impingement syndrome of the shoulder and underwent an open surgical intervention. A longitudinal incision was made, and the subacromial space was exposed. Subsequently, a bursectomy was performed, and the acromion was reshaped through acromioplasty. The rotator cuff was evaluated and found to be intact. The incision was closed, and postoperative care instructions were provided to the patient.

1. Operative Note: The patient with symptomatic impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression. The subacromial space was visualized, and excessive bursal tissue was excised. Acromioplasty was performed to alleviate impingement. The integrity of the rotator cuff tendons was confirmed. Closure was done using absorbable sutures, and postoperative instructions were provided regarding activity restrictions and rehabilitation.

2. Operative Note: A patient with chronic impingement syndrome of the shoulder underwent an open surgical procedure. A deltoid-splitting approach was utilized. The subacromial space was accessed, and the inflamed bursa was resected. Acromioplasty was performed to create more clearance. The rotator cuff tendons were intact and free of tears. The incision was closed in layers, and the patient was advised on postoperative care and rehabilitation exercises.

3. Operative Note: The patient presented with recurrent impingement syndrome of the shoulder. Arthroscopy was performed to address the condition. Subacromial decompression was carried out, removing the inflamed bursa and subacromial spurs. Acromioplasty was performed to provide adequate space. The rotator cuff tendons were evaluated and found to be intact. The arthroscopic portals were closed, and postoperative care instructions were provided.

4. Operative Note: A patient with refractory shoulder impingement syndrome underwent an open surgical intervention. An incision was made over the anterior aspect of the shoulder, exposing the subacromial space. Subsequently, subacromial decompression was performed, excising the bursa and removing impinging structures. Acromioplasty was performed to optimize the subacromial space. The integrity of the rotator cuff was evaluated and found to be intact. The incision was closed, and postoperative instructions were given.

5. Operative Note: The patient presented with severe impingement syndrome of the shoulder. Arthroscopic subacromial decompression was performed, removing the inflamed bursa and any osseous prominences. Acromioplasty was performed to ensure adequate clearance. The rotator cuff tendons were inspected and found to be intact. The arthroscopic portals were closed, and the patient was provided with postoperative care guidelines and rehabilitation instructions.

6. Operative Note: A patient with persistent impingement syndrome of the shoulder underwent an arthroscopic procedure. Subacromial decompression was performed using a shaver and burr, addressing the inflamed bursa and subacromial spurs. Acromioplasty was conducted to alleviate impingement. The rotator cuff tendons were intact without any tears. Closure was performed using sutures, and postoperative care instructions were given.

7. Operative Note: The patient presented with chronic shoulder impingement syndrome. Arthroscopic subacromial decompression was performed, removing the inflamed bursa and addressing acromial spurring. Acromioplasty was performed to increase the subacromial space. The integrity of the rotator cuff was assessed and found to be intact. Closure was performed using absorbable sutures, and the patient was instructed on postoperative precautions and rehabilitation exercises.

8. Operative Note: A patient with recalcitrant shoulder impingement syndrome underwent an open surgical intervention. A longitudinal incision was made over the anterior aspect of the shoulder, allowing access to the subacromial space. Subsequently, subacromial decompression was performed,

excising the inflamed bursa and any impinging structures. Acromioplasty was conducted to optimize the subacromial clearance. The rotator cuff was evaluated and found to be intact. The incision was closed, and postoperative care instructions were provided.

9. Operative Note: The patient presented with impingement syndrome of the shoulder and underwent an arthroscopic subacromial decompression. The subacromial space was inspected, and hypertrophic bursa was excised. Acromioplasty was performed to alleviate impingement. The integrity of the rotator cuff tendons was confirmed. Closure was performed using sutures, and the patient was counseled on postoperative care and rehabilitation exercises.

10. Operative Note: A patient with chronic impingement syndrome of the shoulder underwent an open surgical procedure. An incision was made along the lateral aspect of the shoulder, exposing the subacromial space. Subacromial decompression was performed, excising the inflamed bursa and removing any impinging structures. Acromioplasty was conducted to improve the subacromial clearance. The rotator cuff tendons were intact and free of pathology. Closure was performed, and postoperative instructions were given.

1. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression under general anesthesia. A standard dose of 2% lidocaine with epinephrine was used for local infiltration anesthesia. The procedure was performed successfully, and the patient tolerated the anesthesia well. Postoperative pain was managed with a combination of oral analgesics and local anesthetic infiltration.

2. Operative Note: A patient with impingement syndrome of the shoulder underwent an open surgical intervention under regional anesthesia. A supraclavicular brachial plexus block was performed using a mixture of local anesthetics, achieving adequate sensory and motor blockade. The patient remained comfortable throughout the procedure, and postoperative pain control was achieved with a combination of oral analgesics and intermittent local anesthetic infiltration.

3. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression under monitored anesthesia care (MAC). A moderate sedation level was achieved using intravenous midazolam and fentanyl. Local anesthesia was administered with 1% lidocaine with epinephrine for analgesia and vasoconstriction. The patient remained stable and pain-free during the procedure.

4. Operative Note: A patient with impingement syndrome of the shoulder underwent an open surgical procedure under general anesthesia. Balanced anesthesia was induced with intravenous propofol, and endotracheal intubation was performed. Inhalational isoflurane was used to maintain anesthesia. Postoperatively, the patient received opioid analgesics along with local anesthetic infiltration for pain management.

5. Operative Note: The patient presented with impingement syndrome of the shoulder and underwent an arthroscopic subacromial decompression under local anesthesia with sedation. A combination of 1% lidocaine with epinephrine and conscious sedation using intravenous midazolam and fentanyl was administered. The patient remained relaxed and comfortable throughout the procedure, with adequate pain control achieved.

6. Operative Note: A patient with impingement syndrome of the shoulder underwent an open surgical intervention under general anesthesia with a nerve block. General anesthesia was induced using intravenous propofol, and endotracheal intubation was performed. A preoperative interscalene brachial plexus block was administered for regional anesthesia. The patient had optimal pain control intraoperatively and postoperatively.

7. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression under local anesthesia. Infiltration of the surgical site was performed using 1% lidocaine with epinephrine. Additionally, intravenous conscious sedation was administered using midazolam and remifentanil. The patient remained comfortable and cooperative during the procedure, and postoperative pain was managed with oral analgesics.

8. Operative Note: A patient with impingement syndrome of the shoulder underwent an open surgical procedure under regional anesthesia. A combination of ultrasound-guided interscalene brachial plexus block and general anesthesia was employed. The patient experienced excellent pain relief intraoperatively, and postoperative analgesia was provided using a multimodal approach, including oral analgesics and local anesthetic infiltration.

9. Operative Note: The patient presented with impingement syndrome of the shoulder and underwent an arthroscopic subacromial decompression under general anesthesia. A combination of intravenous propofol and remifentanil was used for anesthesia maintenance. Local infiltration of

the surgical site was performed using 1% lidocaine with epinephrine. The patient had a smooth intraoperative course, and postoperative pain was managed effectively.

10. Operative Note: A patient with impingement syndrome of the shoulder underwent an open surgical intervention under monitored anesthesia care (MAC). Conscious sedation was achieved using intravenous dexmedetomidine and fentanyl. Regional anesthesia was administered via an ultrasound-guided suprascapular nerve block. The patient remained comfortable and pain-free throughout the procedure, with minimal postoperative analgesic requirements.

1. Operative Note: The patient with impingement syndrome of the shoulder and significant bone erosion underwent an arthroscopic subacromial decompression with concomitant acromioclavicular joint resection. Extensive erosion of the acromion and distal clavicle was observed and addressed. The subacromial space was cleared, and the rotator cuff tendons were evaluated and found to be intact. Closure was performed, and postoperative instructions were provided, emphasizing the importance of rehabilitation.

2. Operative Note: A patient with severe impingement syndrome and extensive bone erosion of the shoulder underwent an open surgical intervention. The acromion was found to be significantly eroded, requiring resection. Subacromial decompression was performed, and a partial acromioplasty was conducted. The rotator cuff tendons were evaluated, revealing no evidence of tears. The incision was closed, and postoperative care instructions were given, including early range of motion exercises.

3. Operative Note: The patient presented with chronic impingement syndrome and advanced bone erosion of the shoulder joint. An arthroscopic subacromial decompression was performed, addressing the eroded acromion and removing bursal tissue. Acromioplasty was performed to alleviate impingement. The integrity of the rotator cuff tendons was confirmed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for gradual rehabilitation.

4. Operative Note: A patient with impingement syndrome and severe bone erosion of the shoulder underwent an open surgical procedure. The acromion was extensively eroded, necessitating resection. Subacromial decompression was performed, and an acromioplasty was conducted. The integrity of the rotator cuff was evaluated and found to be intact. The incision was closed, and the patient was given postoperative guidelines for rehabilitation and follow-up.

5. Operative Note: The patient with advanced impingement syndrome and significant bone erosion of the shoulder underwent an arthroscopic subacromial decompression and distal clavicle excision. Extensive erosion of the acromion and distal clavicle was observed and addressed. The subacromial space was cleared, and the rotator cuff tendons were intact. Closure was performed, and postoperative instructions were provided, emphasizing the importance of gentle rehabilitation.

6. Operative Note: A patient with chronic impingement syndrome and marked bone erosion of the shoulder underwent an open surgical intervention. The acromion and distal clavicle showed severe erosion, requiring resection. Subacromial decompression and acromioplasty were performed. The integrity of the rotator cuff tendons was assessed and found to be intact. The incision was closed, and postoperative care instructions were provided, including a progressive rehabilitation program.

7. Operative Note: The patient presented with refractory impingement syndrome and substantial bone erosion of the shoulder joint. An arthroscopic subacromial decompression was performed, addressing the eroded acromion and removing the inflamed bursa. Acromioplasty was conducted to alleviate impingement. The rotator cuff tendons were assessed and found to be intact. Closure was performed, and the patient was educated about postoperative care and the importance of gradual rehabilitation.

8. Operative Note: A patient with severe impingement syndrome and extensive bone erosion of the shoulder underwent an open surgical procedure. The acromion and distal clavicle exhibited significant erosion, necessitating resection. Subacromial decompression and acromioplast

y were performed, providing ample clearance. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative instructions were given, emphasizing the need for early mobilization.

9. Operative Note: The patient presented with chronic impingement syndrome and notable bone erosion of the shoulder joint. An arthroscopic subacromial decompression was performed, addressing the eroded acromion and removing the inflamed bursa. Acromioplasty was conducted to alleviate impingement. The integrity of the rotator cuff tendons was confirmed. Closure was performed, and the patient was instructed on postoperative care, including gradual rehabilitation and activity modification.

10. Operative Note: A patient with extensive impingement syndrome and severe bone erosion of the shoulder underwent an open surgical intervention. The acromion and distal clavicle showed significant erosion, necessitating resection. Subacromial decompression and acromioplasty were performed to relieve impingement. The integrity of the rotator cuff tendons was assessed and found to be intact. Closure was performed, and postoperative care instructions were given, emphasizing the importance of a structured rehabilitation program.

1. Operative Note: The patient with impingement syndrome of the shoulder and severe bone pain underwent an arthroscopic subacromial decompression. Extensive bone spurs were identified and removed, relieving impingement and addressing the source of severe pain. The subacromial space was cleared, and the rotator cuff tendons were evaluated. Closure was performed, and postoperative instructions were given, emphasizing pain management and the importance of a gradual rehabilitation program.

2. Operative Note: A patient with severe impingement syndrome and debilitating bone pain of the shoulder underwent an open surgical intervention. The acromion and distal clavicle exhibited prominent bone spurs, contributing to the patient's severe pain. Subacromial decompression and acromioplasty were performed, eliminating impingement and relieving bone pain. The integrity of the rotator cuff tendons was assessed and found to be intact. Closure was performed, and postoperative pain management strategies were discussed.

3. Operative Note: The patient presented with chronic impingement syndrome and excruciating bone pain in the shoulder. An arthroscopic subacromial decompression was performed to address the bone spurs causing impingement and severe pain. The subacromial space was cleared, and the integrity of the rotator cuff tendons was confirmed. Closure was performed, and postoperative instructions were provided, emphasizing the need for comprehensive pain management and a structured rehabilitation program.

4. Operative Note: A patient with severe impingement syndrome and intense bone pain of the shoulder underwent an open surgical procedure. The acromion and distal clavicle showed significant bone spurs, contributing to the patient's severe pain. Subacromial decompression and acromioplasty were performed, relieving impingement and addressing the underlying cause of bone pain. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative pain management was discussed.

5. Operative Note: The patient with impingement syndrome and severe bone pain in the shoulder underwent an arthroscopic subacromial decompression. Extensive bone spurs were identified and meticulously removed to alleviate impingement and relieve severe bone pain. The subacromial space was cleared, and the integrity of the rotator cuff tendons was assessed. Closure was performed, and postoperative instructions were given, emphasizing comprehensive pain management and the importance of a structured rehabilitation program.

6. Operative Note: A patient with debilitating impingement syndrome and severe bone pain of the shoulder underwent an open surgical intervention. The acromion and distal clavicle exhibited prominent bone spurs, leading to severe pain. Subacromial decompression and acromioplasty were performed, relieving impingement and addressing the underlying cause of bone pain. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative pain management strategies were discussed.

7. Operative Note: The patient presented with chronic impingement syndrome and agonizing bone pain in the shoulder. An arthroscopic subacromial decompression was performed to alleviate impingement and address the bone spurs causing severe pain. The subacromial space was meticulously cleared, and the integrity of the rotator cuff tendons was confirmed. Closure was performed, and postoperative instructions were provided, emphasizing the need for effective pain management and a well-structured rehabilitation program.

8. Operative Note: A patient with severe impingement syndrome and debilitating bone pain of the shoulder underwent an open surgical procedure. The

acromion and distal clavicle showed pronounced bone spurs, contributing to the patient's severe pain. Subacromial decompression and acromioplasty were performed to relieve impingement and alleviate bone pain. The integrity of the rotator cuff tendons was assessed and found to be intact. Closure was performed, and comprehensive postoperative pain management was discussed.

9. Operative Note: The patient with impingement syndrome and severe bone pain in the shoulder underwent an arthroscopic subacromial decompression. Prominent bone spurs were identified and meticulously removed, providing relief from impingement and alleviating severe bone pain. The subacromial space was cleared, and the integrity of the rotator cuff tendons was evaluated. Closure was performed, and postoperative instructions were given, emphasizing the importance of tailored pain management and a structured rehabilitation program.

10. Operative Note: A patient with severe impingement syndrome and incapacitating bone pain of the shoulder underwent an open surgical intervention. The acromion and distal clavicle exhibited significant bone spurs, contributing to the patient's severe pain. Subacromial decompression and acromioplasty were performed, relieving impingement and addressing the source of bone pain. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and comprehensive postoperative pain management strategies were discussed.

1. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression. The subacromial space was meticulously cleared, and the acromion was reshaped to alleviate impingement. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and gradual return to activity.

2. Operative Note: A patient with chronic impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The acromion was reshaped, and excessive bursal tissue was excised. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative care instructions were provided, emphasizing the need for rehabilitation and activity modification.

3. Operative Note: The patient presented with impingement syndrome of the shoulder and underwent an arthroscopic subacromial decompression with acromioplasty. The subacromial space was meticulously cleared, and the acromion was reshaped to eliminate impingement. The rotator cuff tendons were assessed and found to be intact. Closure was performed, and postoperative instructions were given, emphasizing the importance of a structured rehabilitation program.

4. Operative Note: A patient with refractory impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement and create more space in the subacromial region. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative care instructions were provided, emphasizing the need for physical therapy and gradual return to activities.

5. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression with distal clavicle excision. The subacromial space was meticulously cleared, and the acromion and distal clavicle were reshaped to relieve impingement. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and pain management.

6. Operative Note: A patient with severe impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement and create a more spacious subacromial environment. The rotator cuff tendons were evaluated and found to be intact. Closure was performed, and postoperative care instructions were provided, emphasizing the need for physiotherapy and a gradual return to normal activities.

7. Operative Note: The patient presented with chronic impingement syndrome of the shoulder and underwent an arthroscopic subacromial decompression with acromioplasty. The subacromial space was meticulously cleared, and the acromion was reshaped to alleviate impingement. The integrity of the rotator cuff tendons was assessed and found to be intact. Closure was performed, and postoperative instructions were given, emphasizing the importance of a structured rehabilitation program.

8. Operative Note: A patient with impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement and create a more suitable subacromial space. The integrity of the rotator cuff tendons was evaluated and found to be intact.

Closure was performed, and postoperative care instructions were provided, emphasizing the need for physical therapy and gradual return to activities.

9. Operative Note: The patient with severe impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression with distal clavicle resection. The subacromial space was meticulously cleared, and the acromion and distal clavicle were reshaped to alleviate impingement. The integrity of the rotator cuff tendons was assessed and found to be intact. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and pain control.

10. Operative Note: A patient with refractory impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement and provide a more suitable subacromial environment. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative care instructions were provided, emphasizing the need for physiotherapy and a gradual return to normal activities.

1. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression with rotator cuff repair. The subacromial space was meticulously cleared, and the acromion was reshaped to alleviate impingement. A partial-thickness rotator cuff tear was identified and repaired. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and adherence to activity restrictions.

2. Operative Note: A patient with chronic impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. Additionally, a full-thickness rotator cuff tear was identified and repaired using sutures. The integrity of the repaired tendon was confirmed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for rehabilitation and protected motion.

3. Operative Note: The patient presented with impingement syndrome of the shoulder and underwent an arthroscopic subacromial decompression with biceps tenodesis. The subacromial space was meticulously cleared, and the acromion was reshaped to alleviate impingement. Concurrently, the long head of the biceps tendon was tenodesed to reduce pain and improve shoulder function. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and biceps strengthening.

4. Operative Note: A patient with severe impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. In addition, a labral tear was identified and repaired using suture anchors. The integrity of the repaired labrum was confirmed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for rehabilitation and avoiding excessive shoulder stress.

5. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression with superior capsular reconstruction. The subacromial space was meticulously cleared, and the acromion was reshaped to alleviate impingement. Additionally, a massive irreparable rotator cuff tear was addressed by performing superior capsular reconstruction using an acellular dermal allograft. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and protected motion.

6. Operative Note: A patient with chronic impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. Moreover, a Bankart lesion was identified and repaired using suture anchors to stabilize the shoulder joint. Closure was performed, and postoperative care instructions were provided, emphasizing the need for rehabilitation and avoiding excessive shoulder movements.

7. Operative Note: The patient presented with impingement syndrome of the shoulder and underwent an arthroscopic subacromial decompression with SLAP (Superior Labrum Anterior to Posterior) repair. The subacromial space was meticulously cleared, and the acromion was reshaped to alleviate impingement. Concurrently, a SLAP tear was identified and repaired using suture anchors. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and gradual return to sports-specific activities.

8. Operative Note: A patient with severe impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. Additionally, a Hill-Sachs lesion was identified and addressed by performing a remplissage procedure to stabilize the joint and prevent further

dislocations. Closure was performed, and postoperative care instructions were provided, emphasizing the need for rehabilitation and protected motion.

9. Operative Note: The patient with impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression with distal clavicle excision and capsular release. The subacromial space was meticulously cleared, the acromion was reshaped, and the distal clavicle was excised to alleviate impingement. Concurrently, a capsular release was performed to improve shoulder mobility. Closure was performed, and postoperative instructions were given, emphasizing the importance of rehabilitation and gentle stretching exercises.

10. Operative Note: A patient with chronic impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. Additionally, a calcific tendonitis deposit was identified and debrided. Closure was performed, and postoperative care instructions were provided, emphasizing the need for rehabilitation and gradual return to activities, avoiding overhead movements.

1. Operative Note: The patient with impingement syndrome of the shoulder and a severe infection on the extreme moving joint underwent an emergency open surgical intervention. Debridement of the infected tissue was performed, followed by subacromial decompression to alleviate impingement. Extensive irrigation and drainage were performed to control the infection. Closure was performed, and postoperative instructions were given, emphasizing the importance of aggressive antibiotic therapy and close monitoring for signs of persistent infection.

2. Operative Note: A patient with chronic impingement syndrome of the shoulder and a severe infection on the extreme moving joint underwent an urgent open surgical procedure. Subacromial decompression and acromioplasty were performed to address impingement. The infected joint was thoroughly debrided, and all necrotic tissue was removed. Copious irrigation with antimicrobial solution was performed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for intravenous antibiotics and regular wound monitoring.

3. Operative Note: The patient presented with impingement syndrome of the shoulder and an extremely infected joint. An emergency arthroscopic subacromial decompression was performed along with extensive irrigation and debridement of the infected joint. The acromion was reshaped, and the subacromial space was meticulously cleared. Closure was performed, and postoperative instructions were given, emphasizing the importance of aggressive antibiotic therapy, wound care, and close monitoring for signs of persistent infection.

4. Operative Note: A patient with severe impingement syndrome of the shoulder and a highly infected joint underwent an urgent open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The infected joint was thoroughly debrided, and all necrotic tissue was removed. Copious irrigation with antimicrobial solution was performed to control the infection. Closure was performed, and postoperative care instructions were provided, emphasizing the need for intravenous antibiotics and frequent follow-up visits.

5. Operative Note: The patient with impingement syndrome of the shoulder and a severe infection on the extreme moving joint underwent an emergency arthroscopic subacromial decompression. The infected joint was meticulously debrided and irrigated. All visible pus and necrotic tissue were removed. Subsequently, the acromion was reshaped to alleviate impingement. Closure was performed, and postoperative instructions were given, emphasizing the importance of intensive antibiotic therapy and close monitoring for signs of ongoing infection.

6. Operative Note: A patient with chronic impingement syndrome of the shoulder and an extensively infected joint underwent an urgent open surgical procedure. Subacromial decompression and acromioplasty were performed to alleviate impingement. The infected joint was debrided, and thorough irrigation with antimicrobial solution was carried out. Closure was performed, and postoperative care instructions were provided, emphasizing the need for aggressive intravenous antibiotics, wound care, and close monitoring for any signs of persistent infection.

7. Operative Note: The patient presented with impingement syndrome of the shoulder and a severe infection on the extreme moving joint. An emergency arthroscopic subacromial decompression was performed along with extensive debridement of the infected joint. The acromion was reshaped, and the subacromial space was meticulously cleared. Closure was performed, and postoperative instructions were given, emphasizing the importance of intensive antibiotic therapy, wound care, and regular follow-up visits for infection monitoring.

8. Operative Note: A patient with severe impingement syndrome of the shoulder and a highly infected joint underwent an urgent open

surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The infected joint was extensively debrided, and thorough irrigation with antimicrobial solution was performed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for aggressive intravenous antibiotics, wound management, and frequent evaluations to ensure infection control.

9. Operative Note: The patient with impingement syndrome of the shoulder and a severe infection on the extreme moving joint underwent an emergency arthroscopic subacromial decompression. The infected joint was meticulously debrided and irrigated with antibiotic solution. The acromion was reshaped to alleviate impingement. Closure was performed, and postoperative instructions were given, emphasizing the importance of intravenous antibiotic therapy, wound care, and close surveillance for any signs of persistent infection.

10. Operative Note: A patient with chronic impingement syndrome of the shoulder and a highly infected joint underwent an urgent open surgical procedure. Subacromial decompression and acromioplasty were performed to alleviate impingement. The infected joint was thoroughly debrided, and copious irrigation with antimicrobial solution was performed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for intensive antibiotic treatment, wound care, and frequent follow-up examinations to monitor the resolution of the infection.

Certainly! Here are 10 synthetic operative notes pertaining to impingement syndrome of the shoulder, incorporating variation in inflammation:

1. Operative Note: The patient with impingement syndrome of the shoulder and severe inflammatory changes underwent an arthroscopic subacromial decompression. The inflamed subacromial bursa was meticulously cleared, and the acromion was reshaped to alleviate impingement. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative instructions were given, emphasizing the importance of anti-inflammatory medications and rehabilitation.

2. Operative Note: A patient with chronic impingement syndrome of the shoulder and moderate inflammatory changes underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The inflamed bursal tissue was excised, and the acromion was reshaped. The integrity of the rotator cuff tendons was assessed and found to be intact. Closure was performed, and postoperative care instructions were provided, emphasizing the need for anti-inflammatory medications and physical therapy.

3. Operative Note: The patient presented with impingement syndrome of the shoulder and mild inflammatory changes. An arthroscopic subacromial decompression was performed to alleviate impingement. The inflamed subacromial bursa was meticulously cleared, and the acromion was reshaped. Closure was performed, and postoperative instructions were given, emphasizing the importance of anti-inflammatory measures, including rest, ice, and nonsteroidal anti-inflammatory drugs (NSAIDs).

4. Operative Note: A patient with severe impingement syndrome of the shoulder and extensive inflammation underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The inflamed bursal tissue was excised, and the acromion was reshaped. The integrity of the rotator cuff tendons was evaluated and found to be intact. Closure was performed, and postoperative care instructions were provided, emphasizing the need for anti-inflammatory medications and a structured rehabilitation program.

5. Operative Note: The patient with impingement syndrome of the shoulder and moderate to severe inflammation underwent an arthroscopic subacromial decompression. The inflamed subacromial bursa was meticulously cleared, and the acromion was reshaped to alleviate impingement. Additionally, corticosteroid injection was administered intraoperatively to reduce inflammation. Closure was performed, and postoperative instructions were given, emphasizing the importance of anti-inflammatory medications and activity modification.

6. Operative Note: A patient with chronic impingement syndrome of the shoulder and mild to moderate inflammation underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The inflamed bursal tissue was excised, and the acromion was reshaped. Closure was performed, and postoperative care instructions were provided, emphasizing the need for anti-inflammatory measures, such as rest, ice, compression, and NSAIDs.

7. Operative Note: The patient presented with impingement syndrome of the shoulder and moderate inflammatory changes. An arthroscopic subacromial decompression was performed to alleviate impingement. The inflamed subacromial bursa was meticulously cleared, and the acromion was reshaped. Intraoperative application of anti-inflammatory agents was performed. Closure was performed, and postoperative instructions were given, emphasizing the importance of anti-inflammatory medications and a gradual return to normal activities.

8. Operative Note: A patient with severe impingement syndrome of the shoulder and significant inflammation underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The inflamed bursal tissue was excised, and the acromion was reshaped. Intraoperative administration of anti-inflammatory medications was performed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for anti-inflammatory measures, such as medications, cold therapy, and gentle range-of-motion exercises.

9. Operative Note: The patient with impingement syndrome of the shoulder and mild to moderate inflammation underwent an arthroscopic subacromial decompression. The inflamed subacromial bursa was meticulously cleared, and the acromion was reshaped to alleviate impingement. Intraoperative lavage with saline solution was performed to reduce inflammation. Closure was performed, and postoperative instructions were given, emphasizing the importance of anti-inflammatory medications and gradual shoulder mobilization.

10. Operative Note: A patient with chronic impingement syndrome of the shoulder and moderate to severe inflammation underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The inflamed bursal tissue was excised, and the acromion was reshaped. Intraoperative local administration of anti-inflammatory medications was performed. Closure was performed, and postoperative care instructions were provided, emphasizing the need for anti-inflammatory measures, including medication, rest, and physical therapy.

1. Operative Note: The patient with mild impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression. The procedure was successful, and the patient's postoperative pain was well controlled. Follow-up will include a routine postoperative visit in two weeks for assessment of progress and discussion of rehabilitation exercises.

2. Operative Note: A patient with moderate impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The procedure was successful, but the patient experienced moderate postoperative pain and swelling. Follow-up will include weekly visits for the first month to monitor progress and adjust pain management as needed.

3. Operative Note: The patient presented with severe impingement syndrome of the shoulder. An arthroscopic subacromial decompression was performed, and extensive bursal tissue was excised. The patient experienced significant postoperative pain and limited range of motion. Follow-up will include close monitoring with weekly visits for the first six weeks, including imaging studies if necessary, to assess healing progress and adjust rehabilitation accordingly.

4. Operative Note: A patient with mild to moderate impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The procedure was successful, and the patient experienced minimal postoperative pain. Follow-up will include a postoperative visit in two weeks to assess progress and initiate physical therapy exercises.

5. Operative Note: The patient presented with severe impingement syndrome of the shoulder. An arthroscopic subacromial decompression was performed, and extensive bursal tissue was excised. The patient experienced severe postoperative pain and significant functional limitations. Follow-up will include frequent visits, including weekly assessments for the first two months, to closely monitor the patient's progress, pain management, and rehabilitation program.

6. Operative Note: A patient with moderate impingement syndrome of the shoulder underwent an open surgical intervention. Subacromial decompression and acromioplasty were performed to alleviate impingement. The procedure was successful, but the patient experienced moderate postoperative pain and limited range of motion. Follow-up will include bi-weekly visits for the first month to monitor progress, adjust pain management, and optimize the rehabilitation plan.

7. Operative Note: The patient presented with severe impingement syndrome of the shoulder. An arthroscopic subacromial decompression was performed, and extensive bursal tissue was excised. The patient experienced significant postoperative pain and functional limitations. Follow-up will include regular visits every two weeks for the first three months to assess the patient's progress, pain management, and rehabilitation outcomes.

8. Operative Note: A patient with mild impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression. The procedure was successful, and the patient had minimal postoperative pain. Follow-up will include a routine postoperative visit in four weeks to assess progress, review rehabilitation exercises, and address any concerns.

9. Operative Note: The patient presented with moderate impingement syndrome of the shoulder. An open surgical intervention was performed, and subacromial decompression was successfully completed. The patient experienced moderate postoperative pain and limited range of motion. Follow-up will include weekly visits for the first six weeks to monitor progress, adjust pain management, and guide the rehabilitation program.

10. Operative Note: A patient with severe impingement syndrome of the shoulder underwent an arthroscopic subacromial decompression with extensive debridement. The patient experienced severe postoperative pain and significant functional impairment. Follow-up will include close monitoring with frequent visits every week for the first two months to assess healing, manage pain, and tailor the rehabilitation plan to the patient's needs.

## M75.5 Bursitis of shoulder

Operative Note 1:

Patient underwent an arthroscopic subacromial decompression for shoulder bursitis. A 5mm arthroscope was introduced into the subacromial space, revealing inflamed bursa and thickened rotator cuff tendons. Debridement of the bursa was performed using a motorized shaver. Acromioplasty was done to alleviate impingement, and the coracoacromial ligament was released. Hemostasis was ensured, and the incisions were closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 2:

The patient underwent an open bursectomy for chronic shoulder bursitis. A curvilinear incision was made over the shoulder, and the subcutaneous tissues were dissected. The inflamed bursa was identified and carefully excised. Hemostasis was achieved, and the wound was irrigated with saline. The incision was closed using absorbable sutures. The patient tolerated the procedure without any intraoperative complications.

Operative Note 3:

Patient underwent a corticosteroid injection for shoulder bursitis. The patient was positioned comfortably, and the skin overlying the bursa was sterilized. Using aseptic technique, a 22-gauge needle was inserted into the subacromial space under fluoroscopic guidance. A mixture of local anesthetic and corticosteroid was injected into the bursa. The needle was removed, and the injection site was covered with a sterile bandage. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 4:

The patient underwent a distension arthrography for shoulder bursitis. Under fluoroscopic guidance, a needle was inserted into the subacromial space. A mixture of contrast medium and saline was injected to distend the bursa. Multiple images were obtained to evaluate the bursal anatomy and detect any associated pathology. The needle was removed, and the patient experienced no complications during the procedure.

Operative Note 5:

Patient underwent an ultrasound-guided aspiration of the shoulder bursa. The skin was prepared, and the ultrasound probe was placed over the affected area. Using a sterile technique, a needle was inserted into the bursa under real-time ultrasound visualization. Aspiration was performed, and the fluid was sent for analysis. The needle was removed, and a sterile dressing was applied. The procedure was well-tolerated by the patient without any immediate complications.

Operative Note 6:

The patient underwent a bursectomy and acromioplasty for chronic shoulder bursitis. A standard deltopectoral approach was utilized to expose the shoulder joint. The bursa was carefully dissected and excised, followed by the acromioplasty to alleviate impingement. The wound was irrigated, and the deltoid muscle was repaired. The subcutaneous tissues and skin were closed using absorbable sutures. The patient tolerated the procedure well, and there were no intraoperative complications.

Operative Note 7:

Patient underwent a minimally invasive bursectomy for shoulder bursitis. Three small incisions were made, and a camera and instruments were inserted. The inflamed bursa was visualized and meticulously removed using specialized instruments. Hemostasis was achieved, and the incisions were closed with sutures. The patient had an uneventful intraoperative course.

Operative Note 8:

The patient underwent an ultrasound-guided injection of platelet-rich plasma (PRP) for shoulder bursitis. The skin was prepared, and ultrasound guidance was used to locate the bursa accurately. PRP was injected into the bursa using a sterile

technique. The needle was removed, and the injection site was covered with a sterile dressing. The procedure was well-tolerated by the patient without any immediate complications.

Operative Note 9:

Patient underwent an arthroscopic bursectomy and rotator cuff repair for shoulder bursitis with concomitant rotator cuff tear. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was excised, and the rotator cuff tear was repaired using suture anchors. The joint was thoroughly irrigated, and the portals were closed. The patient tolerated the procedure well, and no intraoperative complications were noted.

Operative Note 10:

The patient underwent a percutaneous needle tenotomy for chronic shoulder bursitis. A small incision was made, and a needle was inserted percutaneously into the bursa under ultrasound guidance. The needle was moved in a sweeping motion to release any adhesions or scar tissue. The procedure was well-tolerated, and the patient did not experience any immediate complications. The incision was closed with a steri-strip, and a sterile dressing was applied.

Operative Note 11:

The patient underwent an ultrasound-guided hydrodistension for refractory shoulder bursitis. The skin was prepared, and under real-time ultrasound guidance, a needle was inserted into the subacromial bursa. Saline solution was injected to distend the bursa and create separation of the structures. The procedure was performed without any complications, and the patient tolerated it well.

Operative Note 12:

Patient underwent an arthroscopic debridement and irrigation for acute shoulder bursitis. A 4mm arthroscope was introduced into the subacromial space, revealing inflamed and thickened bursa. Debridement of the bursa was performed using a motorized shaver and arthroscopic instruments. Thorough irrigation of the joint was done to remove any debris. The patient had an uneventful intraoperative course.

Operative Note 13:

The patient underwent an open excision of calcific shoulder bursitis. A curvilinear incision was made over the affected area, and the subcutaneous tissues were dissected. The calcific deposits within the bursa were identified and carefully excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure without any complications.

Operative Note 14:

Patient underwent a fluoroscopy-guided radiofrequency ablation (RFA) for chronic shoulder bursitis. The skin was prepped, and a radiofrequency needle was inserted into the bursa under fluoroscopic guidance. The surrounding nerves responsible for transmitting pain signals were targeted and thermally ablated. The procedure was performed successfully without any immediate complications.

Operative Note 15:

The patient underwent an ultrasound-guided aspiration and corticosteroid injection for septic shoulder bursitis. The skin was prepared, and under real-time ultrasound guidance, the infected bursa was aspirated using a sterile needle. The aspirate was sent for culture and sensitivity testing. Subsequently, a corticosteroid and antibiotic mixture was injected into the bursa. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 16:

Patient underwent a bursectomy and partial acromioplasty for shoulder bursitis with associated subacromial impingement. A deltopectoral approach was used to expose the shoulder joint. The inflamed bursa was carefully excised, and the undersurface of the acromion was smoothed to alleviate impingement. Hemostasis was achieved, and the wound was closed in layers. The patient had an uneventful intraoperative course.

Operative Note 17:

The patient underwent an ultrasound-guided prolotherapy for chronic shoulder bursitis. The skin was prepared, and under ultrasound guidance, a solution of dextrose and local anesthetic was injected into the bursa and surrounding tissues. Multiple injections were performed to stimulate healing and reduce inflammation. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 18:

Patient underwent an arthroscopic bursectomy and biceps tenodesis for shoulder bursitis with concomitant biceps tendon pathology. Arthroscopic portals were established, and the bursa was excised using arthroscopic instruments. Subsequently, a biceps tenodesis was performed to address the associated pathology. The joint was irrigated, and the portals were closed. The patient tolerated the procedure well without any complications.

Operative Note 19:

The patient underwent a subacromial corticosteroid injection for acute flare-up of shoulder bursitis. The skin was prepared, and a needle was inserted into the subacromial space under palpation guidance. Corticosteroid and local anesthetic were injected into the bursa. The needle was removed, and a sterile dressing was applied. The procedure was well-tolerated, and the patient did not experience any immediate complications.

Operative Note 20:

Patient underwent an ultrasound-guided fenestration for recurrent shoulder bursitis. The skin was prepared, and under real-time ultrasound guidance, a needle was inserted into the bursa. Multiple fenestrations were created within the bursal tissue using a needle or specialized instrument. The procedure was performed successfully without any complications, and the patient tolerated it well.

Operative Note 21:

The patient underwent an open bursectomy for chronic shoulder bursitis under general anesthesia. The patient was positioned and prepped in a sterile manner. Anesthesia was induced and maintained as per standard protocol. A curvilinear incision was made over the shoulder, and the subcutaneous tissues were dissected. The inflamed bursa was identified and carefully excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted during anesthesia.

Operative Note 22:

Patient underwent an arthroscopic subacromial decompression and bursectomy for shoulder bursitis under regional anesthesia. The patient received a nerve block for anesthesia. A 5mm arthroscope was introduced into the subacromial space, revealing inflamed bursa and thickened rotator cuff tendons. Debridement of the bursa was performed using a motorized shaver. Acromioplasty was done to alleviate impingement, and the coracoacromial ligament was released. Hemostasis was ensured, and the incisions were closed in layers. The patient tolerated the procedure well, and no immediate complications were noted during anesthesia.

Operative Note 23:

The patient underwent an ultrasound-guided corticosteroid injection for shoulder bursitis under local anesthesia. The skin was prepped, and the bursa was identified under ultrasound guidance. Local anesthetic was administered to numb the area, followed by the injection of corticosteroid into the bursa. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 24:

Patient underwent an arthroscopic bursectomy and rotator cuff repair for shoulder bursitis with concomitant rotator cuff tear under general anesthesia. The patient was positioned and prepped in a sterile manner. Anesthesia was induced and maintained as per standard protocol. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was excised, and the rotator cuff tear was repaired using suture anchors. The joint was thoroughly irrigated, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted during anesthesia.

Operative Note 25:

The patient underwent an open excision of calcific shoulder bursitis under local anesthesia with intravenous sedation. The patient was positioned and prepped in a sterile manner. Local anesthetic was administered to numb the surgical site, and intravenous sedation was provided to maintain comfort. A curvilinear incision was made over the affected area, and the calcific deposits within the bursa were carefully excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted during anesthesia.

Operative Note 26:

Patient underwent a fluoroscopy-guided radiofrequency ablation (RFA) for chronic shoulder bursitis under conscious sedation. The patient was positioned and prepped in a sterile manner. Conscious sedation was administered to maintain comfort and relaxation during the procedure. The skin was prepped, and under fluoroscopic guidance, a radiofrequency needle was inserted into the bursa. The surrounding nerves responsible for transmitting pain signals were targeted and thermally ablated. The patient tolerated the procedure well, and no immediate complications were observed during anesthesia.

Operative Note 27:

The patient underwent an ultrasound-guided hydrodistension for refractory shoulder bursitis under regional anesthesia. The patient received a nerve block for anesthesia. The skin was prepped, and under real-time ultrasound guidance, a needle was inserted into the subacromial bursa. Saline solution was injected to distend the bursa and create separation of the structures. The procedure was performed without any complications, and the patient tolerated it well under anesthesia.

Operative Note 28:

Patient underwent an arthroscopic debridement and irrigation for acute shoulder bursitis under general anesthesia. The patient was positioned and prepped in a sterile manner. Anesthesia was induced and maintained as per standard protocol. A 4mm arthroscope was introduced into the subacromial space, revealing inflamed and thickened bursa. Debridement of the bursa was performed using a motorized shaver and arthroscopic instruments. Thorough irrigation of the joint was done to remove any debris. The patient had an uneventful intraoperative course under anesthesia.

Operative Note 29:

The patient underwent an open bursectomy for chronic shoulder bursitis under spinal anesthesia. The patient was positioned and prepped in a sterile manner. Spinal anesthesia was administered to achieve anesthesia from the mid-chest down. A curvilinear incision was made over the shoulder, and the subcutaneous tissues were dissected. The inflamed bursa was identified and carefully excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted during anesthesia.

Operative Note 30:

Patient underwent an ultrasound-guided aspiration and corticosteroid injection for septic shoulder bursitis under local anesthesia with intravenous sedation. The patient was positioned and prepped in a sterile manner. Local anesthesia was administered to numb the area, and intravenous sedation was provided for relaxation and comfort. Under real-time ultrasound guidance, the infected bursa was aspirated using a sterile needle. The aspirate was sent for culture and sensitivity testing. Subsequently, a corticosteroid and antibiotic mixture was injected into the bursa. The patient tolerated the procedure well, and no immediate complications were observed during anesthesia.

Operative Note 31:

The patient underwent an arthroscopic bursectomy and acromioclavicular (AC) joint debridement for shoulder bursitis with associated AC joint osteoarthritis and bone erosion. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was excised, and the eroded AC joint surfaces were carefully debrided. Any loose fragments or osteophytes were removed. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 32:

Patient underwent an open bursectomy and rotator cuff repair for shoulder bursitis with concomitant rotator cuff tear and bone erosion. A standard deltopectoral approach was utilized to expose the shoulder joint. The inflamed bursa was carefully excised, and the eroded bone was addressed. The rotator cuff tear was repaired using suture anchors, and any bone irregularities were smoothed out. The wound was irrigated, and the incisions were closed in layers. The patient had an uneventful intraoperative course.

Operative Note 33:

The patient underwent an arthroscopic subacromial decompression, bursectomy, and bone grafting for shoulder bursitis with associated bone erosion and acromial cyst formation. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was excised, and the eroded bone was carefully debrided. A bone graft was harvested from the iliac crest and used to fill the defect. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 34:

Patient underwent an open excision of calcific shoulder bursitis and bone erosion. A curvilinear incision was made over the affected area, and the subcutaneous tissues were dissected. The calcific deposits within the bursa were identified and carefully excised. Attention was then turned to the eroded bone, which was debrided and smoothed out. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure without any complications.

Operative Note 35:

The patient underwent an ultrasound-guided aspiration and corticosteroid injection for shoulder bursitis with associated bone erosion. The skin was prepared, and under real-time ultrasound guidance, the infected bursa was aspirated using a sterile needle. Careful attention was given to the adjacent bone erosion. The aspirate was sent for culture and sensitivity testing. Subsequently, a corticosteroid and antibiotic mixture was injected into the bursa. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 36:

Patient underwent an arthroscopic debridement and bone grafting for shoulder bursitis with associated bone erosion. A 5mm arthroscope was introduced into the subacromial space, revealing inflamed bursa and eroded bone surfaces. Debridement of the bursa was performed using a motorized shaver. The eroded bone was carefully prepared, and a bone graft was placed to restore the defect. Hemostasis was ensured, and the incisions were closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 37:

The patient underwent an open bursectomy and acromioplasty with bone erosion repair for shoulder bursitis and bone erosion. A curvilinear incision was made over the shoulder, and the subcutaneous tissues were dissected. The inflamed bursa was identified

and carefully excised. Attention was then turned to the eroded bone, which was addressed by removing any loose fragments and smoothing the irregularities. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 38:

Patient underwent an ultrasound-guided corticosteroid injection for shoulder bursitis with associated bone erosion. The skin was prepped, and the bursa was identified under ultrasound guidance. Local anesthesia was administered to numb the area. Careful attention was given to the adjacent bone erosion. A corticosteroid and local anesthetic mixture were injected into the bursa. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 39:

The patient underwent an arthroscopic subacromial decompression, bursectomy, and bone erosion repair for shoulder bursitis and associated bone erosion. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was excised, and the eroded bone surfaces were carefully addressed. Any loose fragments or irregularities were removed, and the bone was smoothed out. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 40:

Patient underwent an open bursectomy and bone grafting for chronic shoulder bursitis with significant bone erosion. A curvilinear incision was made over the affected area, and the subcutaneous tissues were dissected. The inflamed bursa was carefully excised, and attention was then turned to the eroded bone. The eroded bone surfaces were debrided, and a bone graft was harvested and placed to restore the defect. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 41:

The patient underwent an arthroscopic bursectomy and bone debridement for severe shoulder bursitis with associated bone erosion and debilitating bone pain. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was meticulously excised, and attention was then turned to the eroded bone. The eroded bone surfaces were carefully debrided to alleviate the patient's severe bone pain. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 42:

Patient underwent an open bursectomy and acromioplasty with bone erosion repair for severe shoulder bursitis, acromial impingement, and excruciating bone pain. A curvilinear incision was made over the shoulder, and the subcutaneous tissues were dissected. The inflamed bursa was identified and meticulously excised. Special attention was given to the eroded bone, which was addressed to alleviate the patient's severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 43:

The patient underwent an arthroscopic subacromial decompression, bursectomy, and bone grafting for severe shoulder bursitis with associated bone erosion and incapacitating bone pain. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was excised, and meticulous attention was given to the eroded bone surfaces causing severe bone pain. Bone grafting was performed to address the defect and alleviate the patient's symptoms. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 44:

Patient underwent an open excision of calcific shoulder bursitis and bone erosion for severe bone pain refractory to conservative management. A curvilinear incision was made over the affected area, and the subcutaneous tissues were dissected. The calcific deposits within the bursa were identified and meticulously excised. Special attention was given to the eroded bone, which was addressed to alleviate the patient's severe bone pain. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 45:

The patient underwent an ultrasound-guided aspiration and corticosteroid injection for severe shoulder bursitis with associated bone erosion and excruciating bone pain. The skin was prepared, and under real-time ultrasound guidance, the infected bursa was aspirated using a sterile needle. Attention was also given to the eroded bone surfaces causing severe bone pain. The aspirate was sent for culture and sensitivity testing, and a corticosteroid and antibiotic mixture was injected into the bursa. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 46:

Patient underwent an arthroscopic debridement and bone grafting for severe shoulder bursitis with associated bone erosion and incapacitating bone pain. A 5mm arthroscope was introduced into the subacromial space, revealing inflamed bursa and eroded bone surfaces. Debridement of the bursa was performed using a motorized shaver, and meticulous attention was given to the eroded bone causing severe bone pain. Bone grafting was performed to address the defect and alleviate the patient's symptoms. Hemostasis was ensured, and the incisions were closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 47:

The patient underwent an open bursectomy and acromioclavicular (AC) joint debridement with bone erosion repair for severe shoulder bursitis, AC joint osteoarthritis, and incapacitating bone pain. A standard deltopectoral approach was utilized to expose the shoulder joint. The inflamed bursa was meticulously excised, and attention was then turned to the eroded AC joint surfaces causing severe bone pain. Debridement and bone erosion repair were performed to alleviate the patient's symptoms. The wound was irrigated, and the incisions were closed in layers. The patient had an uneventful intraoperative course.

Operative Note 48:

Patient underwent an ultrasound-guided corticosteroid injection for severe shoulder bursitis with associated bone erosion and debilitating bone pain. The skin was prepped, and the bursa was identified under ultrasound guidance. Local anesthesia was administered to numb the area. Special attention was given to the adjacent eroded bone causing severe bone pain. A corticosteroid and local anesthetic mixture were injected into the bursa. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 49:

The patient underwent an arthroscopic subacromial decompression, bursectomy, and bone erosion repair for severe shoulder bursitis with associated bone erosion and intolerable bone pain. Arthroscopic portals were established, and a 5mm arthroscope was inserted. The inflamed bursa was excised, and meticulous attention was given to the eroded bone surfaces causing severe bone pain. Any loose fragments or irregularities were removed, and the bone was smoothed out. Hemostasis was achieved, and the portals were closed. The patient tolerated the procedure well, and no immediate complications were noted.

Operative Note 50:

Patient underwent an open bursectomy and bone grafting for chronic shoulder bursitis with severe bone erosion and excruciating bone pain. A curvilinear incision was made over the affected area, and the subcutaneous tissues were dissected. The inflamed bursa was carefully excised, and meticulous attention was given to the eroded bone causing severe bone pain. A bone graft was harvested and placed to restore the defect. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were observed.

Operative Note 51:

The patient underwent a surgical intervention for refractory shoulder bursitis with severe bone erosion. A comprehensive approach was taken, including an open bursectomy, subacromial decompression, and acromioclavicular (AC) joint debridement. The inflamed bursa was meticulously excised, and attention was given to the eroded bone surfaces. Subsequently, a bone graft was utilized to address the bone defect. The surgical intervention was successful, and the patient tolerated the procedure well without immediate complications.

Operative Note 52:

Patient underwent an arthroscopic surgical intervention for shoulder bursitis with extensive bone erosion. The procedure involved bursectomy, subacromial decompression, and bone debridement. The inflamed bursa was carefully excised, and the eroded bone surfaces were addressed. Meticulous attention was given to alleviate the patient's symptoms and address the bone pathology. The surgical intervention was uneventful, and the patient had a smooth recovery without immediate complications.

Operative Note 53:

The patient underwent a surgical intervention for severe shoulder bursitis and associated bone erosion. A combination of open and arthroscopic techniques was utilized. An open bursectomy was performed to excise the inflamed bursa, followed by arthroscopic subacromial decompression and bone debridement to address the bone erosion. The surgical intervention was successful in relieving the patient's symptoms, and no immediate complications were encountered.

Operative Note 54:

Patient underwent a surgical intervention for chronic shoulder bursitis with significant bone erosion. An open approach was used, including bursectomy and meticulous debridement of the eroded bone. Attention was given to alleviate the patient's severe symptoms and restore the integrity of the affected area. The surgical intervention was well-tolerated, and the patient had an uneventful immediate postoperative course.

Operative Note 55:

The patient underwent a surgical intervention for recurrent shoulder bursitis with severe bone erosion. The procedure involved an open bursectomy and extensive bone debridement. The inflamed bursa was meticulously excised, and the eroded bone surfaces were addressed to alleviate the patient's symptoms. The surgical intervention was successful, and the patient had a smooth recovery without immediate complications.

Operative Note 56:

Patient underwent a surgical intervention for septic shoulder bursitis with extensive bone erosion. The procedure included an open bursectomy, irrigation, and meticulous debridement of the eroded bone. Special attention was given to address the infection and bone pathology. The surgical intervention was performed successfully, and the patient tolerated the procedure well without immediate complications.

Operative Note 57:

The patient underwent a surgical intervention for acute shoulder bursitis with associated bone erosion. An arthroscopic approach was utilized, including bursectomy and meticulous debridement of the eroded bone. The procedure aimed to alleviate the patient's symptoms and restore normal function. The surgical intervention was uneventful, and the patient had a satisfactory outcome without immediate complications.

Operative Note 58:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and impingement syndrome. The procedure involved an open bursectomy, subacromial decompression, and acromioclavicular (AC) joint debridement. The inflamed bursa was carefully excised, and the eroded bone surfaces were addressed. The surgical intervention was successful in relieving the patient's symptoms and improving shoulder function. No immediate complications were encountered during the procedure.

Operative Note 59:

The patient underwent a surgical intervention for refractory shoulder bursitis with severe bone erosion and associated rotator cuff tear. The procedure included an open bursectomy

, subacromial decompression, rotator cuff repair, and meticulous debridement of the eroded bone. Attention was given to address all pathologies and restore the integrity of the shoulder joint. The surgical intervention was successful, and the patient tolerated the procedure well without immediate complications.

Operative Note 60:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and adhesive capsulitis. The procedure included an open bursectomy, capsular release, and meticulous debridement of the eroded bone. Special attention was given to address both the bursitis and the adhesive capsulitis. The surgical intervention was successful in alleviating the patient's symptoms and improving shoulder mobility. No immediate complications were encountered during the procedure.

Operative Note 61:

The patient underwent a surgical intervention for chronic shoulder bursitis with severe bone erosion and glenohumeral joint instability. The procedure involved an open bursectomy, bone debridement, and stabilization of the joint. The inflamed bursa was meticulously excised, and attention was given to the eroded bone surfaces. The joint was stabilized using appropriate techniques to address the instability. The surgical intervention was successful, and the patient tolerated the procedure well without immediate complications.

Operative Note 62:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and concomitant labral tear. The procedure included an arthroscopic bursectomy, labral repair, and meticulous debridement of the eroded bone. The inflamed bursa was carefully excised, and attention was given to address both the labral tear and the bone pathology. The surgical intervention was successful in alleviating the patient's symptoms and restoring stability to the shoulder joint. No immediate complications were encountered during the procedure.

Operative Note 63:

The patient underwent a surgical intervention for recurrent shoulder bursitis with severe bone erosion and frozen shoulder. The procedure included an open bursectomy, capsular release, and meticulous debridement of the eroded bone. The inflamed bursa was meticulously excised, and attention was given to address the capsular contracture and bone pathology. The surgical intervention was successful in improving range of motion and relieving the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 64:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and rotator cuff impingement. The procedure included an arthroscopic bursectomy, subacromial decompression, and meticulous debridement of the eroded bone. The inflamed bursa was carefully excised, and attention was given to address the impingement and bone pathology. The surgical intervention was successful in relieving the patient's symptoms and improving rotator cuff function. No immediate complications were encountered during the procedure.

Operative Note 65:

The patient underwent a surgical intervention for chronic shoulder bursitis with severe bone erosion and glenoid labrum tear. The procedure included an open bursectomy, labral repair, and meticulous debridement of the eroded bone. The inflamed bursa was meticulously excised, and attention was given to address both the labral tear and the bone pathology. The surgical intervention was successful in alleviating the patient's symptoms and restoring stability to the shoulder joint. No immediate complications were encountered during the procedure.

Operative Note 66:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and recurrent dislocations. The procedure included an open bursectomy, bone debridement, and stabilization of the joint. The inflamed bursa was carefully excised, and attention was given to the eroded bone surfaces. The joint was stabilized using appropriate techniques to address the recurrent dislocations. The surgical intervention was successful, and the patient tolerated the procedure well without immediate complications.

Operative Note 67:

The patient underwent a surgical intervention for chronic shoulder bursitis with severe bone erosion and adhesive capsulitis. The procedure included an open bursectomy, capsular release, and meticulous debridement of the eroded bone. Special attention was given to address both the bursitis and the adhesive capsulitis. The surgical intervention was successful in alleviating the patient's symptoms and improving shoulder mobility. No immediate complications were encountered during the procedure.

Operative Note 68:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and concomitant instability. The procedure included an arthroscopic bursectomy, joint

stabilization, and meticulous debridement of the eroded bone. The inflamed bursa was carefully excised, and attention was given to address both the instability and the bone pathology. The surgical intervention was successful in restoring stability to the shoulder joint and relieving the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 69:

The patient underwent a surgical intervention for refractory shoulder bursitis with severe bone erosion and associated rotator cuff tear. The procedure included an open bursectomy, rotator cuff repair, and meticulous debridement of the eroded bone. Attention was given to address both the bursitis and the rotator cuff pathology. The surgical intervention was successful in restoring rotator cuff integrity and alleviating the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 70:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and impingement syndrome. The procedure included an open bursectomy, subacromial decompression, and meticulous debridement of the eroded bone. The inflamed bursa was carefully excised, and attention was given to address both the impingement and the bone pathology. The surgical intervention was successful in relieving the patient's symptoms and improving shoulder function. No immediate complications were encountered during the procedure.

Operative Note 71:

The patient underwent a surgical intervention for severe shoulder bursitis with extensive bone erosion and an infected glenohumeral joint. The procedure included an open bursectomy, joint debridement, and irrigation. The inflamed bursa was meticulously excised, and attention was given to address the infected joint. Thorough debridement was performed to remove infected tissue and promote healing. The joint was irrigated with antimicrobial solution. The surgical intervention was successful in treating the infection, and the patient tolerated the procedure well without immediate complications.

Operative Note 72:

Patient underwent a surgical intervention for shoulder bursitis with severe bone erosion and a deeply infected extreme moving joint. The procedure included an open bursectomy, extensive joint debridement, and irrigation. The inflamed bursa was carefully excised, and attention was given to address the infected joint. Meticulous debridement was performed to remove infected tissue and promote healing. The joint was thoroughly irrigated with antimicrobial solution. The surgical intervention successfully treated the infection, and the patient had an uneventful immediate postoperative course.

Operative Note 73:

The patient underwent a surgical intervention for recurrent shoulder bursitis with severe bone erosion and an infected extreme moving joint. The procedure included an arthroscopic bursectomy, joint debridement, and irrigation. The inflamed bursa was meticulously excised, and attention was given to address the infected joint. Thorough debridement was performed to remove infected tissue and promote healing. The joint was irrigated with antimicrobial solution. The surgical intervention was successful in treating the infection, and the patient tolerated the procedure well without immediate complications.

Operative Note 74:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and a severely infected extreme moving joint. The procedure included an arthroscopic bursectomy, joint debridement, and irrigation. The inflamed bursa was carefully excised, and attention was given to address the infected joint. Meticulous debridement was performed to remove infected tissue and promote healing. The joint was thoroughly irrigated with antimicrobial solution. The surgical intervention effectively treated the infection, and the patient had a smooth recovery without immediate complications.

Operative Note 75:

The patient underwent a surgical intervention for chronic shoulder bursitis with severe bone erosion and an infected glenohumeral joint. The procedure included an open bursectomy, joint debridement, and lavage. The inflamed bursa was meticulously excised, and attention was given to address the infected joint. Extensive debridement was performed to remove infected tissue and promote healing. The joint was lavaged with antimicrobial solution. The surgical intervention successfully treated the infection, and the patient tolerated the procedure well without immediate complications.

Operative Note 76:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and a deeply infected extreme moving joint. The procedure included an open bursectomy, extensive joint debridement, and lavage. The inflamed bursa was carefully excised, and attention was given to address the infected joint. Meticulous debridement was performed to remove infected tissue and promote healing. The joint was thoroughly irrigated with antimicrobial solution. The surgical intervention effectively treated the infection, and the patient had a satisfactory outcome without immediate complications.

Operative Note 77:

The patient underwent a surgical intervention for refractory shoulder bursitis with severe bone erosion and an infected extreme moving joint. The procedure included an open bursectomy, joint debridement, and irrigation. The inflamed bursa was meticulously excised, and attention was given to address the infected joint. Thorough debridement was performed to remove infected

tissue and promote healing. The joint was irrigated with antimicrobial solution. The surgical intervention successfully treated the infection, and the patient tolerated the procedure well without immediate complications.

Operative Note 78:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and a deeply infected extreme moving joint. The procedure included an open bursectomy, extensive joint debridement, and irrigation. The inflamed bursa was carefully excised, and attention was given to address the infected joint. Meticulous debridement was performed to remove infected tissue and promote healing. The joint was thoroughly irrigated with antimicrobial solution. The surgical intervention effectively treated the infection, and the patient had a smooth recovery without immediate complications.

Operative Note 79:

The patient underwent a surgical intervention for chronic shoulder bursitis with severe bone erosion and an infected glenohumeral joint. The procedure included an arthroscopic bursectomy, joint debridement, and lavage. The inflamed bursa was meticulously excised, and attention was given to address the infected joint. Extensive debridement was performed to remove infected tissue and promote healing. The joint was lavaged with antimicrobial solution. The surgical intervention successfully treated the infection, and the patient tolerated the procedure well without immediate complications.

Operative Note 80:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and a deeply infected extreme moving joint. The procedure included an arthroscopic bursectomy, joint debridement, and lavage. The inflamed bursa was carefully excised, and attention was given to address the infected joint. Meticulous debridement was performed to remove infected tissue and promote healing. The joint was thoroughly irrigated with antimicrobial solution. The surgical intervention effectively treated the infection, and the patient had a satisfactory outcome without immediate complications.

Operative Note 81:

The patient underwent a surgical intervention for shoulder bursitis with severe bone erosion and chronic, inflamed bursa. The procedure included an open bursectomy, meticulous debridement of the eroded bone, and removal of the inflamed bursa. Attention was given to address both the bursitis and the bone pathology. The surgical intervention was successful in relieving inflammation and improving the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 82:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and acutely inflamed bursa. The procedure included an arthroscopic bursectomy, meticulous debridement of the eroded bone, and excision of the inflamed bursa. The inflamed bursa was carefully removed, and attention was given to address the bone pathology. The surgical intervention was successful in alleviating acute inflammation and improving the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 83:

The patient underwent a surgical intervention for recurrent shoulder bursitis with severe bone erosion and chronically inflamed bursa. The procedure included an open bursectomy, meticulous debridement of the eroded bone, and removal of the inflamed bursa. Thorough attention was given to address both the bursitis and the bone pathology. The surgical intervention successfully alleviated chronic inflammation and improved the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 84:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and acutely inflamed bursa. The procedure included an open bursectomy, meticulous debridement of the eroded bone, and excision of the inflamed bursa. The inflamed bursa was meticulously removed, and attention was given to address the bone pathology. The surgical intervention was successful in relieving acute inflammation and improving the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 85:

The patient underwent a surgical intervention for chronic shoulder bursitis with severe bone erosion and markedly inflamed bursa. The procedure included an arthroscopic bursectomy, meticulous debridement of the eroded bone, and excision of the inflamed bursa. Thorough attention was given to address both the bursitis and the bone pathology. The surgical intervention successfully alleviated marked inflammation and improved the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 86:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and acutely inflamed bursa. The procedure included an arthroscopic bursectomy, meticulous debridement of the eroded bone, and removal of the inflamed bursa. The inflamed bursa was carefully excised, and attention was given to address the bone pathology. The surgical intervention effectively relieved acute inflammation and improved the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 87:

The patient underwent a surgical intervention for refractory shoulder bursitis with severe bone erosion and chronically inflamed bursa. The procedure included an open bursectomy, meticulous debridement of the eroded bone, and excision of the inflamed bursa. Thorough attention was given to address both the bursitis and the bone pathology. The surgical intervention successfully alleviated chronic inflammation and improved the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 88:

Patient underwent a surgical intervention for shoulder bursitis with significant bone erosion and acutely inflamed bursa. The procedure included an open bursectomy, meticulous debridement of the er

oded bone, and removal of the inflamed bursa. The inflamed bursa was meticulously excised, and attention was given to address the bone pathology. The surgical intervention effectively relieved acute inflammation and improved the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 89:

The patient underwent a surgical intervention for chronic shoulder bursitis with severe bone erosion and markedly inflamed bursa. The procedure included an arthroscopic bursectomy, meticulous debridement of the eroded bone, and excision of the inflamed bursa. Thorough attention was given to address both the bursitis and the bone pathology. The surgical intervention successfully alleviated marked inflammation and improved the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 90:

Patient underwent a surgical intervention for shoulder bursitis with extensive bone erosion and acutely inflamed bursa. The procedure included an arthroscopic bursectomy, meticulous debridement of the eroded bone, and removal of the inflamed bursa. The inflamed bursa was carefully excised, and attention was given to address the bone pathology. The surgical intervention effectively relieved acute inflammation and improved the patient's symptoms. No immediate complications were encountered during the procedure.

Operative Note 91:

The patient underwent a surgical intervention for shoulder bursitis with mild bone erosion. The procedure included an arthroscopic bursectomy and debridement of the inflamed bursa. Given the mild nature of the bone erosion, postoperative follow-up will focus on pain management, range of motion exercises, and activity modification. The patient will be scheduled for a follow-up appointment in two weeks to assess progress and determine the need for further intervention. Patient education regarding self-care and preventive measures will be provided.

Operative Note 92:

Patient underwent a surgical intervention for shoulder bursitis with moderate bone erosion. The procedure included an open bursectomy, debridement of the eroded bone, and repair of the associated soft tissue damage. Postoperative follow-up will involve regular visits at one, three, and six-month intervals to monitor healing, assess pain levels, and track functional improvement. Imaging studies may be ordered as needed to evaluate bone healing. Rehabilitation protocols, including physical therapy, will be initiated to optimize recovery and restore shoulder function.

Operative Note 93:

The patient underwent a surgical intervention for severe shoulder bursitis with extensive bone erosion and associated rotator cuff tear. The procedure included an open bursectomy, repair of the rotator cuff tear, and meticulous debridement of the eroded bone. Given the severity of the diagnosis, postoperative follow-up will be intensive. Weekly visits for the first month will allow for close monitoring of wound healing, pain management, and range of motion exercises. Imaging studies will be performed at three months to assess bone healing. Rehabilitation will be tailored to the patient's progress.

Operative Note 94:

Patient underwent a surgical intervention for shoulder bursitis with moderate bone erosion. The procedure included an arthroscopic bursectomy, debridement of the eroded bone, and repair of the associated soft tissue damage. Postoperative follow-up will involve regular visits at one, three, and six-month intervals to assess pain levels, monitor range of motion, and evaluate functional improvement. Rehabilitation protocols will be initiated, focusing on strengthening exercises and gradual return to activities. Further intervention will be considered based on the patient's progress and response to conservative measures.

Operative Note 95:

The patient underwent a surgical intervention for severe shoulder bursitis with significant bone erosion and chronic inflammation. The procedure included an open bursectomy, meticulous debridement of the eroded bone, and removal of the inflamed bursa. Given the severity of the diagnosis, postoperative follow-up will involve close monitoring of wound healing, pain management, and infection control. The patient will be seen for weekly appointments in the first month, followed by biweekly visits for the next two months. Further interventions, such as intra-articular injections or additional surgery, may be considered based on the patient's response to treatment.

Operative Note 96:

Patient underwent a surgical intervention for shoulder bursitis with mild bone erosion. The procedure included an arthroscopic bursectomy and debridement of the inflamed bursa. Given the mild nature of the bone erosion, postoperative follow-up will primarily focus on pain management, activity modification, and patient education regarding self-care measures. The patient will be scheduled for a follow-up appointment in four weeks to assess progress, provide further guidance on shoulder exercises, and address any remaining concerns.

Operative Note 97:

The patient underwent a surgical intervention for chronic shoulder bursitis with moderate bone erosion. The procedure included an open bursectomy, debridement of the eroded bone, and repair of the associated soft tissue damage. Postoperative follow-up will involve regular visits at one, three, and six-month intervals to assess pain levels, monitor range of motion, and evaluate functional improvement. Rehabilitation

protocols, including physical therapy, will be initiated to promote healing and restore shoulder function. Further intervention will be considered based on the patient's response to conservative measures.

Operative Note 98:

Patient underwent a surgical intervention for shoulder bursitis with mild bone erosion. The procedure included an arthroscopic bursectomy and debridement of the inflamed bursa. Given the mild nature of the bone erosion, postoperative follow-up will primarily focus on pain management, activity modification, and patient education regarding self-care measures. The patient will be scheduled for a follow-up appointment in six weeks to assess progress, provide further guidance on shoulder exercises, and address any remaining concerns.

Operative Note 99:

The patient underwent a surgical intervention for severe shoulder bursitis with extensive bone erosion and associated rotator cuff tear. The procedure included an open bursectomy, repair of the rotator cuff tear, and meticulous debridement of the eroded bone. Given the severity of the diagnosis, postoperative follow-up will be intensive. Weekly visits for the first two months will allow for close monitoring of wound healing, pain management, and range of motion exercises. Imaging studies will be performed at three months to assess bone healing and evaluate the status of the repaired rotator cuff. Rehabilitation will be tailored to the patient's progress and goals.

Operative Note 100:

Patient underwent a surgical intervention for shoulder bursitis with moderate bone erosion. The procedure included an arthroscopic bursectomy, debridement of the eroded bone, and repair of the associated soft tissue damage. Postoperative follow-up will involve regular visits at one, three, and six-month intervals to assess pain levels, monitor range of motion, and evaluate functional improvement. Rehabilitation protocols, including physical therapy, will be initiated to promote healing and restore shoulder function. Further intervention, such as intra-articular injections or revision surgery, will be considered based on the patient's response to treatment.

## M75.8 Other shoulder lesions

Operative Note 1:

Patient underwent a surgical procedure for a superior labral tear from anterior to posterior (SLAP) lesion in the left shoulder. A standard posterior shoulder approach was utilized, and the labral tear was identified and debrided. Anchors were placed to secure the labrum to the glenoid rim. The procedure was successfully completed, and the patient tolerated it well. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 2:

The patient presented with an acromioclavicular (AC) joint separation in the right shoulder. A small incision was made over the AC joint, and the joint was exposed. The ligaments were visualized and found to be disrupted. The distal clavicle was resected, and the AC joint was stabilized using sutures. The wound was closed in layers, and the patient was given postoperative instructions. The procedure was uneventful, and the patient was discharged in satisfactory condition.

Operative Note 3:

A rotator cuff repair was performed on the patient's right shoulder. The deltoid and subscapularis muscles were carefully mobilized to expose the rotator cuff tear. The tear was debrided, and anchors were placed in the humeral head to secure the rotator cuff tendon. The tendon was then sutured back to its anatomical position. The procedure was successfully completed without complications. The patient was provided with postoperative instructions and discharged in stable condition.

Operative Note 4:

Patient underwent an arthroscopic subacromial decompression procedure for impingement syndrome in the left shoulder. Multiple small incisions were made, and the arthroscope was introduced into the subacromial space. The acromion and the coracoacromial ligament were resected to create more space for the rotator cuff tendons. The procedure was uneventful, and the patient tolerated it well. Postoperative care instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 5:

A Bankart repair was performed on the patient's right shoulder for recurrent anterior shoulder dislocation. The joint was accessed through an anterior approach, and the labrum was visualized. The detached labrum was reattached to the glenoid using anchors. The joint stability was assessed, and it was found to be satisfactory. The wound was closed, and the patient was given postoperative instructions. The procedure was successful, and the patient was discharged in stable condition.

Operative Note 6:

Patient underwent a surgical procedure for a glenohumeral joint septic arthritis in the left shoulder. An arthrotomy was performed, and the joint was irrigated thoroughly. Synovectomy was carried out, and samples were sent for culture and sensitivity testing. Antibiotics were administered intraoperatively. The joint was then closed, and the patient was given instructions for postoperative care. The procedure was uneventful, and the patient was discharged with appropriate antibiotic therapy.

Operative Note 7:

A biceps tenodesis was performed on the patient's right shoulder for a chronic biceps tendon injury. An arthroscopic approach was utilized, and the biceps tendon was identified and released from its attachment. The tendon was then reattached to the humerus using suture anchors. The joint was assessed for stability, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 8:

Patient underwent an open reduction internal fixation (ORIF) for a proximal humerus fracture in the left shoulder. A standard deltopectoral approach was used to access the fracture site. The fracture fragments were reduced and held in place with plates and screws.

The joint stability was confirmed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 9:

An arthroscopic debridement and microfracture procedure were performed on the patient's right shoulder for a chondral defect. Multiple small incisions were made, and the arthroscope was introduced into the joint. The chondral defect was debrided, and microfracture techniques were used to promote cartilage healing. The joint was thoroughly irrigated, and the procedure was successfully completed without complications. Postoperative care instructions were given, and the patient was discharged in stable condition.

Operative Note 10:

The patient underwent a resection of a lipoma in the subacromial space of the right shoulder. The lipoma was identified and excised through a small incision. Hemostasis was achieved, and the wound was closed. The patient tolerated the procedure well, and postoperative care instructions were provided. The patient was discharged in satisfactory condition.

Operative Note 11:

Patient underwent a capsular release procedure for adhesive capsulitis (frozen shoulder) in the left shoulder. An arthroscopic approach was utilized, and the capsule was visualized and released using electrocautery and/or a radiofrequency device. Range of motion was assessed intraoperatively, and the joint stability was confirmed. The procedure was completed successfully, and the patient was discharged with postoperative instructions.

Operative Note 12:

A debridement and repair of a partial-thickness rotator cuff tear were performed on the patient's right shoulder. The arthroscope was introduced into the joint, and the tear was visualized. The torn edges were debrided, and the remaining healthy tissue was mobilized and reattached using sutures or anchors. The integrity of the repair was confirmed, and the joint was irrigated. The procedure was uneventful, and the patient was discharged in stable condition.

Operative Note 13:

The patient underwent an arthroscopic Bankart repair with remplissage for recurrent anterior shoulder instability in the right shoulder. Multiple small incisions were made, and the arthroscope was introduced into the joint. The detached labrum was reattached to the glenoid using anchors, and the Hill-Sachs lesion was addressed by filling the defect with adjacent tissue. The stability of the joint was assessed, and the procedure was successfully completed. Postoperative instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 14:

Patient underwent an arthroscopic acromioplasty and distal clavicle excision for impingement syndrome and AC joint arthritis in the left shoulder. The subacromial space was visualized, and the acromion was resected to create more room for the rotator cuff tendons. Additionally, the distal clavicle was excised to alleviate the symptoms of AC joint arthritis. The joint was irrigated, and the wound was closed. The patient received postoperative care instructions and was discharged in stable condition.

Operative Note 15:

A reverse total shoulder arthroplasty was performed on the patient's right shoulder for rotator cuff tear arthropathy. An incision was made, and the humeral head and glenoid were exposed. The damaged humeral head was removed, and a prosthetic humeral component was implanted. The glenoid was prepared, and a prosthetic glenoid component was fixed in place. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 16:

Patient underwent an open reduction and internal fixation (ORIF) for a clavicle fracture in the left shoulder. An incision was made over the fractured clavicle, and the fracture fragments were reduced and aligned. The fragments were then secured using plates and screws. The integrity of the fixation was confirmed, and the wound was closed. The patient received postoperative care instructions and was discharged in stable condition.

Operative Note 17:

An arthroscopic superior labrum anterior and posterior (SLAP) repair was performed on the patient's right shoulder. The labral tear was visualized, and any frayed or detached tissue was debrided. Anchors were placed in the glenoid, and the labrum was reattached using sutures. The joint stability was assessed, and the procedure was completed successfully. The patient was discharged with postoperative instructions.

Operative Note 18:

Patient underwent a resection of a synovial cyst in the subacromial space of the left shoulder. The cyst was identified and carefully excised through a small incision. Hemostasis was achieved, and the wound was closed. The

patient tolerated the procedure well, and postoperative care instructions were provided. The patient was discharged in satisfactory condition.

Operative Note 19:

A distal clavicle resection was performed on the patient's left shoulder for symptomatic AC joint arthritis. An incision was made over the AC joint, and the distal clavicle was resected using a burr or a bone saw. The joint was irrigated, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 20:

Patient underwent an arthroscopic release of the biceps tendon for biceps tendonitis in the right shoulder. Multiple small incisions were made, and the arthroscope was introduced into the joint. The inflamed biceps tendon was identified and released using electrocautery or a radiofrequency device. The joint was thoroughly irrigated, and the procedure was completed without complications. The patient was discharged with postoperative instructions.

Operative Note 21:

Patient underwent a repair of a superior labral tear from anterior to posterior (SLAP) lesion in the right shoulder under general anesthesia. The patient was induced with intravenous propofol and maintained with inhalational isoflurane. Analgesia was provided with intravenous fentanyl throughout the procedure. A standard posterior shoulder approach was used, and the labral tear was debrided and repaired. The patient tolerated the procedure well, and postoperative instructions were given. The patient was discharged in stable condition.

Operative Note 22:

A distal clavicle resection was performed on the patient's left shoulder under local anesthesia with monitored anesthesia care (MAC). The patient received a local anesthetic injection at the surgical site for anesthesia. An incision was made, and the distal clavicle was resected. Hemostasis was achieved, and the wound was closed. The patient remained comfortable throughout the procedure, and postoperative instructions were provided. The patient was discharged in satisfactory condition.

Operative Note 23:

Patient underwent an arthroscopic subacromial decompression procedure for impingement syndrome in the right shoulder under regional anesthesia. The patient received an interscalene nerve block for anesthesia. Multiple small incisions were made, and the subacromial space was visualized. The acromion and coracoacromial ligament were resected to create more space. The joint was irrigated, and the procedure was completed successfully. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 24:

A rotator cuff repair was performed on the patient's left shoulder under combined spinal-epidural anesthesia. The patient received a spinal anesthesia injection for lower body anesthesia and an epidural catheter for additional pain control. The procedure was performed through an open approach, and the torn rotator cuff tendon was repaired. The joint stability was confirmed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 25:

Patient underwent an arthroscopic Bankart repair for recurrent anterior shoulder dislocation in the right shoulder under general anesthesia. The patient was induced with intravenous propofol and maintained with inhalational sevoflurane. Endotracheal intubation was performed for airway management. The detached labrum was reattached to the glenoid using anchors. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 26:

An open reduction internal fixation (ORIF) was performed on the patient's right shoulder for a proximal humerus fracture under general anesthesia. The patient was induced with intravenous propofol and maintained with inhalational desflurane. Endotracheal intubation was performed for airway control. An incision was made over the fracture site, and the fracture fragments were reduced and fixed with plates and screws. The joint stability was confirmed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 27:

Patient underwent an arthroscopic debridement and microfracture procedure for a chondral defect in the left shoulder under regional anesthesia. The patient received an interscalene nerve block for anesthesia. Multiple small incisions were made, and the arthroscope was introduced into the joint. The chondral defect was debrided, and microfracture techniques were used for cartilage healing. The joint was irrigated, and the procedure was completed successfully. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 28:

A reverse total

shoulder arthroplasty was performed on the patient's left shoulder for rotator cuff tear arthropathy under general anesthesia. The patient was induced with intravenous propofol and maintained with inhalational sevoflurane. Endotracheal intubation was performed for airway management. An incision was made, and the damaged humeral head was removed and replaced with a prosthetic component. The glenoid was prepared, and a prosthetic glenoid component was fixed in place. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 29:

Patient underwent an arthroscopic acromioclavicular (AC) joint reconstruction for AC joint separation in the right shoulder under general anesthesia. The patient was induced with intravenous propofol and maintained with inhalational desflurane. Endotracheal intubation was performed for airway control. The ligaments were repaired using a graft or synthetic ligament. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 30:

A biceps tenodesis was performed on the patient's right shoulder under local anesthesia with monitored anesthesia care (MAC). The patient received a local anesthetic injection at the surgical site for anesthesia. An incision was made, and the biceps tendon was released from its attachment and reattached to the humerus using sutures or anchors. The joint stability was confirmed, and the wound was closed. The patient remained comfortable throughout the procedure, and postoperative instructions were given. The patient was discharged in satisfactory condition.

Operative Note 31:

Patient underwent an open shoulder debridement and bone grafting procedure for bone erosion in the right shoulder. An incision was made, and the joint was accessed. Extensive bone erosion was identified, and the necrotic bone was debrided. A bone graft was harvested from the iliac crest and placed at the site of erosion to promote bone regeneration. The joint was irrigated, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 32:

A reverse total shoulder arthroplasty with glenoid bone grafting was performed on the patient's left shoulder for advanced bone erosion due to cuff tear arthropathy. An incision was made, and the humeral head and glenoid were exposed. The eroded bone was removed, and a prosthetic humeral component and glenoid component with bone graft were implanted. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 33:

Patient underwent an arthroscopic rotator cuff repair with bone augmentation for extensive bone erosion in the right shoulder. The arthroscope was introduced, and the rotator cuff tear and accompanying bone erosion were visualized. The torn edges of the rotator cuff were debrided, and anchors were placed in the remaining healthy bone. The tear was repaired, and bone graft material was placed at the site of erosion for augmentation. The joint stability was confirmed, and the procedure was completed successfully. The patient received postoperative instructions and was discharged in stable condition.

Operative Note 34:

An open reduction and internal fixation (ORIF) with bone grafting were performed on the patient's right shoulder for a proximal humerus fracture with bone erosion. An incision was made, and the fracture fragments were reduced and aligned. The eroded bone was debrided, and a bone graft was obtained and placed to promote healing. The fragments were then fixed with plates and screws. The joint stability was confirmed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 35:

Patient underwent an arthroscopic debridement and bone erosion repair for glenohumeral joint septic arthritis with associated bone erosion in the left shoulder. The joint was accessed, and the infected synovium and eroded bone were debrided. The joint was thoroughly irrigated, and bone graft material was applied to the eroded areas for restoration. The joint stability was assessed, and the wound was closed. The patient received appropriate antibiotic therapy and postoperative instructions. The patient was discharged with follow-up plans.

Operative Note 36:

A distal clavicle resection with bone grafting was performed on the patient's right shoulder for extensive bone erosion and AC joint arthritis. An incision was made over the AC joint, and the eroded distal clavicle was resected. A bone graft was obtained and placed at the eroded site to facilitate healing. Hemostasis was achieved, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 37:

Patient underwent an arthroscopic acromioclavicular (AC) joint reconstruction with bone grafting for severe AC joint separation with bone erosion in the left shoulder. Multiple small incisions were made, and the AC joint was accessed. The eroded bone and damaged ligaments were debrided. A bone graft was obtained and placed at the site of erosion to support the joint reconstruction. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged

in satisfactory condition.

Operative Note 38:

An open shoulder stabilization procedure with bone grafting was performed on the patient's right shoulder for recurrent anterior shoulder dislocation with associated bone erosion. An incision was made, and the torn labrum was debrided. The eroded bone was addressed through bone grafting to restore stability and promote healing. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 39:

Patient underwent an arthroscopic subacromial decompression with bone erosion repair for impingement syndrome with significant bone erosion in the right shoulder. The subacromial space was accessed, and the acromion was resected. The eroded bone was addressed through bone grafting to restore the structural integrity. The joint was irrigated, and the procedure was completed successfully. Postoperative instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 40:

A reverse total shoulder arthroplasty with extensive bone grafting was performed on the patient's left shoulder for severe bone erosion and cuff tear arthropathy. An incision was made, and the damaged humeral head and glenoid were exposed. Extensive bone erosion was noted, and bone grafts were utilized to reconstruct the eroded areas. The prosthetic components were then implanted, and the joint stability was assessed. The wound was closed, and postoperative instructions were given. The patient was discharged in stable condition.

Operative Note 41:

Patient underwent an open reduction internal fixation (ORIF) with bone grafting for a comminuted proximal humerus fracture with severe bone pain in the right shoulder. An incision was made, and the fracture fragments were carefully reduced and aligned. Bone graft was obtained and applied to promote healing and alleviate pain. The fragments were then fixed using plates and screws. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 42:

A total shoulder arthroplasty with bone grafting was performed on the patient's left shoulder for severe glenohumeral arthritis and debilitating bone pain. An incision was made, and the eroded humeral head and glenoid were exposed. The damaged bone was removed, and bone grafts were used to augment the joint surfaces. The prosthetic components were implanted, and joint stability was confirmed. The wound was closed, and postoperative instructions were given. The patient was discharged with adequate pain management and follow-up plans.

Operative Note 43:

Patient underwent an arthroscopic debridement and bone marrow stimulation procedure for severe bone pain and chondral lesions in the right shoulder. The joint was accessed, and the damaged cartilage and underlying bone were debrided. Microfracture techniques were employed to stimulate bone marrow and promote healing. The joint was irrigated, and the procedure was completed successfully. Postoperative pain management and rehabilitation instructions were provided, and the patient was discharged in stable condition.

Operative Note 44:

A radiofrequency ablation procedure was performed on the patient's left shoulder for severe bone pain associated with shoulder joint osteoarthritis. Under fluoroscopic guidance, radiofrequency probes were placed near the affected nerves to ablate the pain signals. The procedure was completed successfully, and the patient reported immediate pain relief. Postoperative instructions were given, and the patient was discharged with appropriate pain management.

Operative Note 45:

Patient underwent an arthroscopic subacromial decompression with bone pain relief procedure for impingement syndrome with severe bone pain in the right shoulder. The subacromial space was accessed, and the acromion was resected. Additionally, bone debridement was performed to alleviate the bone pain. The joint was irrigated, and the procedure was completed without complications. Postoperative pain management instructions were provided, and the patient was discharged in stable condition.

Operative Note 46:

A shoulder denervation procedure was performed on the patient's right shoulder for severe bone pain due to chronic shoulder arthritis. Under arthroscopic guidance, the sensory nerves responsible for transmitting pain signals were identified and ablated. The procedure provided significant relief from bone pain. The joint was irrigated, and the wound was closed. Postoperative pain management instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 47:

Patient underwent an open bone grafting procedure for severe bone pain and bone defects in the right shoulder. An incision was made, and bone graft material was obtained and placed in the eroded areas. The bone graft was carefully positioned to address the pain and promote bone healing. The joint stability was assessed, and the wound was closed. Postoperative pain management instructions were provided, and the patient was discharged in stable condition.

Operative Note 48:

An arthroscopic rotator cuff repair with bone augmentation was performed on the patient's left shoulder for severe bone pain associated with rotator cuff tear and bone erosion. The arthroscope was introduced, and the torn rotator cuff was debrided. Bone graft material was applied to the eroded areas to support the repair and alleviate pain. The joint stability was confirmed, and the procedure was completed

successfully. Postoperative pain management instructions were given, and the patient was discharged in stable condition.

Operative Note 49:

Patient underwent an open reduction and internal fixation (ORIF) with bone grafting for a complex humeral shaft fracture with severe bone pain in the right shoulder. An incision was made, and the fracture fragments were reduced and aligned. Bone graft was obtained and placed at the fracture site to enhance stability and relieve pain. The fragments were then fixed using plates and screws. The joint stability was assessed, and the wound was closed. Postoperative pain management instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 50:

A reverse total shoulder arthroplasty with extensive bone grafting was performed on the patient's right shoulder for severe bone pain and cuff tear arthropathy. An incision was made, and the eroded humeral head and glenoid were exposed. Bone grafts were utilized to reconstruct the severely damaged bone and alleviate pain. The prosthetic components were implanted, and joint stability was assessed. The wound was closed, and postoperative pain management instructions were given. The patient was discharged in stable condition.

Operative Note 51:

Patient underwent an arthroscopic Bankart repair with surgical intervention for recurrent shoulder dislocation and associated bone erosion in the right shoulder. The arthroscope was introduced, and the labral tear and eroded bone were visualized. The torn labrum was repaired using sutures, and surgical intervention was performed to address the bone erosion. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 52:

A shoulder capsular release with surgical intervention was performed on the patient's left shoulder for adhesive capsulitis with severe pain and limited range of motion. An incision was made, and the tight and thickened joint capsule was released surgically. Manipulation under anesthesia was performed to further improve the range of motion. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged with rehabilitation plans.

Operative Note 53:

Patient underwent an open reduction internal fixation (ORIF) with surgical intervention for a displaced clavicle fracture with bone erosion and severe pain in the right shoulder. An incision was made, and the fracture fragments were reduced and aligned. Surgical intervention was performed to address the bone erosion and stabilize the fracture using plates and screws. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 54:

A bursectomy with surgical intervention was performed on the patient's right shoulder for severe subacromial bursitis and persistent pain. An incision was made, and the inflamed bursa was excised surgically. The joint and bursal space were thoroughly irrigated. Surgical intervention was also performed to address any associated bone spurs. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 55:

Patient underwent an arthroscopic decompression with surgical intervention for severe bone pain and impingement syndrome in the right shoulder. The subacromial space was accessed, and the acromion and coracoacromial ligament were surgically resected to alleviate the bone pain. The joint was irrigated, and any associated bone spurs were addressed. The procedure was completed successfully, and postoperative instructions were provided. The patient was discharged in stable condition.

Operative Note 56:

A surgical release of the long head of the biceps tendon was performed on the patient's left shoulder for severe pain and biceps tendonitis. An incision was made, and the long head of the biceps tendon was released surgically from its attachment. Any associated bone spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 57:

Patient underwent an arthroscopic debridement with surgical intervention for severe bone pain and osteoarthritis in the right shoulder. The joint was accessed, and the damaged cartilage and bone were debrided surgically. Any loose bodies were removed, and the joint was thoroughly irrigated. The joint stability was assessed, and the wound was closed. Postoperative pain management instructions were provided, and the patient was discharged in stable condition.

Operative Note 58:

A surgical reduction and fixation with bone grafting were performed on the patient's right shoulder for a displaced proximal humerus fracture with severe bone pain. An incision was made, and the fracture fragments were carefully reduced and aligned. Surgical intervention was performed to stabilize the fracture using plates, screws, and bone grafts. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in satisfactory condition.

Operative Note 59:

Patient underwent an open acromioclavicular (AC) joint reconstruction with surgical intervention for severe bone pain and AC joint separation in the left shoulder. An incision was made, and the damaged ligaments and eroded bone were surgically addressed. The AC joint was reconstructed using surgical techniques, and any associated bone spurs were removed. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 60:

A reverse total shoulder arthroplasty with surgical intervention and bone grafting was performed on the patient's right shoulder for severe bone pain, rotator cuff tear arthropathy, and associated bone erosion. An incision was made, and the eroded humeral head and glenoid were exposed. Surgical intervention and bone grafting were performed to address the bone erosion and restore joint stability. The prosthetic components were implanted, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 61:

Patient underwent an arthroscopic subacromial decompression with surgical intervention for severe bone pain and rotator cuff impingement in the right shoulder. The subacromial space was accessed, and the acromion and coracoacromial ligament were surgically resected to alleviate the bone pain and create more space for the rotator cuff. Any associated bone spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 62:

A surgical excision of a scapular tumor was performed on the patient's left shoulder for severe bone pain and suspected malignancy. An incision was made, and the tumor was carefully excised, ensuring clear margins. The surrounding bone was also addressed through surgical intervention. The wound was closed, and appropriate tissue samples were sent for pathological examination. Postoperative instructions were given, and the patient was referred for further oncological evaluation.

Operative Note 63:

Patient underwent an open shoulder stabilization procedure with surgical intervention for recurrent shoulder dislocation with associated bone erosion and severe pain in the right shoulder. An incision was made, and the torn labrum was repaired using sutures. Surgical intervention was performed to address the bone erosion and provide stability using bone grafts and fixation devices. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 64:

A surgical removal of a calcific deposit was performed on the patient's right shoulder for severe bone pain and calcific tendinitis. An incision was made, and the calcific deposit within the tendon was carefully excised. Any associated bone spurs were addressed through surgical intervention. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 65:

Patient underwent an arthroscopic debridement with surgical intervention for severe bone pain and infection in the right shoulder joint. The joint was accessed, and the infected synovium and damaged cartilage were debrided surgically. Any eroded bone was addressed through surgical intervention. The joint was thoroughly irrigated, and the procedure was completed successfully. Postoperative instructions were provided, and the patient was discharged with appropriate antibiotic therapy.

Operative Note 66:

A surgical exploration and repair of a nerve entrapment was performed on the patient's left shoulder for severe bone pain and suspected nerve compression. An incision was made, and the affected nerve was identified and released surgically. Any associated bone abnormalities or spurs were addressed. The wound was closed, and postoperative instructions were given. The patient reported immediate relief from bone pain and was discharged in stable condition.

Operative Note 67:

Patient underwent an open reduction internal fixation (ORIF) with surgical intervention for a complex shoulder fracture with severe bone pain in the right shoulder. An incision was made, and the fracture fragments were reduced and aligned. Surgical intervention was performed to stabilize the fracture using plates, screws, and other fixation devices. Any associated bone defects were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in satisfactory condition.

Operative Note 68:

A surgical release of the pectoralis minor tendon was performed on the patient's right shoulder for severe bone pain and thoracic outlet syndrome. An incision was made, and the pectoralis minor tendon was surgically released to alleviate compression on the nerves and blood vessels. Any associated bone abnormalities or spurs were addressed. The wound was closed, and postoperative instructions were given. The patient reported significant improvement in bone pain

and was discharged in stable condition.

Operative Note 69:

Patient underwent an arthroscopic osteochondral autograft transplantation with surgical intervention for severe bone pain and osteochondral defect in the right shoulder. The joint was accessed, and the damaged cartilage and underlying bone were debrided. Surgical intervention was performed to graft healthy autograft tissue onto the defect. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 70:

A surgical reconstruction of the superior labrum (SLAP) was performed on the patient's left shoulder for severe bone pain and a SLAP tear. An incision was made, and the torn labrum was repaired surgically using sutures and anchors. Any associated bone abnormalities or spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 71:

Patient underwent an urgent surgical debridement and irrigation for severe infection in the glenohumeral joint of the right shoulder. An incision was made, and the joint was thoroughly debrided to remove infected tissues. Copious irrigation with antimicrobial solution was performed to eliminate the infection. Any associated bone erosions or spurs were addressed surgically. The joint stability was assessed, and a temporary wound closure was performed. Postoperative instructions were given, and the patient was scheduled for further wound management and antibiotic therapy.

Operative Note 72:

A surgical drainage and debridement procedure was performed on the patient's left shoulder for a severe joint infection. An incision was made, and the infected joint was carefully drained and irrigated. Necrotic tissues and pus were debrided surgically. Any eroded bone or foreign bodies were addressed. The joint stability was assessed, and a drain was placed for continued drainage. The wound was left open for further wound management. Postoperative instructions were given, and the patient was started on appropriate antibiotic therapy.

Operative Note 73:

Patient underwent an emergent surgical intervention for a severe joint infection in the right shoulder. The joint was accessed, and extensive debridement was performed to remove infected tissues and pus. Copious irrigation with antimicrobial solution was done. Any eroded bone or necrotic tissues were addressed surgically. The joint stability was assessed, and a temporary wound closure was performed. Postoperative instructions were given, and the patient was admitted for continued wound management, antibiotic therapy, and close monitoring.

Operative Note 74:

A surgical irrigation and debridement procedure was performed on the patient's left shoulder for a severe joint infection. The joint was accessed, and the infected synovium and surrounding tissues were thoroughly irrigated. Necrotic tissues and purulent material were debrided surgically. Any bone erosions or spurs were addressed. The joint stability was assessed, and a drain was placed for ongoing irrigation. The wound was closed partially for further wound management. Postoperative instructions were given, and the patient was scheduled for follow-up visits and antibiotic therapy.

Operative Note 75:

Patient underwent an open joint exploration with extensive debridement for a severe infection in the right shoulder joint. An incision was made, and the infected joint was meticulously explored and debrided to remove infected tissues. Thorough irrigation with antimicrobial solution was performed. Any bone erosions or necrotic tissues were addressed surgically. The joint stability was assessed, and a temporary wound closure was performed. Postoperative instructions were given, and the patient was admitted for close monitoring, wound management, and intravenous antibiotic therapy.

Operative Note 76:

A surgical washout and debridement procedure were performed on the patient's left shoulder for a severe joint infection. The joint was accessed, and copious irrigation was done to flush out infected materials. Extensive debridement of necrotic tissues and pus was performed surgically. Any associated bone erosions or foreign bodies were addressed. The joint stability was assessed, and a drain was placed for continuous drainage. The wound was left open for further wound management. Postoperative instructions were given, and the patient was started on appropriate antibiotic therapy.

Operative Note 77:

Patient underwent an urgent surgical intervention for a severe joint infection in the right shoulder. The joint was accessed, and a thorough debridement was performed to remove infected tissues. The joint and surrounding tissues were extensively irrigated with antimicrobial solution. Any eroded bone or necrotic tissues were addressed surgically. The joint stability was assessed, and a temporary wound closure was performed. Postoperative instructions were given, and the patient was admitted for continued wound management, intravenous antibiotics,

and close monitoring.

Operative Note 78:

A surgical irrigation and debridement procedure was performed on the patient's left shoulder for a severe joint infection. The joint was accessed, and the infected synovium and surrounding tissues were meticulously irrigated. Debridement of necrotic tissues and purulent material was performed surgically. Any bone erosions or foreign bodies were addressed. The joint stability was assessed, and a drain was placed for ongoing irrigation. The wound was partially closed for further wound management. Postoperative instructions were given, and the patient was scheduled for follow-up visits and antibiotic therapy.

Operative Note 79:

Patient underwent an open joint exploration with extensive debridement for a severe infection in the right shoulder joint. An incision was made, and the infected joint was meticulously explored and debrided to remove infected tissues. Thorough irrigation with antimicrobial solution was performed. Any eroded bone or necrotic tissues were addressed surgically. The joint stability was assessed, and a temporary wound closure was performed. Postoperative instructions were given, and the patient was admitted for close monitoring, wound management, and intravenous antibiotic therapy.

Operative Note 80:

A surgical washout and debridement procedure were performed on the patient's left shoulder for a severe joint infection. The joint was accessed, and copious irrigation was done to flush out infected materials. Extensive debridement of necrotic tissues and pus was performed surgically. Any associated bone erosions or foreign bodies were addressed. The joint stability was assessed, and a drain was placed for continuous drainage. The wound was left open for further wound management. Postoperative instructions were given, and the patient was started on appropriate antibiotic therapy.

Operative Note 81:

Patient underwent an arthroscopic synovectomy with surgical intervention for severe inflammation in the right shoulder joint. The joint was accessed, and the inflamed synovial tissue was carefully excised using arthroscopic instruments. Any associated bone abnormalities or spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 82:

A surgical bursectomy with surgical intervention was performed on the patient's left shoulder for severe inflammation and recurrent bursitis. An incision was made, and the inflamed bursa was excised surgically. The joint and surrounding tissues were thoroughly irrigated. Surgical intervention was also performed to address any associated bone spurs. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 83:

Patient underwent an arthroscopic debridement with surgical intervention for severe inflammation and inflammatory arthritis in the right shoulder. The joint was accessed, and the damaged cartilage and inflamed tissues were debrided surgically. Any loose bodies were removed, and the joint was thoroughly irrigated. The joint stability was assessed, and the wound was closed. Postoperative pain management instructions were provided, and the patient was discharged in stable condition.

Operative Note 84:

A surgical excision of an inflamed synovial cyst was performed on the patient's left shoulder for severe inflammation and symptomatic cyst formation. An incision was made, and the cyst was carefully excised, ensuring complete removal. Any associated bone abnormalities or spurs were addressed surgically. The wound was closed, and postoperative instructions were given. The patient reported relief from inflammation, and was discharged in stable condition.

Operative Note 85:

Patient underwent an open joint exploration with synovectomy for severe inflammation and synovial hypertrophy in the right shoulder joint. An incision was made, and the hypertrophic synovium was meticulously excised to reduce inflammation. Any associated bone erosions or spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged with follow-up plans for further management of inflammation.

Operative Note 86:

A surgical release of the joint capsule was performed on the patient's left shoulder for severe inflammation and adhesive capsulitis. An incision was made, and the tight and thickened joint capsule was released surgically. Any associated bone abnormalities or spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged with rehabilitation plans to address the inflammation.

Operative Note 87:

Patient underwent an arthroscopic debridement with synovectomy for severe inflammation and plica syndrome in the right shoulder. The joint was accessed, and the inflamed synovium and plica were carefully excised using arthroscopic instruments. Any associated bone abnormalities or spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were provided, and the patient was discharged in stable condition.

Operative Note 88:

A surgical removal of an inflamed bursal tissue was performed on the patient's left shoulder for severe inflammation and bursitis. An incision was made, and the inflamed bursa was excised surgically. Any associated bone abnormalities or spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged in stable condition.

Operative Note 89:

Patient underwent an open joint exploration with extensive synovectomy for severe inflammation and rheumatoid arthritis in the right shoulder

joint. An incision was made, and the inflamed synovium was meticulously excised to reduce inflammation. Any associated bone erosions or spurs were addressed surgically. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged with plans for further management of the inflammatory condition.

Operative Note 90:

A surgical bursectomy with debridement was performed on the patient's left shoulder for severe inflammation and infected bursitis. An incision was made, and the inflamed bursa was excised surgically. Thorough irrigation was performed to eliminate infection. Any associated bone abnormalities or spurs were addressed. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was discharged with appropriate antibiotic therapy and plans for follow-up.

Operative Note 91:

Patient underwent an arthroscopic debridement and repair of a partial-thickness rotator cuff tear in the right shoulder. The torn tendon edges were meticulously debrided, and the healthy tissue was sutured together. The joint stability was assessed, and the wound was closed. Postoperative instructions were given, and the patient was scheduled for a follow-up visit in 6 weeks to evaluate the healing and discuss rehabilitation options based on the severity of the tear.

Operative Note 92:

A surgical excision of a benign tumor was performed on the patient's left shoulder. The tumor was carefully excised, ensuring clear margins. The wound was closed, and postoperative instructions were given. The patient will have a follow-up appointment in 2 weeks to assess the surgical site and determine the need for further treatment based on the pathological findings.

Operative Note 93:

Patient underwent an open reduction internal fixation (ORIF) of a complex shoulder fracture in the right shoulder. The fracture fragments were reduced and aligned, and fixation was achieved using plates, screws, and other fixation devices. The joint stability was assessed, and the wound was closed. The patient will have a follow-up appointment in 1 week for an initial evaluation of the fracture healing and further management based on the severity of the fracture.

Operative Note 94:

A surgical repair of a Bankart lesion was performed on the patient's left shoulder for recurrent shoulder dislocation. The torn labrum was repaired using sutures and anchors. The joint stability was assessed, and the wound was closed. The patient will have a follow-up appointment in 4 weeks to evaluate the success of the repair and discuss rehabilitation options based on the severity of the instability.

Operative Note 95:

Patient underwent an arthroscopic debridement and microfracture procedure for a chondral defect in the right shoulder joint. The damaged cartilage was debrided, and microfractures were created to stimulate the formation of new cartilage. The joint stability was assessed, and the wound was closed. The patient will have a follow-up appointment in 6 weeks to assess the healing of the cartilage defect and determine the need for further intervention based on the severity of the defect.

Operative Note 96:

A surgical excision of a suspicious lesion was performed on the patient's left shoulder. The lesion was carefully excised, ensuring clear margins. The wound was closed, and postoperative instructions were given. The patient will have a follow-up appointment in 1 week to discuss the histopathology results and determine the need for further treatment based on the severity of the lesion.

Operative Note 97:

Patient underwent an open joint exploration for an undiagnosed shoulder pathology in the right shoulder. The joint was explored thoroughly, and any abnormal findings were addressed. The joint stability was assessed, and the wound was closed. The patient will have a follow-up appointment in 2 weeks to discuss the results of further investigations and determine the need for additional treatment based on the severity of the pathology.

Operative Note 98:

A surgical excision of a lipoma was performed on the patient's left shoulder. The lipoma was carefully excised, ensuring complete removal. The wound was closed, and postoperative instructions were given. The patient will have a follow-up appointment in 2 weeks to assess the surgical site and determine the need for further treatment based on the severity of the lipoma.

Operative Note 99:

Patient underwent an arthroscopic debridement and synovectomy for synovial inflammation in the right shoulder joint. The inflamed synovium was excised, and any loose bodies were removed. The joint stability was assessed, and the wound was closed. The patient will have a follow-up appointment

in 4 weeks to evaluate the success of the procedure and determine the need for further treatment based on the severity of the inflammation.

Operative Note 100:

A surgical repair of a superior labrum anterior to posterior (SLAP) tear was performed on the patient's left shoulder. The torn labrum was repaired using sutures and anchors. The joint stability was assessed, and the wound was closed. The patient will have a follow-up appointment in 6 weeks to assess the success of the repair and discuss rehabilitation options based on the severity of the tear.

## M75.9 Shoulder lesion, unspecified

1. Patient presented with a shoulder lesion characterized by a rotator cuff tear. Arthroscopic examination confirmed the tear, and a repair was performed using anchors and sutures. Patient tolerated the procedure well, and postoperative pain was managed with analgesics. Range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and further rehabilitation.

2. The patient's shoulder lesion was identified as a Bankart lesion on imaging. An arthroscopic stabilization procedure was performed, including labral repair and capsular tightening. Patient's vital signs remained stable throughout the surgery, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Scheduled for a follow-up appointment in two weeks.

3. A patient with a glenoid labrum tear presented with a shoulder lesion. Arthroscopic examination revealed a detached labrum, which was reattached using suture anchors. Patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and progress evaluation.

4. The patient underwent surgery for a shoulder lesion characterized by adhesive capsulitis. Manipulation under anesthesia and arthroscopic capsular release were performed successfully. Patient's vital signs were stable throughout the procedure, and postoperative pain was managed effectively. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled in two weeks for further evaluation.

5. A patient with a shoulder lesion due to osteoarthritis underwent a total shoulder replacement. The procedure involved removing the damaged joint surfaces and implanting a prosthetic shoulder joint. Patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for wound assessment and rehabilitation progress.

6. The patient's shoulder lesion was diagnosed as a SLAP tear. Arthroscopic repair of the labrum was performed using suture anchors. The patient tolerated the procedure well, and postoperative pain was managed with analgesics. Passive range of motion exercises initiated on day 1 post-op. Scheduled for a follow-up appointment in two weeks for suture removal and further rehabilitation guidance.

7. A patient with a recurrent shoulder dislocation presented with a shoulder lesion. Arthroscopic Bankart repair was performed, including labral reattachment and capsular tightening. The patient's vital signs remained stable throughout the surgery, and postoperative pain was effectively managed. Active-assisted range of motion exercises initiated on day 2 post-op. Scheduled for a follow-up appointment in two weeks for progress evaluation.

8. The patient's shoulder lesion was identified as a massive rotator cuff tear. Arthroscopic rotator cuff repair was performed using double-row fixation technique. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

9. A patient with a shoulder lesion due to recurrent anterior shoulder instability underwent a Latarjet procedure. The coracoid process was harvested and fixed to the anterior glenoid rim to provide stability. The patient tolerated the surgery well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for wound assessment and rehabilitation progress.

10. The patient's shoulder lesion was diagnosed as a biceps tendon tear. Arthroscopic tenodesis was performed to reattach the tendon to the bone. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Passive range of motion exercises initiated on day 1 post-op.Scheduled for a follow-up appointment in two weeks for suture removal and further rehabilitation guidance.

1. A patient with a shoulder lesion due to a proximal humeral fracture underwent an open reduction and internal fixation (ORIF) procedure. The fracture fragments were realigned and secured with plates and screws. The patient tolerated the surgery well, and postoperative pain was effectively managed. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled in six weeks for radiographic evaluation and rehabilitation progress.

2. The patient presented with a shoulder lesion characterized by a superior labrum anterior to posterior (SLAP) tear. Arthroscopic SLAP repair was performed using suture anchors. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

3. A patient with a shoulder lesion due to calcific tendinitis underwent an arthroscopic procedure for calcium deposit removal. The deposits were visualized and removed using specialized instruments. The patient tolerated the surgery well, and postoperative pain was managed effectively. Passive range of motion exercises initiated on day 1 post-op. Scheduled for a follow-up appointment in two weeks for progress evaluation.

4. The patient's shoulder lesion was diagnosed as a subacromial impingement syndrome. Arthroscopic subacromial decompression was performed, including acromioplasty and bursectomy. The patient's vital signs remained stable throughout the surgery, and postoperative pain was effectively managed. Active-assisted range of motion exercises initiated on day 2 post-op. Scheduled for a follow-up appointment in four weeks for wound assessment and rehabilitation progress.

5. A patient with a shoulder lesion due to a glenohumeral dislocation underwent a Bankart repair procedure. The detached labrum was reattached using suture anchors. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

6. The patient's shoulder lesion was identified as a humeral avulsion of the glenohumeral ligament (HAGL) lesion. Open repair of the avulsed ligament was performed, securing it back to the bone. The patient tolerated the procedure well, and postoperative pain was managed effectively. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled in four weeks for progress evaluation.

7. A patient with a shoulder lesion due to a massive irreparable rotator cuff tear underwent a superior capsule reconstruction (SCR) procedure. The graft was secured between the superior glenoid and the greater tuberosity to restore shoulder stability. The patient tolerated the surgery well, and postoperative pain was effectively managed. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for wound assessment and rehabilitation progress.

8. The patient's shoulder lesion was diagnosed as a multidirectional instability. Arthroscopic capsular plication was performed, tightening the loose shoulder joint capsule. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Active range of motion exercises initiated on day 2 post-op. Scheduled for a follow-up appointment in four weeks for progress evaluation.

9. A patient with a shoulder lesion due to a glenoid labrum tear and associated bone loss underwent a Latarjet procedure. The coracoid process was harvested and fixed to the anterior glenoid to provide stability and restore the labrum. The patient tolerated the surgery well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 3

post-op. Follow-up scheduled in six weeks for radiographic evaluation and rehabilitation progress.

10. The patient presented with a shoulder lesion characterized by a frozen shoulder (adhesive capsulitis). Arthroscopic capsular release was performed to improve shoulder mobility. The patient's vital signs remained stable throughout the surgery, and postoperative pain was effectively managed. Passive range of motion exercises initiated on day 1 post-op. Scheduled for a follow-up appointment in four weeks for progress evaluation and further rehabilitation guidance.

1. Patient presented with a shoulder lesion characterized by a rotator cuff tear. Under general anesthesia, arthroscopic examination confirmed the tear, and a repair was performed using anchors and sutures. Patient tolerated the procedure well, and postoperative pain was managed with moderate analgesics. Range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and further rehabilitation.

2. The patient's shoulder lesion was identified as a Bankart lesion on imaging. Under regional anesthesia, an arthroscopic stabilization procedure was performed, including labral repair and capsular tightening. Patient's vital signs remained stable throughout the surgery, and postoperative pain was managed effectively with a combination of local anesthetics and opioids. Active-assisted range of motion exercises initiated on day 2 post-op. Scheduled for a follow-up appointment in two weeks.

3. A patient with a glenoid labrum tear presented with a shoulder lesion. Under general anesthesia, arthroscopic examination revealed a detached labrum, which was reattached using suture anchors. Patient tolerated the procedure well, and postoperative pain was controlled with a low-dose epidural infusion. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and progress evaluation.

4. The patient underwent surgery for a shoulder lesion characterized by adhesive capsulitis. Under local anesthesia with sedation, manipulation under anesthesia and arthroscopic capsular release were performed successfully. Patient's vital signs were stable throughout the procedure, and postoperative pain was managed effectively with a combination of local anesthesia and oral analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled in two weeks for further evaluation.

5. A patient with a shoulder lesion due to osteoarthritis underwent a total shoulder replacement. Under general anesthesia, the procedure involved removing the damaged joint surfaces and implanting a prosthetic shoulder joint. Patient tolerated the surgery well, and postoperative pain was controlled effectively using a patient-controlled analgesia pump. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for wound assessment and rehabilitation progress.

6. The patient's shoulder lesion was diagnosed as a SLAP tear. Under regional anesthesia, arthroscopic repair of the labrum was performed using suture anchors. The patient tolerated the procedure well, and postoperative pain was managed with a combination of local anesthetics and systemic analgesics. Passive range of motion exercises initiated on day 1 post-op. Scheduled for a follow-up appointment in two weeks for suture removal and further rehabilitation guidance.

7. A patient with a recurrent shoulder dislocation presented with a shoulder lesion. Under general anesthesia, arthroscopic Bankart repair was performed, including labral reattachment and capsular tightening. The patient's vital signs remained stable throughout the surgery, and postoperative pain was effectively managed using a multimodal analgesic regimen. Active-assisted range of motion exercises initiated on day 2 post-op. Scheduled for a follow-up appointment in two weeks for progress evaluation.

8. The patient's shoulder lesion was identified as a massive rotator cuff tear. Under regional anesthesia, arthroscopic rotator cuff repair was performed using double-row fixation technique. The patient tolerated the procedure well, and postoperative pain was controlled with a combination of regional anesthesia and oral analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

9. A patient with a shoulder lesion due to recurrent anterior shoulder instability underwent a Latarjet procedure. Under general anesthesia, the coracoid process was harvested and fixed to

the anterior glenoid rim to provide stability. The patient tolerated the surgery well, and postoperative pain was managed effectively using intravenous patient-controlled analgesia. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for wound assessment and rehabilitation progress.

10. The patient's shoulder lesion was diagnosed as a biceps tendon tear. Under regional anesthesia, arthroscopic tenodesis was performed to reattach the tendon to the bone. The patient tolerated the procedure well, and postoperative pain was controlled with a combination of regional anesthesia and oral analgesics. Passive range of motion exercises initiated on day 1 post-op. Scheduled for a follow-up appointment in two weeks for suture removal and further rehabilitation guidance.

1. The patient presented with a shoulder lesion characterized by a massive rotator cuff tear and significant bone erosion. Under general anesthesia, an open rotator cuff repair was performed, involving debridement of the torn tendon and bone augmentation using allograft material. Patient tolerated the procedure well, and postoperative pain was managed with analgesics. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation.

2. A patient with a shoulder lesion due to rheumatoid arthritis presented with severe bone erosion and glenoid deformity. Under regional anesthesia, a total shoulder arthroplasty was performed, involving the removal of eroded bone surfaces and implantation of a glenoid and humeral component. Patient tolerated the surgery well, and postoperative pain was effectively managed. Active range of motion exercises initiated on day 3 post-op. Follow-up scheduled in six weeks for wound assessment and rehabilitation progress.

3. The patient's shoulder lesion was diagnosed as a Hill-Sachs lesion with significant bone erosion. Under general anesthesia, an arthroscopic remplissage procedure was performed to fill the defect with local soft tissue. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

4. A patient with a shoulder lesion due to recurrent shoulder dislocations presented with glenoid bone loss. Under regional anesthesia, a Latarjet procedure was performed to address the bone loss by transferring the coracoid process and fixing it to the anterior glenoid. The patient tolerated the surgery well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for radiographic evaluation and rehabilitation progress.

5. The patient presented with a shoulder lesion characterized by a large, irreparable rotator cuff tear and extensive humeral head bone erosion. Under general anesthesia, a reverse shoulder arthroplasty was performed, involving the removal of the eroded bone and implantation of a reverse prosthesis. Patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 3 post-op. Follow-up scheduled in six weeks for wound assessment and rehabilitation progress.

6. A patient with a shoulder lesion due to advanced osteoarthritis presented with significant glenoid and humeral head bone erosion. Under regional anesthesia, a total shoulder arthroplasty was performed, involving the resection of eroded bone surfaces and implantation of a glenoid and humeral component. The patient tolerated the surgery well, and postoperative pain was managed with a combination of regional anesthesia and systemic analgesics. Passive range of motion exercises initiated on day 2 post-op. Scheduled for a follow-up appointment in six weeks for progress evaluation.

7. The patient's shoulder lesion was identified as a glenoid labrum tear with associated bone erosion. Under general anesthesia, arthroscopic labral repair was performed, and the eroded bone was addressed with microfracture or bone grafting. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

8. A patient with a shoulder lesion due to chronic osteomyelitis presented with extensive bone erosion in the humeral head. Under regional anesthesia, a two-stage procedure was performed, including thorough debridement of infected bone and subsequent antibiotic spacer placement. Patient's

vital signs remained stable throughout the surgery, and postoperative pain was managed effectively. Follow-up scheduled for antibiotic therapy continuation and further evaluation.

9. The patient's shoulder lesion was diagnosed as an acromioclavicular (AC) joint separation with accompanying bone erosion. Under regional anesthesia, an open AC joint reconstruction was performed, involving the stabilization of the joint with grafts or synthetic ligaments. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Passive range of motion exercises initiated on day 1 post-op. Scheduled for a follow-up appointment in four weeks for progress evaluation and rehabilitation guidance.

10. A patient with a shoulder lesion due to metastatic cancer presented with bone erosion in the humeral head. Under general anesthesia, a tumor resection and reconstruction procedure were performed, involving the removal of the eroded bone and subsequent bone grafting or prosthetic implantation. The patient tolerated the surgery well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for wound assessment and further oncological evaluation.

1. The patient presented with a shoulder lesion and severe bone pain due to metastatic cancer. Under general anesthesia, a palliative surgery was performed to stabilize the shoulder joint and alleviate pain, including tumor debulking and fixation with cement or prosthetic implantation. The patient tolerated the procedure well, and postoperative pain was managed with a multimodal analgesic approach. Follow-up scheduled for pain assessment and further supportive care.

2. A patient with a shoulder lesion and severe bone pain due to avascular necrosis (AVN) of the humeral head underwent a total shoulder replacement. Under regional anesthesia, the procedure involved removing the necrotic bone and implanting a prosthetic joint. The patient tolerated the surgery well, and postoperative pain was effectively managed using a combination of regional anesthesia and systemic analgesics. Follow-up scheduled for wound assessment and pain evaluation.

3. The patient's shoulder lesion was diagnosed as a glenoid labrum tear with severe bone pain. Under general anesthesia, arthroscopic labral repair was performed, and the eroded bone was addressed with microfracture or bone grafting. The patient tolerated the procedure well, and postoperative pain was controlled with analgesics. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal, pain assessment, and further rehabilitation guidance.

4. A patient with a shoulder lesion and severe bone pain due to complex regional pain syndrome (CRPS) underwent a sympathectomy procedure. Under regional anesthesia, the sympathetic nerves responsible for pain transmission were selectively targeted and treated. The patient tolerated the surgery well, and postoperative pain was effectively managed with a combination of regional anesthesia and pain medications. Follow-up scheduled for pain evaluation and further management.

5. The patient presented with a shoulder lesion and severe bone pain caused by a glenohumeral joint infection. Under general anesthesia, an open debridement procedure was performed, involving the removal of infected tissue and bone, followed by irrigation and antibiotic treatment. The patient tolerated the surgery well, and postoperative pain was managed with intravenous antibiotics and analgesics. Follow-up scheduled for wound assessment, pain evaluation, and further infectious disease management.

6. A patient with a shoulder lesion and severe bone pain due to osteomyelitis underwent a sequestrectomy procedure. Under regional anesthesia, the infected bone sequestrum was removed to alleviate pain and prevent further spread of the infection. The patient tolerated the procedure well, and postoperative pain was controlled effectively with a combination of regional anesthesia and systemic analgesics. Follow-up scheduled for wound assessment, pain evaluation, and antibiotic therapy continuation.

7. The patient's shoulder lesion was identified as a severe rotator cuff tear with associated bone pain. Under general anesthesia, an open rotator cuff repair was performed, involving the debridement of the torn tendon and bone augmentation using autograft or allograft material. Patient tolerated the procedure well, and postoperative pain was managed with analgesics. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal, pain assessment, and further rehabilitation.

8. A patient with a shoulder lesion and severe bone pain due to complex shoulder regional pain syndrome underwent a radiofrequency ablation procedure. Under local anesthesia with sedation, the affected nerves responsible for pain were targeted and treated using radiofrequency energy. The patient tolerated the procedure well, and postoperative pain was effectively managed with a combination of local anesthesia and pain medications. Follow-up scheduled for pain evaluation and further management.

9. The patient presented with a shoulder lesion and severe bone pain due to an acute fracture of the proximal

humerus. Under regional anesthesia, an open reduction and internal fixation procedure were performed, involving the alignment and stabilization of the fractured bone using plates, screws, or intramedullary nails. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled for radiographic evaluation, pain assessment, and further rehabilitation.

10. A patient with a shoulder lesion and severe bone pain due to a traumatic dislocation underwent a closed reduction procedure. Under general anesthesia, the dislocated shoulder joint was manually manipulated and relocated into its proper position. The patient tolerated the procedure well, and postoperative pain was managed with analgesics. Active range of motion exercises initiated on day 1 post-op. Follow-up scheduled for pain assessment, stability evaluation, and further rehabilitation guidance.

1. The patient presented with a shoulder lesion characterized by a rotator cuff tear. Under general anesthesia, an arthroscopic rotator cuff repair was performed using suture anchors. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

2. A patient with a shoulder lesion due to recurrent shoulder dislocations underwent a Bankart repair. Under regional anesthesia, an arthroscopic stabilization procedure was performed, involving the reattachment of the torn labrum and tightening of the joint capsule. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

3. The patient's shoulder lesion was diagnosed as adhesive capsulitis (frozen shoulder). Under local anesthesia with sedation, an arthroscopic capsular release was performed to improve shoulder mobility. The patient tolerated the procedure well, and postoperative pain was managed with a combination of local anesthesia and oral analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

4. A patient with a shoulder lesion due to osteoarthritis underwent a shoulder arthroscopy with joint debridement. Under regional anesthesia, the procedure involved removing loose fragments and smoothing out damaged cartilage. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for progress evaluation and further management.

5. The patient presented with a shoulder lesion and a suspected SLAP tear. Under general anesthesia, an arthroscopic SLAP repair was performed, involving the reattachment of the torn labrum to the glenoid rim. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

6. A patient with a shoulder lesion and biceps tendonitis underwent a biceps tenodesis procedure. Under regional anesthesia, the long head of the biceps tendon was released and reattached to a more stable location on the humerus. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

7. The patient's shoulder lesion was diagnosed as a partial-thickness rotator cuff tear. Under general anesthesia, an arthroscopic rotator cuff repair was performed using a single-row suture technique. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

8. A patient with a shoulder lesion and recurrent instability underwent a capsular shift procedure. Under regional anesthesia, the joint capsule was tightened and repositioned to improve stability. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

9. The patient presented with a shoulder lesion and a suspected labral tear. Under general anesthesia, an arthroscopic labral repair was performed, involving the reattachment of the torn labrum to the glenoid rim. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises

initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

10. A patient with a shoulder lesion and chronic impingement syndrome underwent an arthroscopic subacromial decompression. Under regional anesthesia, the acromion was reshaped, and the subacromial space was enlarged to relieve pressure on the underlying structures. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

1. The patient presented with a shoulder lesion and recurrent instability. Under general anesthesia, an open Bankart repair was performed, involving the reattachment of the torn labrum and reconstruction of the anterior capsule. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

2. A patient with a shoulder lesion and severe osteoarthritis underwent a shoulder hemiarthroplasty. Under regional anesthesia, the damaged humeral head was replaced with a prosthetic component. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

3. The patient's shoulder lesion was diagnosed as a superior labral tear from anterior to posterior (SLAP) and a concomitant biceps tendon tear. Under general anesthesia, an arthroscopic SLAP repair and biceps tenodesis were performed. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

4. A patient with a shoulder lesion and chronic rotator cuff tendinopathy underwent a rotator cuff debridement and acromioplasty. Under regional anesthesia, the damaged tendon was cleared of degenerated tissue, and the acromion was reshaped to reduce impingement. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

5. The patient presented with a shoulder lesion and a suspected SLAP tear. Under general anesthesia, an arthroscopic SLAP repair was performed using a double-row suture technique. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

6. A patient with a shoulder lesion and multidirectional instability underwent a capsular plication procedure. Under regional anesthesia, the joint capsule was tightened and sutured to improve stability. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

7. The patient's shoulder lesion was diagnosed as a glenohumeral joint infection. Under general anesthesia, an open debridement and irrigation procedure was performed, involving the removal of infected tissue and thorough cleaning of the joint. The patient tolerated the surgery well, and postoperative pain was managed with intravenous antibiotics and analgesics. Follow-up scheduled for wound assessment, infectious disease management, and further rehabilitation guidance.

8. A patient with a shoulder lesion and an irreparable rotator cuff tear underwent a superior capsular reconstruction. Under regional anesthesia, a graft was used to create a bridge between the glenoid and humeral head, providing stability and function. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

9. The patient presented with a shoulder lesion and a suspected acromioclavicular (AC) joint separation. Under general anesthesia, an open AC joint reconstruction was performed, involving the stabilization of the joint using autograft or synthetic ligaments. The patient tolerated the procedure well, and post

operative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for suture removal and further rehabilitation guidance.

10. A patient with a shoulder lesion and severe rheumatoid arthritis underwent a total shoulder arthroplasty. Under regional anesthesia, the damaged joint components were replaced with prosthetic components. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

1. The patient presented with a shoulder lesion and severe infection involving the glenohumeral joint. Under general anesthesia, an open joint debridement and irrigation procedure were performed, involving thorough removal of infected tissue and irrigation with antimicrobial solutions. The patient tolerated the surgery well, and postoperative pain was managed with intravenous antibiotics and analgesics. Follow-up scheduled for wound assessment, infectious disease management, and further rehabilitation guidance.

2. A patient with a shoulder lesion and severe septic arthritis of the shoulder joint underwent an arthroscopic lavage and drainage procedure. Under regional anesthesia, the infected joint was thoroughly irrigated and drained to remove pus and debris. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled for wound assessment, infection management, and further rehabilitation guidance.

3. The patient's shoulder lesion was diagnosed as a deep infection involving the glenohumeral joint following a previous surgery. Under general anesthesia, an open revision procedure was performed, involving removal of infected hardware, extensive debridement, and placement of antibiotic-loaded cement spacers. The patient tolerated the procedure well, and postoperative pain was managed with intravenous antibiotics and analgesics. Follow-up scheduled for wound assessment, infection control, and further management.

4. A patient with a shoulder lesion and a severe infection of the acromioclavicular (AC) joint underwent an open joint exploration and debridement procedure. Under regional anesthesia, the infected joint was thoroughly cleaned, and necrotic tissue was removed. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled for wound assessment, infection management, and further rehabilitation guidance.

5. The patient presented with a shoulder lesion and a deep infection involving the rotator cuff. Under general anesthesia, an open debridement and repair procedure were performed, involving the removal of infected tissue, repair of the damaged rotator cuff, and placement of antibiotic-impregnated beads. The patient tolerated the surgery well, and postoperative pain was managed with intravenous antibiotics and analgesics. Follow-up scheduled for wound assessment, infection control, and further rehabilitation.

6. A patient with a shoulder lesion and severe septic bursitis underwent an open bursectomy procedure. Under regional anesthesia, the infected bursa was excised, and thorough irrigation was performed. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled for wound assessment, infection management, and further rehabilitation guidance.

7. The patient's shoulder lesion was diagnosed as an infected Glenoid Labrum Tear (GLT). Under general anesthesia, an arthroscopic debridement and lavage procedure were performed, involving the removal of infected tissue and thorough irrigation of the joint. The patient tolerated the surgery well, and postoperative pain was managed with intravenous antibiotics and analgesics. Follow-up scheduled for wound assessment, infection control, and further rehabilitation guidance.

8. A patient with a shoulder lesion and severe septic arthritis of the acromioclavicular (AC) joint underwent an open joint debridement and irrigation procedure. Under regional anesthesia, the infected joint was thoroughly cleaned, and infected tissue was removed. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled for wound assessment, infection management, and further rehabilitation guidance.

9. The patient presented with a shoulder lesion and a deep infection involving the biceps tendon sheath. Under general anesthesia, an open debridement and washout procedure were performed, involving the removal of infected tissue and irrigation with antimicrobial solutions. The patient tolerated the surgery well, and postoperative pain was managed with

intravenous antibiotics and analgesics. Follow-up scheduled for wound assessment, infection control, and further rehabilitation.

10. A patient with a shoulder lesion and severe septic arthritis of the glenohumeral joint underwent an open joint debridement and irrigation procedure. Under regional anesthesia, the infected joint was thoroughly cleaned, and necrotic tissue was removed. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled for wound assessment, infection management, and further rehabilitation guidance.

1. The patient presented with a shoulder lesion and severe inflammation of the subacromial bursa. Under general anesthesia, an arthroscopic subacromial decompression was performed, involving the removal of inflamed tissue and enlargement of the subacromial space. The patient tolerated the surgery well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

2. A patient with a shoulder lesion and chronic inflammation of the glenohumeral joint underwent an arthroscopic synovectomy. Under regional anesthesia, the inflamed synovium was removed to alleviate symptoms and reduce inflammation. The patient tolerated the procedure well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

3. The patient's shoulder lesion was diagnosed as adhesive capsulitis (frozen shoulder) with significant inflammation. Under local anesthesia with sedation, an arthroscopic capsular release and debridement were performed to improve shoulder mobility and reduce inflammation. The patient tolerated the procedure well, and postoperative pain was managed with a combination of local anesthesia and oral analgesics. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

4. A patient with a shoulder lesion and severe inflammation due to rheumatoid arthritis underwent a shoulder arthroscopy with joint debridement. Under regional anesthesia, the inflamed joint components were cleared of inflammatory tissue and debris. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled in six weeks for progress evaluation and further management.

5. The patient presented with a shoulder lesion and chronic bursitis associated with significant inflammation. Under general anesthesia, an open bursectomy procedure was performed, involving the excision of the inflamed bursa to alleviate symptoms and reduce inflammation. The patient tolerated the surgery well, and postoperative pain was managed effectively. Follow-up scheduled for wound assessment, inflammation control, and further rehabilitation guidance.

6. A patient with a shoulder lesion and severe inflammation of the acromioclavicular (AC) joint underwent an open joint debridement and synovectomy procedure. Under regional anesthesia, the inflamed joint tissues were removed to alleviate symptoms and reduce inflammation. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled for wound assessment, inflammation control, and further rehabilitation guidance.

7. The patient's shoulder lesion was diagnosed as a rotator cuff tendinopathy with marked inflammation. Under general anesthesia, an arthroscopic rotator cuff debridement and irrigation were performed, involving the removal of inflamed tissue and thorough irrigation of the affected area. The patient tolerated the procedure well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

8. A patient with a shoulder lesion and severe inflammation of the biceps tendon underwent a biceps tenotomy and tenodesis procedure. Under regional anesthesia, the inflamed tendon was released and reattached to a more stable location on the humerus. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Passive range of motion exercises initiated on day 1 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

9. The patient presented with a shoulder lesion and significant inflammation associated with calcific tendinitis. Under general anesthesia, an

arthroscopic calcium deposit removal and debridement were performed, involving the extraction of calcific deposits and removal of inflamed tissue. The patient tolerated the surgery well, and postoperative pain was managed effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

10. A patient with a shoulder lesion and severe inflammation of the glenoid labrum underwent an arthroscopic labral debridement and repair procedure. Under regional anesthesia, the inflamed labrum was cleared of degenerated tissue, and the torn edges were repaired. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Active-assisted range of motion exercises initiated on day 2 post-op. Follow-up scheduled for progress evaluation and further rehabilitation guidance.

1. The patient presented with a shoulder lesion and a large full-thickness rotator cuff tear. Under general anesthesia, an open rotator cuff repair was performed, involving the reattachment of the torn tendon to the humerus. The patient tolerated the surgery well, and postoperative pain was managed effectively. Follow-up scheduled at 2 weeks for suture removal and further evaluation based on the tear size and healing progress.

2. A patient with a shoulder lesion and a suspected SLAP tear underwent an arthroscopic SLAP repair. Under regional anesthesia, the torn labrum was reattached using suture anchors. The patient tolerated the procedure well, and postoperative pain was controlled effectively. Follow-up scheduled at 4 weeks for progress evaluation and further rehabilitation guidance based on the tear severity and associated symptoms.

3. The patient's shoulder lesion was diagnosed as a recurrent anterior shoulder dislocation. Under general anesthesia, an open Bankart repair was performed, involving the reconstruction of the torn labrum and stabilization of the joint. The patient tolerated the surgery well, and postoperative pain was managed effectively. Follow-up scheduled at 2 weeks for suture removal and further evaluation based on the severity of instability and joint stability.

4. A patient with a shoulder lesion and severe osteoarthritis underwent a total shoulder arthroplasty. Under regional anesthesia, the damaged joint components were replaced with prosthetic components. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled at 6 weeks for progress evaluation and further rehabilitation guidance, with subsequent follow-ups depending on the severity of arthritis and functional outcomes.

5. The patient presented with a shoulder lesion and suspected infection of the glenohumeral joint. Under general anesthesia, an open joint debridement and irrigation were performed, involving the removal of infected tissue and thorough cleaning of the joint. The patient tolerated the surgery well, and postoperative pain was managed with intravenous antibiotics and analgesics. Follow-up scheduled at 1 week for wound assessment and infection control, with further evaluations based on the severity of infection and response to treatment.

6. A patient with a shoulder lesion and a large, irreparable rotator cuff tear underwent a superior capsular reconstruction. Under regional anesthesia, a graft was used to bridge the gap between the glenoid and humeral head, providing stability and function. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled at 6 weeks for progress evaluation, with subsequent follow-ups based on the severity of tear and functional recovery.

7. The patient's shoulder lesion was diagnosed as a severe glenohumeral joint instability with associated bone loss. Under general anesthesia, an open Latarjet procedure was performed, involving the transfer of bone and stabilization of the joint. The patient tolerated the surgery well, and postoperative pain was managed effectively. Follow-up scheduled at 2 weeks for suture removal and further evaluation based on the severity of instability and bone loss.

8. A patient with a shoulder lesion and severe impingement syndrome underwent an arthroscopic subacromial decompression. Under regional anesthesia, the acromion was reshaped, and the subacromial space was enlarged to relieve pressure on the underlying structures. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled at 4 weeks for progress evaluation and further rehabilitation guidance based on the severity of impingement and functional improvement.

9. The patient presented with a shoulder lesion and a suspected posterior labral tear. Under general anesthesia, an arthroscopic posterior labral repair was performed, involving the reattachment of the torn labrum. The

patient tolerated the procedure well, and postoperative pain was managed effectively. Follow-up scheduled at 6 weeks for progress evaluation and further rehabilitation guidance based on the severity of tear and associated symptoms.

10. A patient with a shoulder lesion and severe multidirectional instability underwent an open capsular shift procedure. Under regional anesthesia, the capsule was tightened and repositioned to restore stability to the joint. The patient tolerated the surgery well, and postoperative pain was controlled effectively. Follow-up scheduled at 2 weeks for suture removal and further evaluation based on the severity of instability and functional outcomes.

## M76.0 Gluteal tendinitis

## M76.1 Psoas tendinitis

1. Patient presented with localized pain in the hip region. Physical examination revealed tenderness over the psoas muscle. Diagnosis of psoas tendinitis was made. Patient was prescribed a combination of rest, ice, and non-steroidal anti-inflammatory drugs (NSAIDs) for pain relief. Physical therapy was recommended for strengthening and stretching exercises.

2. Psoas tendinitis confirmed with MRI showing inflammation around the psoas tendon. Patient received ultrasound-guided corticosteroid injection for pain management. Home exercise program provided for stretching and strengthening of the hip muscles. Follow-up appointment scheduled in four weeks.

3. Patient complained of persistent hip pain exacerbated by hip flexion. Physical examination revealed tenderness and limited range of motion. Diagnosis of psoas tendinitis confirmed. Patient advised to modify activities and avoid excessive hip flexion. Prescribed NSAIDs and referred to a physical therapist for rehabilitation.

4. MRI findings consistent with psoas tendinitis, showing inflammation and thickening of the psoas tendon. Patient prescribed a course of oral corticosteroids for pain and inflammation reduction. Emphasized the importance of avoiding activities that aggravate symptoms. Patient instructed to follow up in two weeks.

5. Patient presented with chronic hip pain radiating to the groin. Clinical examination indicated tenderness along the psoas muscle. Diagnosis of psoas tendinitis made. Patient underwent a series of ultrasound-guided corticosteroid injections for pain relief. Home exercise program prescribed to improve hip flexibility and strength.

6. Psoas tendinitis confirmed based on clinical symptoms and imaging findings. Patient administered a local anesthetic and corticosteroid injection guided by ultrasound. Prescribed NSAIDs and advised to gradually resume normal activities. Physical therapy recommended for stretching and strengthening exercises. Follow-up scheduled in six weeks.

7. Patient reported sharp pain in the hip region during activities requiring hip flexion. Physical examination revealed tenderness over the psoas tendon. Diagnosis of psoas tendinitis established. Patient prescribed NSAIDs for pain management. Provided instructions for a modified exercise program focusing on gentle stretching and strengthening of the hip muscles.

8. Imaging studies demonstrated inflammation and thickening of the psoas tendon, consistent with psoas tendinitis. Patient received a corticosteroid injection under ultrasound guidance for pain relief. Advised to avoid exacerbating activities and given a home exercise program to improve flexibility and strengthen the hip muscles.

9. Patient presented with recurrent hip pain worsened by prolonged sitting. Clinical examination revealed tenderness and restricted range of motion in the hip joint. Diagnosis of psoas tendinitis made. Prescribed NSAIDs for pain relief and referred to a physical therapist for specialized rehabilitation exercises.

10. MRI findings consistent with psoas tendinitis, showing inflammation around the psoas tendon. Patient received a corticosteroid injection for pain relief. Instructed to modify activities and avoid excessive hip flexion. Home exercise program provided to improve flexibility and strengthen the hip muscles. Follow-up scheduled in four weeks to assess response to treatment.

1. Patient presented with dull aching pain in the hip region. Physical examination revealed localized tenderness and pain upon hip flexion. Diagnosis of psoas tendinitis confirmed. Prescribed NSAIDs and advised on the use of heat therapy for pain management. Recommended gentle stretching exercises and gradual return to normal activities.

2. Psoas tendinitis diagnosed based on clinical symptoms and imaging findings. Patient received ultrasound-guided corticosteroid injection for pain relief and reduction of inflammation. Provided instructions for activity modification and ergonomic adjustments. Physical therapy referral made for comprehensive rehabilitation.

3. Patient complained of deep groin pain exacerbated by hip movements. Examination revealed tenderness over the psoas muscle. Diagnosis of psoas tendinitis made. Administered local anesthetic and corticosteroid injection for immediate pain relief. Advised on the importance of maintaining a balanced exercise routine.

4. MRI scan confirmed psoas tendinitis with evidence of tendon inflammation and thickening. Patient prescribed a combination of NSAIDs and physical therapy. Emphasized the need for proper warm-up and stretching exercises prior to physical activity. Scheduled follow-up appointment in six weeks.

5. Patient presented with hip pain and discomfort during prolonged sitting. Clinical examination indicated tenderness and limited range of motion. Diagnosis of psoas tendinitis confirmed. Prescribed NSAIDs for pain relief and advised on the use of ice packs. Recommended specific stretching exercises targeting the psoas muscle.

6. Imaging studies revealed inflammation and degeneration of the psoas tendon, consistent with psoas tendinitis. Patient received a corticosteroid injection for pain management. Encouraged to avoid activities that aggravate symptoms and instructed on proper body mechanics. Follow-up arranged in four weeks.

7. Chronic hip pain exacerbated by repetitive hip flexion reported by the patient. Physical examination revealed psoas muscle tenderness. Diagnosis of psoas tendinitis established. Prescribed NSAIDs for pain control and referred to a physical therapist for a tailored rehabilitation program.

8. MRI findings showed thickening and edema of the psoas tendon, confirming the diagnosis of psoas tendinitis. Patient received a corticosteroid injection under ultrasound guidance for targeted treatment. Provided instructions for gentle stretching exercises and advised on the importance of maintaining good posture.

9. Patient presented with hip and groin pain that worsened with activities requiring hip extension. Physical examination revealed localized tenderness over the psoas muscle. Diagnosis of psoas tendinitis confirmed. Prescribed NSAIDs and recommended a gradual return to physical activity with proper warm-up and cool-down exercises.

10. Imaging studies indicated inflammation and tendon thickening in the psoas muscle, consistent with psoas tendinitis. Patient received ultrasound-guided corticosteroid injection for pain relief. Advised on the use of a lumbar support pillow and ergonomic modifications to reduce strain on the hip. Provided a home exercise program focusing on core stabilization and hip strengthening.

1. Patient presented with hip pain exacerbated by movement. Clinical examination revealed tenderness over the psoas muscle. Diagnosis of psoas tendinitis confirmed. Administered a local anesthetic and a lower dosage of corticosteroid injection for pain relief. Recommended gentle stretching exercises and prescribed NSAIDs.

2. Psoas tendinitis diagnosed based on clinical symptoms and imaging findings. Patient received an ultrasound-guided corticosteroid injection with a higher dosage for pain management. Advised on activity modification and referred to a physical therapist for tailored rehabilitation exercises.

3. Patient complained of persistent hip pain and restricted range of motion. Physical examination indicated tenderness over the psoas tendon. Diagnosis of psoas tendinitis confirmed. Administered a lower dosage of corticosteroid injection for pain relief and prescribed NSAIDs. Emphasized the importance of gradual return to normal activities.

4. MRI findings consistent with psoas tendinitis, showing inflammation and thickening of the psoas tendon. Patient received an ultrasound-guided corticosteroid injection with a higher dosage for pain relief. Advised on activity modification and prescribed a more aggressive physical therapy regimen.

5. Patient presented with chronic hip pain radiating to the groin. Clinical examination indicated tenderness along the psoas muscle. Diagnosis of psoas tendinitis made. Administered a lower dosage of corticosteroid injection for pain relief and prescribed NSAIDs. Recommended gentle stretching exercises and gradual resumption of activities.

6. Psoas tendinitis confirmed based on clinical symptoms and imaging findings. Patient received an ultrasound-guided corticosteroid injection with a higher dosage for pain relief. Advised on activity modification and referred to a physical therapist for a more intensive rehabilitation program.

7. Patient reported sharp pain in the hip region during activities requiring hip flexion. Physical examination revealed tenderness over the psoas tendon. Diagnosis of psoas tendinitis established. Administered a lower dosage of corticosteroid injection for pain relief and prescribed NSAIDs. Provided instructions for modified exercise program with gentle stretching and strengthening exercises.

8. Imaging studies demonstrated inflammation and thickening of the psoas tendon, consistent with psoas tendinitis. Patient received an ultrasound-guided corticosteroid injection with a higher dosage for pain relief. Advised on activity modification and prescribed a more comprehensive physical therapy regimen.

9. Patient presented with recurrent hip pain worsened by prolonged sitting. Clinical examination revealed tenderness and restricted range of motion in the hip joint. Diagnosis of psoas tendinitis made. Administered a lower dosage of corticosteroid injection for pain relief and prescribed NSAIDs. Referred to a physical therapist for specialized rehabilitation exercises.

10. MRI findings consistent with psoas tendinitis, showing inflammation around the psoas tendon. Patient received an ultrasound-guided corticosteroid injection with a higher dosage for pain relief. Administered a local anesthetic to minimize discomfort. Advised on activity modification and prescribed a more intensive physical therapy program.

1. Patient presented with severe hip pain and limited range of motion. Physical examination revealed tenderness over the psoas tendon and signs of bone erosion on imaging studies. Diagnosis of psoas tendinitis with associated bone erosion confirmed. Administered a corticosteroid injection for pain relief and referred to an orthopedic specialist for further evaluation.

2. Psoas tendinitis with evidence of bone erosion observed on imaging studies. Patient received an ultrasound-guided corticosteroid injection for pain management. Orthopedic consultation scheduled to assess the extent of bone erosion and determine appropriate treatment options.

3. Patient complained of persistent hip pain and imaging studies revealed bone erosion around the psoas tendon, consistent with psoas tendinitis. Administered a corticosteroid injection for pain relief. Referred to a rheumatologist for further evaluation and management of underlying inflammatory conditions.

4. MRI findings demonstrated bone erosion adjacent to the psoas tendon, indicating advanced psoas tendinitis. Patient received an ultrasound-guided corticosteroid injection for pain management. Recommended close monitoring of symptoms and referred to an orthopedic surgeon for consideration of surgical intervention if necessary.

5. Patient presented with chronic hip pain and imaging studies revealed significant bone erosion in the area of the psoas tendon. Diagnosis of advanced psoas tendinitis with bone erosion confirmed. Administered a corticosteroid injection for pain relief and referred to a musculoskeletal radiologist for further evaluation and possible intervention.

6. Psoas tendinitis with associated bone erosion detected on imaging studies. Patient received an ultrasound-guided corticosteroid injection for pain management. Referred to an orthopedic specialist for consideration of advanced imaging modalities and potential surgical intervention.

7. Patient reported severe hip pain and imaging studies showed extensive bone erosion around the psoas tendon, indicating advanced psoas tendinitis. Administered a corticosteroid injection for pain relief and referred to an orthopedic surgeon for evaluation of possible surgical options.

8. MRI findings demonstrated significant bone erosion adjacent to the psoas tendon, confirming advanced psoas tendinitis. Administered a corticosteroid injection for pain relief and referred to a rheumatologist for further assessment and management of underlying inflammatory conditions.

9. Patient presented with chronic hip pain and imaging studies revealed progressive bone erosion in the region of the psoas tendon. Administered a corticosteroid injection for pain relief and referred to an orthopedic specialist for a comprehensive evaluation and consideration of surgical options.

10. Psoas tendinitis with evidence of bone erosion observed on imaging studies. Patient received an ultrasound-guided corticosteroid injection for pain management. Referred to a musculoskeletal radiologist for further assessment and possible intervention to address the bone erosion.

1. Patient presented with excruciating bone pain in the hip region, associated with advanced psoas tendinitis and extensive bone erosion. Administered a high-dose corticosteroid injection for immediate pain relief. Urgent orthopedic consultation arranged to evaluate the severity of bone involvement and explore surgical intervention options.

2. Severe bone pain reported by the patient, indicative of advanced psoas tendinitis with extensive bone erosion. Administered a combination of intravenous and local anesthetic with a corticosteroid injection for intense pain management. Referred to a multidisciplinary team for further evaluation and consideration of palliative measures.

3. Patient presented with debilitating bone pain in the hip region due to advanced psoas tendinitis and significant bone erosion. Administered a higher dosage of corticosteroid injection for immediate pain relief. Collaboration with a pain management specialist initiated to develop a comprehensive pain management plan.

4. Severe bone pain in the hip reported by the patient, suggestive of advanced psoas tendinitis with extensive bone erosion. Administered a potent corticosteroid injection combined with a nerve block for maximum pain relief. Referred to an orthopedic oncologist for further evaluation and possible intervention.

5. Patient experienced severe and persistent bone pain in the hip region, secondary to advanced psoas tendinitis and substantial bone erosion. Administered a high-dose corticosteroid injection along with strong oral analgesics for intense pain control. Coordinated care with a palliative care specialist for ongoing pain management support.

6. Severe bone pain in the hip attributed to advanced psoas tendinitis and significant bone erosion. Administered a potent corticosteroid injection combined with a long-acting local anesthetic for immediate pain relief. Collaboration with a pain management team initiated to optimize pain control and enhance the patient's quality of life.

7. Patient presented with excruciating bone pain localized to the hip, indicating advanced psoas tendinitis with extensive bone erosion. Administered a higher dosage of corticosteroid injection under ultrasound guidance for optimal pain relief. Immediate referral made to a pain specialist for further assessment and implementation of advanced pain management techniques.

8. Severe bone pain reported by the patient, suggestive of advanced psoas tendinitis with extensive bone erosion. Administered a potent corticosteroid injection combined with intravenous analgesics for immediate and systemic pain relief. Coordinated care with a palliative care team for ongoing pain management and support.

9. Patient experienced severe, incapacitating bone pain in the hip region, associated with advanced psoas tendinitis and significant bone erosion. Administered a high-dose corticosteroid injection combined with nerve block for maximal pain relief. Urgent consultation with a pain management specialist arranged for comprehensive pain control strategies.

10. Severe bone pain in the hip region due to advanced psoas tendinitis and extensive bone erosion. Administered a potent corticosteroid injection supplemented with intravenous analgesics for rapid and intensive pain relief. Coordinated care with an orthopedic specialist and pain management team to explore all possible treatment options for pain control.

1. Patient with severe bone pain and advanced psoas tendinitis underwent surgical intervention. Surgical procedure involved debridement of the affected psoas tendon, repair of any associated bone erosion, and release of tight structures. Postoperative pain management and rehabilitation program initiated to optimize recovery and alleviate symptoms.

2. Due to intractable bone pain associated with advanced psoas tendinitis, the patient underwent surgical intervention. The procedure involved a psoas tendon release and debridement, addressing the bone erosion. Close postoperative monitoring and a comprehensive rehabilitation plan were implemented for pain relief and functional improvement.

3. Surgical intervention was performed for the patient with severe bone pain caused by advanced psoas tendinitis and extensive bone erosion. The procedure included psoas tendon repair, bone grafting, and stabilization. Postoperative pain management and physical therapy were initiated to facilitate recovery and improve quality of life.

4. Invasive surgical intervention was required for the patient experiencing incapacitating bone pain due to advanced psoas tendinitis and significant bone erosion. The surgical procedure involved psoas tendon debridement, bone grafting, and joint stabilization. Comprehensive postoperative care and rehabilitation were initiated to manage pain and promote functional restoration.

5. Patient underwent surgical intervention as a treatment modality for severe bone pain associated with advanced psoas tendinitis and extensive bone erosion. The surgical procedure involved psoas tendon release, bone resection, and joint reconstruction. Postoperative pain management and physical therapy were implemented to optimize recovery outcomes.

6. Surgical intervention was performed for the patient with excruciating bone pain attributed to advanced psoas tendinitis and substantial bone erosion. The procedure involved psoas tendon repair, bone resection, and joint fusion. Multimodal pain management and structured rehabilitation were initiated to enhance postoperative recovery.

7. Due to severe bone pain resulting from advanced psoas tendinitis and significant bone erosion, the patient underwent surgical intervention. The surgical procedure included psoas tendon debridement, bone augmentation, and joint resurfacing. Postoperative pain control and physiotherapy were instituted to facilitate functional rehabilitation.

8. Invasive surgical intervention was undertaken for the patient suffering from debilitating bone pain due to advanced psoas tendinitis and extensive bone erosion. The surgical procedure involved psoas tendon release, bone reconstruction, and joint stabilization. A comprehensive postoperative plan was implemented to manage pain and restore function.

9. Surgical intervention was pursued for the patient experiencing severe bone pain caused by advanced psoas tendinitis and significant bone erosion. The procedure encompassed psoas tendon repair, bone grafting, and joint arthroplasty. Postoperative pain management and rehabilitative measures were implemented to optimize recovery and alleviate symptoms.

10. The patient underwent surgical intervention to address the severe bone pain associated with advanced psoas tendinitis and extensive bone erosion. The surgical procedure involved psoas tendon debridement, bone resection, and joint reconstruction. A multidisciplinary approach incorporating postoperative pain management and rehabilitation was initiated for optimal outcomes.

1. Surgical intervention was performed to alleviate severe bone pain in the hip region caused by advanced psoas tendinitis and extensive bone erosion. The procedure involved psoas tendon excision, bone debridement, and joint arthroplasty. Postoperative pain control and physical therapy were implemented to promote healing and improve functional outcomes.

2. Invasive surgical intervention was undertaken for the patient with debilitating bone pain due to advanced psoas tendinitis and significant bone erosion. The procedure included psoas tendon reconstruction, bone grafting, and joint stabilization. Postoperative pain management and rehabilitation were initiated to optimize recovery and restore mobility.

3. Patient underwent surgical intervention to address intractable bone pain associated with advanced psoas tendinitis and extensive bone erosion. The surgical procedure involved psoas tendon release, bone resurfacing, and joint fusion. Postoperative pain control measures and physical therapy were initiated to facilitate healing and enhance functional capacity.

4. Surgical intervention was performed for the patient with severe bone pain resulting from advanced psoas tendinitis and substantial bone erosion. The procedure included psoas tendon repair, bone augmentation, and joint reconstruction. Comprehensive postoperative pain management and rehabilitation protocols were implemented to maximize recovery outcomes.

5. Due to severe bone pain associated with advanced psoas tendinitis and significant bone erosion, the patient underwent surgical intervention. The surgical procedure involved psoas tendon debridement, bone remodeling, and joint realignment. Postoperative pain control strategies and a structured rehabilitation program were initiated for optimal recovery.

6. Surgical intervention was pursued for the patient experiencing incapacitating bone pain caused by advanced psoas tendinitis and extensive bone erosion. The procedure encompassed psoas tendon reconstruction, bone resection, and joint replacement. Comprehensive postoperative care, including pain management and physical therapy, was implemented to facilitate recovery.

7. Invasive surgical intervention was performed to address severe bone pain attributed to advanced psoas tendinitis and substantial bone erosion. The surgical procedure involved psoas tendon release, bone grafting, and joint arthrodesis. Postoperative pain control and rehabilitative measures were instituted to promote functional restoration and alleviate symptoms.

8. Surgical intervention was undertaken for the patient with excruciating bone pain resulting from advanced psoas tendinitis and significant bone erosion. The procedure included psoas tendon debridement, bone reconstruction, and joint resurfacing. Multimodal postoperative pain management and physical therapy were initiated to optimize recovery outcomes.

9. Patient underwent surgical intervention to alleviate severe bone pain associated with advanced psoas tendinitis and extensive bone erosion. The surgical procedure involved psoas tendon repair, bone resection, and joint fusion. A comprehensive postoperative plan was implemented, including pain management strategies and structured rehabilitation, to facilitate recovery.

10. Surgical intervention was pursued for the patient suffering from severe bone pain caused by advanced psoas tendinitis and significant bone erosion. The procedure involved psoas tendon excision, bone reconstruction, and joint arthroplasty. A multidisciplinary approach incorporating postoperative pain management and rehabilitative measures was initiated for optimal outcomes.

1. The patient presented with severe bone pain and a highly infectious process involving the extreme moving joint due to advanced psoas tendinitis. Urgent surgical intervention was performed, including joint debridement, thorough irrigation, and removal of necrotic tissue. Broad-spectrum antibiotics were administered, and the patient was closely monitored for signs of systemic infection.

2. Infection involving the extreme moving joint was observed in a patient with advanced psoas tendinitis. Surgical intervention was immediately performed, including joint exploration, debridement, and thorough irrigation. Intravenous antibiotics were initiated, and infectious disease consultation was sought for further management.

3. Severe infection on the extreme moving joint was identified in the context of advanced psoas tendinitis. The patient underwent urgent surgical intervention, including extensive joint debridement, irrigation, and drainage. Intravenous antibiotics were administered, and close monitoring of the infection markers was initiated.

4. Invasive surgical intervention was performed to address a severe infection involving the extreme moving joint associated with advanced psoas tendinitis. The procedure involved thorough joint debridement, irrigation, and removal of infected tissues. Broad-spectrum antibiotics were initiated, and infectious disease consultation was obtained for further treatment guidance.

5. The patient presented with a highly infected extreme moving joint secondary to advanced psoas tendinitis. Urgent surgical intervention was performed, including joint exploration, debridement, and copious irrigation. Intravenous antibiotics were administered, and infectious disease specialists were involved in the management of the infection.

6. Severe infection involving the extreme moving joint was observed in a patient with advanced psoas tendinitis. Surgical intervention was performed, including extensive joint debridement, irrigation, and removal of infected tissues. Intravenous antibiotics were initiated, and the patient was closely monitored for signs of systemic sepsis.

7. The patient exhibited severe infection on the extreme moving joint associated with advanced psoas tendinitis. Urgent surgical intervention was performed, involving joint debridement, irrigation, and the placement of antibiotic beads. Intravenous antibiotics were administered, and infectious disease consultation was sought for further guidance.

8. Invasive surgical intervention was performed for a severe infection on the extreme moving joint in the context of advanced psoas tendinitis. The procedure included joint exploration, thorough debridement, and irrigation. Intravenous antibiotics were initiated, and the patient's inflammatory markers were closely monitored.

9. The patient presented with a highly infectious process involving the extreme moving joint due to advanced psoas tendinitis. Urgent surgical intervention was performed, including joint debridement, extensive irrigation, and removal of necrotic tissues. Intravenous antibiotics were administered, and infectious disease specialists were involved in the management of the infection.

10. Severe infection on the extreme moving joint was identified in a patient with advanced psoas tendinitis. Surgical intervention was immediately performed, involving thorough joint debridement, irrigation, and removal of infected tissues. Intravenous antibiotics were initiated, and close surveillance for signs of persistent infection was initiated.

1. The patient presented with severe inflammation involving the extreme moving joint due to advanced psoas tendinitis. Urgent surgical intervention was performed, including joint debridement, thorough irrigation, and removal of inflamed tissues. Anti-inflammatory medications were initiated postoperatively to manage the inflammatory response.

2. Inflammation involving the extreme moving joint was observed in a patient with advanced psoas tendinitis. Surgical intervention was immediately performed, including joint exploration, debridement, and irrigation. Non-steroidal anti-inflammatory drugs (NSAIDs) were prescribed to alleviate inflammation and manage pain.

3. Severe inflammation on the extreme moving joint was identified in the context of advanced psoas tendinitis. The patient underwent urgent surgical intervention, including extensive joint debridement, irrigation, and removal of inflamed tissues. Corticosteroid injections were administered intraoperatively to address inflammation.

4. Invasive surgical intervention was performed to address a severe inflammatory response involving the extreme moving joint associated with advanced psoas tendinitis. The procedure involved thorough joint debridement, irrigation, and removal of inflamed tissues. Postoperatively, a combination of NSAIDs and corticosteroids was prescribed to manage inflammation.

5. The patient presented with a highly inflamed extreme moving joint secondary to advanced psoas tendinitis. Urgent surgical intervention was performed, including joint exploration, debridement, and copious irrigation. Anti-inflammatory medications, including corticosteroids, were administered postoperatively to control inflammation.

6. Severe inflammation involving the extreme moving joint was observed in a patient with advanced psoas tendinitis. Surgical intervention was performed, including extensive joint debridement, irrigation, and removal of inflamed tissues. Non-steroidal anti-inflammatory drugs (NSAIDs) were prescribed postoperatively to alleviate inflammation and reduce pain.

7. The patient exhibited severe inflammation on the extreme moving joint associated with advanced psoas tendinitis. Urgent surgical intervention was performed, involving joint debridement, irrigation, and the placement of anti-inflammatory medication locally. Systemic corticosteroids were also administered postoperatively to address the inflammatory response.

8. Invasive surgical intervention was performed for a severe inflammatory response on the extreme moving joint in the context of advanced psoas tendinitis. The procedure included joint exploration, thorough debridement, and irrigation. Postoperatively, a combination of NSAIDs and corticosteroids was prescribed to manage inflammation and promote healing.

9. The patient presented with a highly inflamed extreme moving joint due to advanced psoas tendinitis. Urgent surgical intervention was performed, including joint debridement, extensive irrigation, and removal of inflamed tissues. Localized anti-inflammatory medications, such as corticosteroid injections, were administered to address inflammation.

10. Severe inflammation on the extreme moving joint was identified in a patient with advanced psoas tendinitis. Surgical intervention was immediately performed, involving thorough joint debridement, irrigation, and removal of inflamed tissues. Postoperatively, a tailored anti-inflammatory regimen was implemented to manage the inflammatory response and promote recovery.

1. The patient's follow-up plan will be determined based on the severity of the diagnosis of psoas tendinitis. If the condition is mild, conservative management with physical therapy and anti-inflammatory medications will be recommended. For moderate cases, a combination of physical therapy, pain management techniques, and periodic follow-up evaluations will be advised. In severe cases, close monitoring by a specialist, aggressive physical therapy, and possible surgical intervention may be required, with follow-up visits scheduled accordingly.

2. Based on the severity of the diagnosis, the patient will be followed up accordingly. In cases of mild psoas tendinitis, a conservative approach involving rest, activity modification, and physical therapy will be recommended, with periodic follow-up evaluations to assess progress. For moderate cases, a combination of conservative management and targeted interventions, such as corticosteroid injections, may be implemented, with more frequent follow-up visits. Severe cases may require surgical consultation, leading to a more intensive follow-up plan to monitor postoperative recovery and address any complications.

3. The patient's follow-up plan will be tailored to the severity of the diagnosis. Mild cases of psoas tendinitis may only require self-care measures and occasional check-ins to monitor progress. Moderate cases may involve a combination of physical therapy, pain management, and regular follow-up appointments to assess response to treatment. In severe cases, close collaboration with a specialist will be necessary, with frequent follow-up visits to evaluate the effectiveness of the treatment plan, potentially including surgical intervention or alternative therapies.

4. Depending on the severity of the diagnosis, the patient will have a follow-up plan. For mild psoas tendinitis, a conservative approach with rest, activity modification, and anti-inflammatory medications may be recommended, with periodic follow-up visits to monitor improvement. Moderate cases may require a more comprehensive treatment plan, including physical therapy, targeted interventions, and regular follow-up evaluations. In severe cases, an aggressive treatment approach, such as surgical intervention, may be necessary, with frequent follow-up visits to ensure proper healing and address any complications.

5. The follow-up strategy will be determined by the severity of the diagnosis of psoas tendinitis. For mild cases, the patient may be advised to continue self-care measures at home and schedule periodic follow-up appointments to assess progress. Moderate cases may require a combination of conservative management, physical therapy, and intermittent follow-up visits to monitor response to treatment. Severe cases may necessitate regular follow-up visits, potentially involving additional interventions or surgical consultation, to ensure optimal management and recovery.

6. Based on the severity of the diagnosis, the patient's follow-up plan will be customized. Mild cases of psoas tendinitis may only require self-care measures and occasional follow-up appointments to track improvement. Moderate cases may involve a more structured treatment plan, including physical therapy, pain management techniques, and regular follow-up evaluations to monitor progress. Severe cases may require frequent follow-up visits to assess response to treatment, potentially involving specialists or additional interventions as deemed necessary.

7. The patient's follow-up plan will be determined by the severity of the diagnosis. Mild cases of psoas tendinitis may be managed with conservative measures, such as rest and over-the-counter pain medications, with periodic follow-up visits to assess symptom resolution. For moderate cases, a combination of conservative treatments and targeted interventions, such as physical therapy or corticosteroid injections, may be recommended, with more frequent follow-up evaluations. Severe cases may require specialized care, potentially including surgical intervention, and a close follow-up schedule to ensure proper healing and functional recovery.

8. Depending on the severity of the diagnosis, the patient's follow-up plan will vary. Mild cases of psoas tendinitis may necessitate only intermittent follow-up appointments to monitor

symptoms and progress with self-care measures. Moderate cases may require regular follow-up visits to assess response to conservative treatments, physical therapy, and pain management interventions. Severe cases may involve a more intensive follow-up plan, potentially including surgical interventions, frequent evaluations, and close collaboration with specialists to optimize outcomes.

9. The follow-up approach will be determined based on the severity of the diagnosis of psoas tendinitis. Mild cases may require periodic follow-up visits to monitor symptom improvement and ensure appropriate self-care measures are being followed. Moderate cases may necessitate regular follow-up appointments for continued physical therapy, pain management, and evaluation of treatment effectiveness. Severe cases may require a more frequent follow-up schedule, potentially involving specialized interventions or surgical consultations, to address the complex nature of the condition.

10. Depending on the severity of the diagnosis, the patient's follow-up plan will be individualized. For mild cases of psoas tendinitis, periodic follow-up evaluations may be recommended to assess response to conservative measures and provide guidance as needed. Moderate cases may involve regular follow-up visits to track progress, adjust treatment plans, and implement targeted interventions. Severe cases may require a multidisciplinary approach, involving frequent follow-up appointments with specialists, to ensure comprehensive management and optimize outcomes.

## M76.2 Iliac crest spur

1. Operative Note: I performed a right iliac crest spur excision under general anesthesia. The incision was made over the iliac crest, and dissection was carried down to the periosteum. The bony spur was identified and carefully excised using an osteotome. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well without any complications.

2. Operative Note: Intraoperatively, a left iliac crest spur excision was performed. After appropriate anesthesia, an incision was made along the iliac crest. Blunt dissection was carried out, and the bony spur was visualized. Careful excision of the spur was performed using a rongeur. Hemostasis was ensured, and the wound was closed in layers. The patient had an uneventful recovery postoperatively.

3. Operative Note: Under general anesthesia, I performed a bilateral iliac crest spur excision. Incisions were made over the iliac crests bilaterally, and dissection was carried down to the bony prominences. Using a high-speed burr, the spurs were meticulously removed. Hemostasis was achieved, and the wounds were closed. The patient tolerated the procedure well and was discharged with appropriate postoperative instructions.

4. Operative Note: A right iliac crest spur excision was performed under local anesthesia. A small incision was made directly over the spur, and meticulous dissection was carried out. The spur was carefully removed using a burr, ensuring preservation of surrounding structures. Hemostasis was achieved, and the wound was closed with sutures. The patient reported immediate relief of symptoms postoperatively.

5. Operative Note: Intraoperatively, a left iliac crest spur excision was performed under spinal anesthesia. An incision was made over the prominence, and dissection was carried down to the bony spur. The spur was excised using an osteotome, taking care to avoid damage to surrounding tissues. Hemostasis was secured, and the wound was closed. The patient's pain improved significantly after the procedure.

6. Operative Note: I performed a right iliac crest spur excision using a minimally invasive approach. Under fluoroscopic guidance, a small incision was made near the spur. A specialized burr was used to carefully remove the spur while preserving the integrity of adjacent structures. Hemostasis was achieved, and the incision was closed. The patient experienced immediate relief and was discharged the same day.

7. Operative Note: Bilateral iliac crest spur excision was performed using an arthroscopic technique. Small incisions were made bilaterally, and arthroscopic instruments were introduced. The spurs were visualized and excised under direct visualization. Hemostasis was ensured, and the incisions were closed. The patient had a smooth postoperative course and reported resolution of symptoms.

8. Operative Note: A right iliac crest spur excision was performed using a robotic-assisted approach. The patient was positioned and docked according to the robotic system's requirements. Under robotic guidance, a small incision was made, and the spur was meticulously removed using robotic instruments. Hemostasis was achieved, and the incision was closed. The patient experienced significant improvement in pain and function.

9. Operative Note: Intraoperatively, a left iliac crest spur excision was performed using an endoscopic technique. After establishing the necessary portals, an endoscope was introduced, providing visualization of the spur. The spur was carefully resected using specialized endoscopic instruments. Hemostasis was obtained, and the portals were closed. The patient had a successful outcome, with resolution of symptoms.

10. Operative Note: I performed a right iliac crest spur excision with concomitant bone grafting. An incision was made over the iliac crest, and the spur was identified and excised using a burr. Following spur removal, a bone graft was harvested from the contralateral iliac crest and placed at the excision site. Hemostasis was achieved, and the wound was closed. The patient's recovery was uneventful, and follow-up imaging showed graft incorporation.

1. Operative Note: I performed a bilateral iliac crest spur excision with fascial release. Under general anesthesia, incisions were made bilaterally over the iliac crests. The spurs were identified and meticulously excised using a combination of osteotomes and rongeurs. Concurrently, tight fascial bands were released to alleviate tension. Hemostasis was achieved, and the wounds were closed. The patient demonstrated improved range of motion and was discharged with appropriate postoperative care instructions.

2. Operative Note: Intraoperatively, a right iliac crest spur excision with arthrodesis was performed. After sterile preparation and draping, a midline incision was made over the iliac crest. The spur was visualized and carefully removed using a burr. To enhance stability, an iliac crest bone graft was harvested and placed in the excision site, followed by internal fixation with screws. The patient tolerated the procedure well, and postoperative imaging showed proper alignment.

3. Operative Note: A left iliac crest spur excision with endoscopic bursectomy was performed under spinal anesthesia. Following appropriate positioning, a small incision was made over the iliac crest, and an endoscope was introduced. The spur was located and resected using endoscopic burrs. Additionally, the inflamed bursa was excised to relieve compression. Hemostasis was ensured, and the incision was closed. The patient experienced resolution of pain and returned to normal activities.

4. Operative Note: I performed a right iliac crest spur excision with platelet-rich plasma (PRP) injection. After sterile preparation, an incision was made over the iliac crest, exposing the spur. The spur was meticulously removed using osteotomes. Subsequently, PRP was prepared and injected into the surrounding tissues to enhance healing. Hemostasis was achieved, and the wound was closed. The patient reported reduced pain and improved function during follow-up visits.

5. Operative Note: Intraoperatively, a left iliac crest spur excision with percutaneous radiofrequency ablation (RFA) was performed. Under fluoroscopic guidance, a small incision was made, and a radiofrequency probe was inserted near the spur. RFA was applied to thermally ablate the spur and surrounding tissues. Hemostasis was obtained, and the incision was closed. The patient experienced significant pain relief and returned to daily activities without limitations.

6. Operative Note: Bilateral iliac crest spur excision with autologous stem cell therapy was performed. After appropriate anesthesia, incisions were made bilaterally over the iliac crests. The spurs were meticulously removed using burrs. Autologous stem cells were harvested from the patient's bone marrow and injected into the excision sites to promote healing. Hemostasis was achieved, and the wounds were closed. The patient demonstrated improved pain and functional outcomes.

7. Operative Note: A right iliac crest spur excision with ultrasound-guided steroid injection was performed. Following sterile preparation, a small incision was made over the iliac crest, and the spur was identified and excised using specialized instruments. Subsequently, under ultrasound guidance, a steroid solution was injected into the surrounding tissues for anti-inflammatory effect. Hemostasis was achieved, and the incision was closed. The patient reported decreased pain and improved mobility.

8. Operative Note: Intraoperatively, a left iliac crest spur excision with extracorporeal shockwave therapy (ESWT) was performed. After appropriate anesthesia, an incision was made over the iliac crest, and the spur was identified

and removed. ESWT was administered to the excision site to promote tissue regeneration and pain reduction. Hemostasis was ensured, and the incision was closed. The patient had a favorable postoperative course with diminished symptoms.

9. Operative Note: I performed a right iliac crest spur excision with simultaneous physical therapy consultation. After sterile preparation, an incision was made over the iliac crest, and the spur was meticulously excised. Following the procedure, the patient was evaluated by a physical therapist for tailored rehabilitation exercises to promote optimal recovery and prevent future complications. Hemostasis was achieved, and the wound was closed. The patient made significant progress during the rehabilitation program.

10. Operative Note: Bilateral iliac crest spur excision with neuromodulation was performed. Under general anesthesia, incisions were made bilaterally over the iliac crests, and the spurs were carefully removed. Additionally, a neuromodulation device was implanted near the excision sites to provide targeted pain relief through electrical stimulation. Hemostasis was obtained, and the wounds were closed. The patient experienced a reduction in pain intensity and improved quality of life.

1. Operative Note: I performed a right iliac crest spur excision under local anesthesia with sedation. The patient was prepped and draped, and a small incision was made over the iliac crest. The spur was identified and excised using specialized instruments. Local anesthesia was administered to the surgical site, and the patient remained comfortable throughout the procedure. Hemostasis was achieved, and the wound was closed in layers. The patient had a smooth recovery without any complications.

2. Operative Note: Intraoperatively, a left iliac crest spur excision was performed under spinal anesthesia. After sterile preparation, a midline incision was made over the iliac crest. The bony spur was identified and meticulously excised using osteotomes. The patient remained stable under spinal anesthesia throughout the procedure, and adequate pain control was achieved. Hemostasis was ensured, and the wound was closed. The patient experienced relief of symptoms postoperatively.

3. Operative Note: Bilateral iliac crest spur excision was performed under general anesthesia. After induction, incisions were made bilaterally over the iliac crests. The spurs were meticulously removed using burrs. The patient remained hemodynamically stable throughout the procedure, and appropriate pain management was provided. Hemostasis was achieved, and the wounds were closed. The patient had an uneventful recovery and reported improved functionality during follow-up visits.

4. Operative Note: A right iliac crest spur excision was performed under regional anesthesia. After proper positioning and sterile preparation, an incision was made over the iliac crest. The spur was identified and excised using specialized instruments. The patient received regional anesthesia, which provided effective pain control during the procedure. Hemostasis was achieved, and the wound was closed. The patient had a satisfactory postoperative course without any complications.

5. Operative Note: Intraoperatively, a left iliac crest spur excision was performed under monitored anesthesia care (MAC). Following sterile preparation, an incision was made over the iliac crest, and the spur was meticulously removed. The patient received MAC, which included a combination of intravenous sedation and analgesia. The patient remained comfortable and responsive throughout the procedure. Hemostasis was ensured, and the incision was closed. The patient had a smooth recovery and reported reduced pain.

6. Operative Note: I performed a right iliac crest spur excision under general anesthesia with a reduced dosage. After appropriate induction, a small incision was made over the iliac crest, and the spur was excised. The anesthesia dosage was adjusted to ensure optimal patient safety and comfort. Hemostasis was achieved, and the wound was closed. The patient had a satisfactory postoperative recovery without any adverse events.

7. Operative Note: A left iliac crest spur excision was performed under local anesthesia with increased dosage. Following sterile preparation, an incision was made over the iliac crest, and the spur was meticulously removed. Local anesthesia was administered at an increased dosage to provide adequate pain control during the procedure. Hemostasis was obtained, and the incision was closed. The patient reported minimal discomfort and had a favorable outcome.

8. Operative Note: Intraoperatively, a bilateral iliac crest spur excision was performed under general anesthesia with balanced analgesia. Incisions were made bilaterally, and the spurs were carefully excised. The anesthesia approach included a combination of intravenous analgesics, regional anesthesia, and inhalation agents to achieve balanced pain control and patient comfort. Hemostasis was ensured, and the wounds were closed. The patient experienced satisfactory pain relief and

had a smooth recovery.

9. Operative Note: A right iliac crest spur excision was performed under spinal anesthesia with intravenous sedation. After positioning and sterile preparation, an incision was made over the iliac crest, and the spur was excised. Spinal anesthesia was administered to provide intraoperative pain control, while intravenous sedation ensured patient relaxation. Hemostasis was achieved, and the incision was closed. The patient had a comfortable intraoperative period and reported improved symptoms postoperatively.

10. Operative Note: Bilateral iliac crest spur excision was performed under general anesthesia with patient-controlled analgesia (PCA). Following induction, incisions were made bilaterally, and the spurs were meticulously excised. The patient received general anesthesia for overall comfort, while PCA allowed the patient to self-administer analgesic medication for personalized pain control. Hemostasis was obtained, and the wounds were closed. The patient had satisfactory pain management and a successful recovery.

1. Operative Note: I performed a right iliac crest spur excision with bone grafting due to significant bone erosion. Under general anesthesia, an incision was made over the iliac crest. The eroded spur was meticulously excised, and the resulting bone defect was filled with a bone graft harvested from the patient's iliac crest. Hemostasis was achieved, and the wound was closed. The patient showed favorable recovery with improved bone integrity on postoperative imaging.

2. Operative Note: Intraoperatively, a left iliac crest spur excision with bone cement augmentation was performed to address extensive bone erosion. After appropriate anesthesia, an incision was made over the iliac crest. The eroded spur was excised, and bone cement was used to fill the void and provide structural support. Hemostasis was ensured, and the wound was closed. The patient demonstrated improved stability and pain relief postoperatively.

3. Operative Note: Bilateral iliac crest spur excision with allograft transplantation was performed to address severe bone erosion. Incisions were made bilaterally over the iliac crests, and the eroded spurs were carefully removed. Allograft bone was obtained and placed in the defect sites to restore bone structure. Hemostasis was achieved, and the wounds were closed. The patient showed satisfactory healing and improved bone density on follow-up evaluations.

4. Operative Note: A right iliac crest spur excision with synthetic bone substitute implantation was performed due to extensive bone erosion. Following appropriate anesthesia, an incision was made over the iliac crest. The eroded spur was excised, and a synthetic bone substitute was inserted into the defect to promote bone regeneration. Hemostasis was obtained, and the incision was closed. The patient had a favorable recovery with progressive bone healing observed on subsequent imaging.

5. Operative Note: Intraoperatively, a left iliac crest spur excision with autograft transplantation was performed to address bone erosion. After sterile preparation, an incision was made over the iliac crest, and the eroded spur was meticulously excised. Autograft bone from the patient's iliac crest was harvested and transplanted into the defect. Hemostasis was ensured, and the wound was closed. The patient showed promising bone integration and improved functional outcomes.

6. Operative Note: I performed a right iliac crest spur excision with bone fixation using screws to stabilize eroded bone fragments. Under general anesthesia, an incision was made over the iliac crest. The eroded spur was meticulously excised, and the remaining bone fragments were aligned and fixed using screws. Hemostasis was achieved, and the wound was closed. The patient demonstrated enhanced stability and gradual bone regeneration during the postoperative period.

7. Operative Note: A left iliac crest spur excision with bone grafting and titanium mesh reconstruction was performed to address extensive bone erosion. After appropriate anesthesia, an incision was made over the iliac crest. The eroded spur was excised, and a bone graft was inserted into the defect. A titanium mesh was placed to provide structural support. Hemostasis was obtained, and the incision was closed. The patient had a successful recovery with improved bone architecture.

8. Operative Note: Intraoperatively, a bilateral iliac crest spur excision with bone morphogenetic protein (BMP) application was performed to address significant bone erosion. Incisions were made bilaterally, and the eroded spurs were meticulously removed. BMP was applied to stimulate bone regeneration and fill the defect sites. Hemostasis was ensured, and the wounds were closed

. The patient demonstrated progressive bone healing and improved functional outcomes during follow-up visits.

9. Operative Note: A right iliac crest spur excision with bone autograft and resorbable scaffold implantation was performed to address bone erosion. Following sterile preparation, an incision was made over the iliac crest, and the eroded spur was excised. Autograft bone was harvested and placed in the defect, along with a resorbable scaffold for support and guided tissue regeneration. Hemostasis was achieved, and the wound was closed. The patient showed satisfactory bone integration and gradual scaffold resorption.

10. Operative Note: Bilateral iliac crest spur excision with bone substitute granules and platelet-rich plasma (PRP) application was performed to address extensive bone erosion. Incisions were made bilaterally, and the eroded spurs were meticulously removed. Bone substitute granules were placed in the defect sites, followed by PRP application to enhance bone regeneration. Hemostasis was obtained, and the wounds were closed. The patient demonstrated favorable bone healing and improved functional outcomes.

1. Operative Note: I performed a right iliac crest spur excision to alleviate severe bone pain. Under general anesthesia, an incision was made over the iliac crest, and the painful spur was meticulously excised. The procedure provided immediate relief from bone pain. Hemostasis was achieved, and the wound was closed. The patient reported significant improvement in pain levels and resumed daily activities without discomfort.

2. Operative Note: Intraoperatively, a left iliac crest spur excision with neurolysis was performed to address severe bone pain and associated nerve compression. Following sterile preparation, an incision was made over the iliac crest. The spur was carefully excised, and neurolysis was performed to relieve pressure on the adjacent nerves. Hemostasis was ensured, and the wound was closed. The patient experienced substantial pain relief and showed improved nerve function postoperatively.

3. Operative Note: Bilateral iliac crest spur excision with continuous local anesthetic infusion was performed to manage severe bone pain. Incisions were made bilaterally over the iliac crests, and the painful spurs were meticulously removed. Continuous local anesthetic infusion was initiated at the surgical sites to provide prolonged pain relief. Hemostasis was achieved, and the wounds were closed. The patient reported significantly reduced bone pain and improved quality of life.

4. Operative Note: A right iliac crest spur excision with epidural analgesia was performed to address severe bone pain. Following appropriate anesthesia, an incision was made over the iliac crest, and the painful spur was excised. Epidural analgesia was administered to provide effective pain control during and after the procedure. Hemostasis was obtained, and the incision was closed. The patient experienced significant pain relief and had a smooth recovery.

5. Operative Note: Intraoperatively, a left iliac crest spur excision with peripheral nerve block was performed to alleviate severe bone pain. After sterile preparation, an incision was made over the iliac crest, and the painful spur was meticulously removed. Peripheral nerve block was administered to provide targeted pain relief. Hemostasis was ensured, and the incision was closed. The patient reported substantial reduction in bone pain and improved mobility.

6. Operative Note: I performed a right iliac crest spur excision with preemptive analgesia to address severe bone pain. Under general anesthesia, an incision was made over the iliac crest, and the painful spur was excised. Preemptive analgesia techniques, such as local anesthetic infiltration and systemic analgesics, were employed to minimize postoperative pain. Hemostasis was achieved, and the wound was closed. The patient experienced significantly less bone pain in the early postoperative period.

7. Operative Note: A left iliac crest spur excision with intravenous patient-controlled analgesia (PCA) was performed to manage severe bone pain. Following sterile preparation, an incision was made over the iliac crest, and the painful spur was meticulously removed. Intravenous PCA was initiated to allow the patient to self-administer analgesic medication for personalized pain control. Hemostasis was obtained, and the incision was closed. The patient reported improved pain management and satisfaction with the PCA system.

8. Operative Note: Intraoperatively, a bilateral iliac crest spur excision with multimodal analgesia was performed to alleviate severe bone pain. Incisions were made bilaterally over the iliac crests, and the painful spurs were meticulously excised. Multimodal analgesia, combining different classes of pain medications, was utilized to provide comprehensive pain relief. Hem

ostasis was ensured, and the wounds were closed. The patient experienced significant reduction in bone pain and had an uneventful recovery.

9. Operative Note: A right iliac crest spur excision with nerve ablation was performed to address severe bone pain and nerve-related symptoms. After appropriate anesthesia, an incision was made over the iliac crest, and the painful spur was excised. Nerve ablation techniques were employed to interrupt pain signals and provide long-lasting relief. Hemostasis was achieved, and the wound was closed. The patient reported remarkable improvement in bone pain and enhanced functionality.

10. Operative Note: Bilateral iliac crest spur excision with continuous epidural analgesia infusion was performed to manage severe bone pain. Incisions were made bilaterally, and the painful spurs were meticulously removed. Continuous epidural analgesia infusion was initiated to provide sustained pain relief. Hemostasis was obtained, and the wounds were closed. The patient experienced substantial alleviation of bone pain and demonstrated improved physical function during the recovery period.

1. Operative Note: I performed a right iliac crest spur excision with arthroscopic-assisted technique. Under general anesthesia, arthroscopic portals were established, and the spur was visualized using a camera-guided system. Specialized instruments were used to meticulously excise the spur while preserving surrounding structures. Hemostasis was achieved, and the wound was closed. The patient had a successful procedure with improved symptoms and range of motion postoperatively.

2. Operative Note: Intraoperatively, a left iliac crest spur excision with endoscopic approach was performed. Following sterile preparation, a small incision was made, and an endoscope was inserted to visualize the spur. Through additional small incisions, specialized instruments were used to carefully remove the spur. Hemostasis was ensured, and the incisions were closed. The patient had a smooth recovery and reported reduced pain and improved function.

3. Operative Note: Bilateral iliac crest spur excision with open surgical technique was performed. Incisions were made bilaterally over the iliac crests, and the spurs were identified and excised using osteotomes and bone rongeurs. Hemostasis was achieved, and the wounds were closed. The patient had a successful surgical intervention with notable relief of pain and improved mobility during the postoperative period.

4. Operative Note: A right iliac crest spur excision with minimally invasive approach was performed. After appropriate anesthesia, a small incision was made, and specialized instruments were used to carefully remove the spur. The minimally invasive technique allowed for reduced tissue trauma and quicker recovery. Hemostasis was obtained, and the incision was closed. The patient had a favorable outcome with decreased pain and improved functionality.

5. Operative Note: Intraoperatively, a left iliac crest spur excision with percutaneous radiofrequency ablation (RFA) was performed. Following sterile preparation, a needle electrode was inserted under imaging guidance to target the spur. Radiofrequency energy was then applied to ablate the spur and surrounding pain-generating nerves. Hemostasis was ensured, and the incision site was closed. The patient reported significant pain relief and improved quality of life following the RFA procedure.

6. Operative Note: I performed a right iliac crest spur excision with open reduction and internal fixation. Under general anesthesia, an incision was made over the iliac crest, and the spur was excised. Fractured or unstable bone fragments were reduced and fixed using plates, screws, or other internal fixation devices. Hemostasis was achieved, and the wound was closed. The patient demonstrated improved stability and reduced pain postoperatively.

7. Operative Note: A left iliac crest spur excision with microdiscectomy technique was performed. Following sterile preparation, a small incision was made, and a microscope or magnifying loupes were used to visualize the spur. Specialized instruments were used to meticulously remove the spur, minimizing tissue trauma. Hemostasis was ensured, and the incision was closed. The patient had a successful microdiscectomy with significant relief of bone pain and improved function.

8. Operative Note: Bilateral iliac crest spur excision with percutaneous endoscopic discectomy (PED) technique was performed. Incisions were made bilaterally, and an endoscope was inserted to visualize and remove the spurs. The PED technique allowed for minimal tissue disruption and faster recovery. Hemostasis was achieved, and the wounds were closed. The patient had a favorable outcome with reduced bone pain and improved mobility.

9. Operative Note: A right

iliac crest spur excision with navigated surgery was performed. Under general anesthesia, a preoperative imaging-based navigation system was utilized to accurately locate the spur. The navigation system provided real-time guidance during the surgical procedure. Hemostasis was obtained, and the wound was closed. The patient had a successful navigation-assisted surgery with significant reduction in bone pain and improved surgical accuracy.

10. Operative Note: Intraoperatively, a left iliac crest spur excision with laser-assisted technique was performed. Following sterile preparation, a laser fiber was inserted through a small incision to vaporize and remove the spur. The laser-assisted technique allowed for precise and targeted removal of the spur with minimal damage to surrounding tissues. Hemostasis was ensured, and the incision was closed. The patient reported improved pain relief and quicker recovery following the laser-assisted procedure.

1. Operative Note: I performed a right iliac crest spur excision with ultrasound-guided intervention. Under local anesthesia, an ultrasound probe was used to precisely locate the spur. A small incision was made, and the spur was carefully excised using specialized instruments. Hemostasis was achieved, and the wound was closed. The patient experienced significant pain relief and improved functionality postoperatively.

2. Operative Note: Intraoperatively, a left iliac crest spur excision with cryoablation was performed. Following sterile preparation, a cryoprobe was inserted to freeze and destroy the spur. Cryoablation provided targeted and controlled destruction of the spur while minimizing damage to surrounding tissues. Hemostasis was ensured, and the incision was closed. The patient had a successful cryoablation procedure with notable reduction in bone pain.

3. Operative Note: Bilateral iliac crest spur excision with extracorporeal shockwave lithotripsy (ESWL) was performed. Incisions were made bilaterally over the iliac crests, and shockwaves were delivered to the spurs using a specialized device. ESWL fragmented the spurs, allowing for easier removal. Hemostasis was achieved, and the wounds were closed. The patient demonstrated improved pain relief and enhanced functional outcomes.

4. Operative Note: A right iliac crest spur excision with nerve decompression was performed. Under general anesthesia, an incision was made over the iliac crest, and the spur was meticulously excised. Nerve decompression techniques were employed to alleviate pressure on surrounding nerves. Hemostasis was obtained, and the wound was closed. The patient reported significant relief from bone pain and improved sensory function.

5. Operative Note: Intraoperatively, a left iliac crest spur excision with platelet-rich plasma (PRP) injection was performed. Following sterile preparation, the spur was carefully excised, and PRP was injected into the surgical site to promote tissue healing and reduce inflammation. Hemostasis was ensured, and the incision was closed. The patient experienced improved pain relief and demonstrated accelerated recovery with PRP therapy.

6. Operative Note: I performed a right iliac crest spur excision with shockwave therapy. Under local anesthesia, shockwaves were administered to the spur using a specialized device. Shockwave therapy promoted tissue regeneration and reduced pain. Hemostasis was achieved, and the wound was closed. The patient had a successful procedure with decreased bone pain and improved functional outcomes.

7. Operative Note: A left iliac crest spur excision with autologous stem cell therapy was performed. Following sterile preparation, the spur was meticulously excised, and autologous stem cells derived from the patient's own bone marrow or adipose tissue were injected into the surgical site to promote tissue repair and regeneration. Hemostasis was ensured, and the incision was closed. The patient reported significant pain relief and showed signs of improved tissue healing.

8. Operative Note: Bilateral iliac crest spur excision with percutaneous radiofrequency denervation was performed. Incisions were made bilaterally over the iliac crests, and radiofrequency electrodes were used to selectively ablate the nerves responsible for transmitting pain signals. Hemostasis was achieved, and the wounds were closed. The patient experienced substantial relief from bone pain and demonstrated improved mobility following the denervation procedure.

9. Operative Note: A right iliac crest spur excision with bone remodeling procedure was performed. Under general anesthesia, the spur was excised, and bone remodeling techniques were employed to reshape and contour the surrounding bone structures. Hemostasis was obtained, and the wound

was closed. The patient showed improved bone alignment and reported reduced pain postoperatively.

10. Operative Note: Intraoperatively, a left iliac crest spur excision with corticosteroid injection was performed. Following sterile preparation, the spur was meticulously excised, and a corticosteroid solution was injected into the surgical site to reduce inflammation and alleviate pain. Hemostasis was ensured, and the incision was closed. The patient had a successful procedure with significant reduction in bone pain and improved functional outcomes.

1. Operative Note: I performed a right iliac crest spur excision with debridement and joint washout due to severe infection affecting the adjacent moving joint. Under general anesthesia, an incision was made over the iliac crest, and the infected spur was meticulously excised. Extensive debridement was performed to remove infected tissue, and the joint was thoroughly washed out with antibiotic solution. Hemostasis was achieved, and the wound was closed. The patient received appropriate antibiotic therapy and demonstrated improved joint function during follow-up.

2. Operative Note: Intraoperatively, a left iliac crest spur excision with open joint debridement and irrigation was performed to address severe infection in the adjacent moving joint. Following sterile preparation, an incision was made over the iliac crest, and the infected spur was excised. The joint was opened, and thorough debridement and irrigation were performed to remove infected material. Hemostasis was ensured, and the incision was closed. The patient received targeted antibiotic treatment and showed improved joint mobility and reduced signs of infection.

3. Operative Note: Bilateral iliac crest spur excision with arthroscopic debridement and joint lavage was performed to manage severe infection in the extreme moving joint. Incisions were made bilaterally, and arthroscopic portals were established. The infected spurs were meticulously excised, and the joint was visualized and debrided using arthroscopic techniques. Lavage with antibiotic solution was performed to irrigate the joint. Hemostasis was achieved, and the wounds were closed. The patient demonstrated improved joint function and decreased signs of infection postoperatively.

4. Operative Note: A right iliac crest spur excision with antibiotic bead placement was performed to address severe infection in the extreme moving joint. Under general anesthesia, an incision was made over the iliac crest, and the infected spur was excised. Antibiotic-impregnated beads were placed in the surgical site to provide localized antibiotic therapy. Hemostasis was obtained, and the wound was closed. The patient received systemic antibiotics and showed significant improvement in joint function and decreased signs of infection.

5. Operative Note: Intraoperatively, a left iliac crest spur excision with intra-articular antibiotic injection was performed to manage severe infection in the extreme moving joint. Following sterile preparation, an incision was made over the iliac crest, and the infected spur was meticulously excised. Antibiotic solution was injected directly into the joint to deliver targeted therapy. Hemostasis was ensured, and the incision was closed. The patient received appropriate systemic antibiotics and showed improved joint function and decreased signs of infection.

6. Operative Note: I performed a right iliac crest spur excision with staged debridement and joint spacer implantation due to severe infection in the extreme moving joint. Under general anesthesia, an incision was made over the iliac crest, and the infected spur was excised. Staged debridement was performed to remove infected tissue, and a temporary joint spacer was implanted to maintain joint space and facilitate healing. Hemostasis was achieved, and the wound was closed. The patient received targeted antibiotic therapy and demonstrated improved joint function during the treatment period.

7. Operative Note: A left iliac crest spur excision with arthrodesis was performed to address severe infection in the extreme moving joint. Following sterile preparation, an incision was made over the iliac crest, and the infected spur was meticulously excised. Arthrodesis was performed to fuse the joint, eliminating motion and reducing the risk of infection spread. Hemostasis was ensured,

and the incision was closed. The patient received appropriate antibiotic treatment and showed improved joint stability and decreased signs of infection.

8. Operative Note: Bilateral iliac crest spur excision with vacuum-assisted closure (VAC) therapy was performed to manage severe infection in the extreme moving joint. Incisions were made bilaterally over the iliac crests, and the infected spurs were excised. VAC therapy was initiated to promote wound healing and control infection. Hemostasis was achieved, and the wounds were closed. The patient received targeted antibiotic therapy and demonstrated improved wound healing and reduced signs of infection.

9. Operative Note: A right iliac crest spur excision with joint arthroplasty was performed to address severe infection in the extreme moving joint. Under general anesthesia, an incision was made over the iliac crest, and the infected spur was meticulously excised. The joint was reconstructed using an artificial joint implant. Hemostasis was obtained, and the wound was closed. The patient received appropriate antibiotic treatment and showed improved joint function and decreased signs of infection.

10. Operative Note: Intraoperatively, a left iliac crest spur excision with local tissue flap reconstruction was performed to manage severe infection in the extreme moving joint. Following sterile preparation, an incision was made over the iliac crest, and the infected spur was excised. Local tissue flaps were utilized to reconstruct the surgical site, promoting healing and reducing infection risk. Hemostasis was ensured, and the incision was closed. The patient received targeted antibiotic therapy and demonstrated improved wound healing and reduced signs of infection.

1. Operative Note: I performed a right iliac crest spur excision with anti-inflammatory medication injection to address severe inflammation associated with the spur. Under local anesthesia, an incision was made over the iliac crest, and the inflamed spur was meticulously excised. Anti-inflammatory medication was injected into the surgical site to reduce inflammation. Hemostasis was achieved, and the wound was closed. The patient experienced significant relief from inflammation and improved functional outcomes.

2. Operative Note: Intraoperatively, a left iliac crest spur excision with corticosteroid injection was performed to manage severe inflammation in the surrounding tissues. Following sterile preparation, the inflamed spur was carefully excised, and corticosteroid solution was injected into the surgical site to alleviate inflammation. Hemostasis was ensured, and the incision was closed. The patient reported reduced inflammation and improved pain control following the procedure.

3. Operative Note: Bilateral iliac crest spur excision with non-steroidal anti-inflammatory drug (NSAID) therapy was performed to address chronic inflammation associated with the spurs. Incisions were made bilaterally, and the inflamed spurs were meticulously excised. Postoperatively, the patient was prescribed NSAIDs to reduce inflammation and manage pain. Hemostasis was achieved, and the wounds were closed. The patient demonstrated decreased inflammation and improved functionality after the surgery.

4. Operative Note: A right iliac crest spur excision with intraoperative cold therapy was performed to manage acute inflammation in the surgical area. Under general anesthesia, an incision was made over the iliac crest, and the inflamed spur was meticulously excised. Cold therapy was applied intraoperatively to reduce inflammation and minimize tissue damage. Hemostasis was obtained, and the wound was closed. The patient experienced significant reduction in inflammation and improved postoperative recovery.

5. Operative Note: Intraoperatively, a left iliac crest spur excision with local cryotherapy was performed to address inflammation in the surrounding tissues. Following sterile preparation, the inflamed spur was carefully excised, and local cryotherapy was applied to the surgical site to reduce inflammation and swelling. Hemostasis was ensured, and the incision was closed. The patient reported decreased inflammation and improved pain relief after the procedure.

6. Operative Note: I performed a right iliac crest spur excision with anti-inflammatory dressing application. Under general anesthesia, an incision was made over the iliac crest, and the inflamed spur was meticulously excised. A specialized anti-inflammatory dressing was applied to the surgical site to provide continuous release of anti-inflammatory medication. Hemostasis was achieved, and the wound was closed. The patient demonstrated reduced inflammation and improved wound healing following the procedure.

7. Operative Note: A left iliac crest spur excision with low-level laser therapy (LLLT) was performed to address chronic inflammation associated with the spur. Following sterile preparation, the inflamed spur was meticulously excised, and LLLT was applied to the surgical site to reduce inflammation and promote tissue healing. Hemostasis was ensured, and the incision was closed. The patient reported decreased inflammation and improved pain management after the surgery.

8. Operative Note: Bilateral iliac crest spur excision with anti-inflammatory diet recommendation was performed to manage chronic inflammation in the patient. Incisions were made bilaterally, and the inflamed spurs were meticulously excised. The patient was advised to follow an anti-inflammatory diet, rich in fruits, vegetables, and omega-3 fatty acids, to reduce systemic inflammation. Hemostasis was achieved, and the wounds were closed. The patient demonstrated improved inflammation control and overall

well-being postoperatively.

9. Operative Note: A right iliac crest spur excision with local application of anti-inflammatory ointment was performed. Under general anesthesia, an incision was made over the iliac crest, and the inflamed spur was carefully excised. An anti-inflammatory ointment was applied to the surgical site to provide localized relief from inflammation. Hemostasis was obtained, and the wound was closed. The patient experienced decreased inflammation and improved comfort following the procedure.

10. Operative Note: Intraoperatively, a left iliac crest spur excision with acupuncture therapy was performed to address chronic inflammation associated with the spur. Following sterile preparation, the inflamed spur was meticulously excised, and acupuncture therapy was administered to reduce inflammation and promote healing. Hemostasis was ensured, and the incision was closed. The patient reported reduced inflammation and improved pain management after the procedure.

1. Operative Note: I performed a right iliac crest spur excision in a patient with mild symptoms. Postoperatively, the patient was advised to rest and apply ice packs to the surgical site for pain management. A follow-up appointment was scheduled in two weeks to assess the healing progress and determine the need for further intervention or physical therapy.

2. Operative Note: Intraoperatively, a left iliac crest spur excision was performed in a patient with moderate symptoms. Following the procedure, the patient was prescribed pain medication and instructed to limit weight-bearing activities for several weeks. A follow-up appointment was scheduled in one month to evaluate pain levels and assess the need for additional interventions such as corticosteroid injections or physical therapy.

3. Operative Note: Bilateral iliac crest spur excision was performed in a patient with severe symptoms and limited mobility. Postoperatively, the patient was admitted for inpatient rehabilitation to manage pain, improve mobility, and receive intensive physical therapy. Follow-up assessments were scheduled at regular intervals during the rehabilitation period to monitor progress and adjust the treatment plan accordingly.

4. Operative Note: A right iliac crest spur excision was performed in a patient with mild-to-moderate symptoms. The patient was advised to engage in physical therapy exercises focused on strengthening the surrounding muscles and improving range of motion. A follow-up appointment was scheduled in six weeks to evaluate the response to conservative treatment and determine the need for further intervention.

5. Operative Note: Intraoperatively, a left iliac crest spur excision was performed in a patient with severe symptoms and signs of nerve compression. Postoperatively, the patient was referred to a pain management specialist for assessment and potential nerve block procedures. Follow-up appointments were scheduled as per the pain management specialist's recommendations to monitor pain levels and explore additional treatment options.

6. Operative Note: Bilateral iliac crest spur excision was performed in a patient with moderate symptoms and evidence of bone erosion. Postoperatively, the patient was referred to a rheumatologist for further evaluation and management of the underlying condition causing the bone erosion. Follow-up appointments were scheduled in collaboration with the rheumatologist to monitor the disease progression and adjust the treatment plan accordingly.

7. Operative Note: A right iliac crest spur excision was performed in a patient with mild symptoms and no evidence of bone erosion or severe inflammation. Postoperatively, the patient was advised to gradually increase physical activity and engage in regular exercises to maintain joint flexibility and strength. A follow-up appointment was scheduled in three months to assess the long-term outcome and provide further guidance if needed.

8. Operative Note: Intraoperatively, a left iliac crest spur excision was performed in a patient with severe symptoms and a history of recurrent infections. Postoperatively, the patient was prescribed a prolonged course of antibiotic therapy and closely monitored for signs of infection. Follow-up appointments were scheduled at frequent intervals to assess wound healing, monitor infection control, and adjust the antibiotic regimen if necessary.

9. Operative Note: Bilateral iliac crest spur excision was performed in a patient with moderate symptoms and a concurrent diagnosis of osteoporosis. Postoperatively, the patient was referred to an endocrinologist for comprehensive management of osteoporosis and optimization of bone health. Follow-up appointments were scheduled in collaboration with the endocrinologist to monitor bone density and evaluate the need for additional interventions.

10. Operative Note: A right iliac crest spur excision was performed in a patient with mild-to-moderate symptoms and a significant impact on daily activities. Postoperatively, the patient was referred to a physical therapist for a structured rehabilitation program. Follow-up appointments were scheduled in coordination with the physical therapist to assess progress, modify the exercise regimen, and ensure optimal recovery.

## M76.3 Iliotibial band syndrome

1. Operative Note: Patient underwent iliotibial band release surgery under general anesthesia. A 3 cm incision was made over the lateral aspect of the knee. The iliotibial band was identified and released using sharp dissection. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no immediate complications were noted.

2. Operative Note: Iliotibial band tenotomy was performed on the patient's left knee. A 4 cm incision was made over the lateral femoral condyle. The iliotibial band was carefully identified, and a longitudinal tenotomy was created using a scalpel. Bleeding was controlled, and the wound was closed in layers. The patient was transferred to the recovery room in stable condition.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band. Standard portals were established, and a diagnostic arthroscopy was performed. Significant fibrous thickening and inflammation were noted in the iliotibial band. The diseased tissue was debrided using a shaver and electrocautery. Hemostasis was ensured, and the portals were closed. The patient tolerated the procedure well without any complications.

4. Operative Note: Iliotibial band release with Z-plasty was performed on the patient's right knee. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was dissected and released, and a Z-plasty was created to lengthen the structure. Hemostasis was achieved, and the wound was closed in layers. The patient's postoperative course was uneventful.

5. Operative Note: Patient underwent minimally invasive iliotibial band release. Two small incisions were made over the lateral aspect of the knee. Specialized instruments were used to release the iliotibial band, allowing for improved mobility and reduced friction. Hemostasis was ensured, and the incisions were closed with sutures. The patient was discharged on the same day and instructed to follow up for postoperative care.

6. Operative Note: Arthroscopic bursectomy and iliotibial band release were performed on the patient's left knee. Standard portals were established, and a thorough examination of the joint was conducted. The inflamed bursa was excised, and the iliotibial band was released using a shaver and radiofrequency device. The knee was irrigated, and the portals were closed. The patient had an uneventful recovery.

7. Operative Note: Iliotibial band stretching and lengthening procedure were performed on the patient's bilateral knees. A medial and lateral incision were made over each knee. The iliotibial band was carefully dissected, and a series of lengthening incisions were made. Tension in the band was reduced, and the incisions were closed. The patient was started on a rehabilitation program postoperatively.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy. A curvilinear incision was made over the lateral femoral condyle. The iliotibial band was released longitudinally, and the inflamed bursa was excised. Hemostasis was achieved, and the wound was closed with sutures. The patient's pain and range of motion significantly improved postoperatively.

9. Operative Note: Iliotibial band fractional lengthening was performed on the patient's right knee. A 4 cm incision was made over the lateral femoral condyle. The iliotibial band was partially incised, allowing for increased flexibility. Hemostasis was achieved, and the

incision was closed. The patient was advised on postoperative rehabilitation exercises and scheduled for follow-up.

10. Operative Note: Endoscopic iliotibial band release was performed on the patient's left knee. Two small incisions were made, and an endoscope was inserted. The iliotibial band was visualized, and a portion was released using specialized instruments. The procedure was completed without complications, and the incisions were closed. The patient was discharged with instructions for physical therapy.

1. Operative Note: Patient underwent ultrasound-guided corticosteroid injection for the treatment of iliotibial band syndrome. The lateral aspect of the knee was prepared and draped in a sterile manner. Under ultrasound guidance, a needle was inserted into the inflamed area of the iliotibial band. A mixture of corticosteroid and local anesthetic was injected. The patient tolerated the procedure well, and post-injection instructions were provided.

2. Operative Note: Iliotibial band release with mini-open technique was performed on the patient's right knee. A 4 cm incision was made over the lateral femoral condyle. The iliotibial band was carefully released using a combination of sharp dissection and electrocautery. Hemostasis was achieved, and the wound was closed in layers. The patient's pain and functional limitations were expected to improve postoperatively.

3. Operative Note: Patient underwent arthroscopic lateral release for iliotibial band syndrome. Standard portals were established, and a thorough examination of the knee was performed. The tight and inflamed iliotibial band was released using a shaver and radiofrequency device. Care was taken to protect neurovascular structures. The knee joint was irrigated, and the portals were closed. The patient was provided with postoperative instructions and scheduled for follow-up.

4. Operative Note: Iliotibial band tenodesis was performed on the patient's left knee. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was detached from its insertion point, and the distal end was reattached using suture anchors. Stability was assessed, and the wound was closed. The patient was instructed to bear weight as tolerated and follow a prescribed rehabilitation program.

5. Operative Note: Patient underwent iliotibial band release with autologous tenocyte injection. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was carefully released, and tenocytes harvested from the patient's own body were injected into the affected area. Hemostasis was ensured, and the wound was closed. The patient was advised on postoperative care and encouraged to follow up for further evaluation.

6. Operative Note: Open iliotibial band lengthening was performed on the patient's bilateral knees. A medial and lateral incision were made over each knee. The iliotibial band was dissected and lengthened to alleviate tension. The incisions were closed, and appropriate dressings were applied. The patient was started on physical therapy and provided with postoperative instructions.

7. Operative Note: Iliotibial band release with arthroscopic-assisted technique was performed on the patient's right knee. Standard portals were established, and the joint was visualized. A combination of arthroscopic instruments and small incisions was used to release the iliotibial band. The knee was thoroughly irrigated, and the portals were closed. The patient's knee stability and range of motion were expected to improve following surgery.

8. Operative Note: Patient underwent percutaneous needle tenotomy for the treatment of chronic iliotibial band syndrome. The lateral aspect of the knee was prepared and draped. Under fluoroscopic guidance, a needle was inserted percutaneously into the iliotibial band and moved in a repetitive motion to create microtears. The procedure was performed without complications, and the patient was provided with post-procedure instructions.

9. Operative Note: Iliotibial band release with endoscopic technique was performed on the patient's left knee. Two

small incisions were made, and an endoscope was inserted. The iliotibial band was visualized and released using specialized endoscopic instruments. The procedure was completed successfully, and the incisions were closed. The patient was given instructions for postoperative care and referred for physical therapy.

10. Operative Note: Patient underwent shockwave therapy for the treatment of iliotibial band syndrome. The lateral aspect of the knee was prepared and draped. Focused shockwaves were applied to the affected area using a specialized device. The procedure was well-tolerated, and the patient was advised on post-treatment care and recommended follow-up.

1. Operative Note: Patient underwent iliotibial band release surgery under general anesthesia with moderate sedation. A 4 cm incision was made over the lateral aspect of the knee. The iliotibial band was identified and released using sharp dissection. Hemostasis was achieved, and the wound was closed in layers. The patient remained stable throughout the procedure, and the anesthesia dosage was carefully monitored.

2. Operative Note: Iliotibial band tenotomy was performed on the patient's left knee under local anesthesia with intravenous sedation. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was carefully identified, and a longitudinal tenotomy was created using a scalpel. Bleeding was controlled, and the wound was closed in layers. The patient was comfortable and responsive during the procedure.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band under spinal anesthesia. Standard portals were established, and a diagnostic arthroscopy was performed. Significant fibrous thickening and inflammation were noted in the iliotibial band. The diseased tissue was debrided using a shaver and electrocautery. Hemostasis was ensured, and the portals were closed. The patient remained hemodynamically stable under the chosen anesthesia dosage.

4. Operative Note: Iliotibial band release with Z-plasty was performed on the patient's right knee under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was dissected and released, and a Z-plasty was created to lengthen the structure. Hemostasis was achieved, and the wound was closed in layers. The anesthesia dosage was adjusted throughout the procedure to maintain optimal depth.

5. Operative Note: Patient underwent minimally invasive iliotibial band release under regional anesthesia. Two small incisions were made over the lateral aspect of the knee. Specialized instruments were used to release the iliotibial band, allowing for improved mobility and reduced friction. Hemostasis was ensured, and the incisions were closed with sutures. The patient remained comfortable and cooperative during the surgery.

6. Operative Note: Operative Note: Arthroscopic bursectomy and iliotibial band release were performed on the patient's left knee under monitored anesthesia care. Standard portals were established, and a thorough examination of the joint was conducted. The inflamed bursa was excised, and the iliotibial band was released using a shaver and radiofrequency device. The knee was irrigated, and the portals were closed. The patient remained sedated and pain-free throughout the procedure.

7. Operative Note: Iliotibial band stretching and lengthening procedure were performed on the patient's bilateral knees under general anesthesia with deep neuromuscular blockade. A medial and lateral incision were made over each knee. The iliotibial band was carefully dissected, and a series of lengthening incisions were made. Tension in the band was reduced, and the incisions were closed. The anesthesia dosage was closely monitored to ensure optimal muscle relaxation.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy under local anesthesia with intravenous sedation. A curvilinear incision was made over the lateral femoral condyle. The iliotibial band was released longitudinally, and the inflamed bursa was excised. Hemostasis was achieved, and the wound was closed with sutures. The patient remained calm and

responsive under the chosen anesthesia dosage.

9. Operative Note: Iliotibial band fractional lengthening was performed on the patient's right knee under general anesthesia with controlled hypotension. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was partially incised, allowing for increased flexibility. Hemostasis was achieved, and the anesthesia dosage was adjusted to maintain the desired blood pressure levels. The patient tolerated the procedure well.

10. Operative Note: Patient underwent endoscopic iliotibial band release under local anesthesia with monitored anesthesia care. Two small incisions were made, and an endoscope was inserted. The iliotibial band was visualized and released using specialized endoscopic instruments. The procedure was completed successfully, and the anesthesia dosage was carefully controlled to keep the patient comfortable and responsive throughout.

1. Operative Note: Patient underwent iliotibial band release surgery with bone erosion repair under general anesthesia. A 4 cm incision was made over the lateral aspect of the knee. The eroded bone was debrided and prepared for grafting. The iliotibial band was released, and a bone graft was secured in the eroded area using screws. Hemostasis was achieved, and the wound was closed. The patient's postoperative course was closely monitored for proper bone healing.

2. Operative Note: Iliotibial band tenotomy with bone erosion debridement was performed on the patient's left knee under local anesthesia with intravenous sedation. A 5 cm incision was made over the lateral femoral condyle. The eroded bone was carefully debrided, and the iliotibial band was longitudinally tenotomized. The wound was closed, and the patient was provided with postoperative instructions for bone healing and rehabilitation.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band with bone erosion microfracture under spinal anesthesia. Standard portals were established, and a diagnostic arthroscopy was performed. Significant bone erosion in the iliotibial band insertion site was noted and addressed using a microfracture technique. Hemostasis was ensured, and the portals were closed. The patient's postoperative progress was closely monitored for bone healing.

4. Operative Note: Iliotibial band release with Z-plasty and bone erosion reconstruction was performed on the patient's right knee under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The eroded bone was carefully debrided, and the iliotibial band was released with a Z-plasty technique. Bone graft material was inserted and secured in the eroded area. Hemostasis was achieved, and the wound was closed in layers.

5. Operative Note: Patient underwent minimally invasive iliotibial band release with bone erosion repair under regional anesthesia. Two small incisions were made over the lateral aspect of the knee. The eroded bone was addressed using a minimally invasive technique, and bone graft material was placed to promote bone regeneration. The iliotibial band was released, and the incisions were closed. The patient was advised on postoperative care for proper bone healing.

6. Operative Note: Arthroscopic bursectomy, iliotibial band release, and bone erosion debridement were performed on the patient's left knee under monitored anesthesia care. Standard portals were established, and a thorough examination of the joint was conducted. The eroded bone in the iliotibial band insertion site was debrided, and the iliotibial band was released using a shaver. Hemostasis was ensured, and the portals were closed. The patient's bone erosion was addressed to facilitate healing.

7. Operative Note: Iliotibial band stretching and lengthening procedure with bone erosion reconstruction were performed on the patient's bilateral knees under general anesthesia. A medial and lateral incision were made over each knee. The eroded bone was carefully debrided, and bone graft material was placed. The iliotibial band was dissected and lengthened to alleviate tension. The incisions were closed, and appropriate dressings were applied. Postoperative monitoring was initiated to ensure bone healing.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy and bone erosion repair under local anesthesia with intravenous sedation. A curvilinear incision was made over the lateral fem

oral condyle. The eroded bone was debrided, and bone graft material was secured in place. The iliotibial band was released longitudinally, and the inflamed bursa was excised. Hemostasis was achieved, and the wound was closed with sutures. The patient's bone erosion was addressed to promote proper healing.

9. Operative Note: Iliotibial band fractional lengthening with bone erosion reconstruction was performed on the patient's right knee under general anesthesia with controlled hypotension. A 5 cm incision was made over the lateral femoral condyle. The eroded bone was debrided, and bone graft material was placed to restore integrity. The iliotibial band was partially incised to reduce tension. Hemostasis was achieved, and the incisions were closed. The anesthesia dosage and blood pressure were carefully managed throughout the procedure.

10. Operative Note: Patient underwent endoscopic iliotibial band release with bone erosion repair under local anesthesia with monitored anesthesia care. Two small incisions were made, and an endoscope was inserted. The eroded bone was carefully debrided, and bone graft material was placed using specialized endoscopic instruments. The iliotibial band was released, and the incisions were closed. The anesthesia dosage was adjusted to ensure patient comfort and responsiveness during the procedure.

1. Operative Note: Patient underwent iliotibial band release surgery with bone debridement and severe bone pain management under general anesthesia. A 4 cm incision was made over the lateral aspect of the knee. The eroded bone was meticulously debrided, and local anesthetics were administered to the affected area to alleviate severe bone pain. The iliotibial band was released, and the wound was closed. The patient's pain was effectively managed throughout the procedure.

2. Operative Note: Iliotibial band tenotomy with bone debridement and severe bone pain relief was performed on the patient's left knee under regional anesthesia. A 5 cm incision was made over the lateral femoral condyle. The eroded bone was carefully debrided, and nerve blocks were administered to provide targeted pain relief. The iliotibial band was longitudinally tenotomized, and the wound was closed. The patient's severe bone pain was effectively managed during the surgery.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band with bone recontouring and severe bone pain management under spinal anesthesia. Standard portals were established, and a diagnostic arthroscopy was performed. Extensive bone pain was noted, and the eroded bone was meticulously recontoured. Local anesthetics were administered to manage severe bone pain. The portals were closed, and the patient's pain was effectively controlled throughout the procedure.

4. Operative Note: Iliotibial band release with bone erosion repair and severe bone pain relief was performed on the patient's right knee under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The eroded bone was addressed, and local anesthetics were injected to manage severe bone pain. Bone graft material was secured in the eroded area. Hemostasis was achieved, and the wound was closed in layers.

5. Operative Note: Patient underwent minimally invasive iliotibial band release with bone debridement and severe bone pain management under local anesthesia with intravenous sedation. Two small incisions were made over the lateral aspect of the knee. The eroded bone was meticulously debrided, and nerve blocks were administered to alleviate severe bone pain. The iliotibial band was released, and the incisions were closed. The patient's pain was effectively managed during the surgery.

6. Operative Note: Arthroscopic bursectomy, iliotibial band release, and severe bone pain management were performed on the patient's left knee under monitored anesthesia care. Standard portals were established, and a thorough examination of the joint was conducted. Extensive bone pain was addressed using a combination of nerve blocks and local anesthetics. The iliotibial band was released, and the portals were closed. The patient's severe bone pain was effectively controlled throughout the procedure.

7. Operative Note: Iliotibial band stretching and lengthening procedure with bone debridement and severe bone pain management were performed on the patient's bilateral knees under general anesthesia. A medial and lateral incision were made over each knee. The eroded bone was meticulously debrided, and local anesthetics were administered to manage severe bone pain. The iliotibial band was dissected and lengthened, and the incisions were closed. The patient's pain was effectively managed during the surgery.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy, bone debridement, and severe bone pain relief under local anesthesia with intravenous sedation. A curvilinear incision

was made over the lateral femoral condyle. The eroded bone was meticulously debrided, and nerve blocks were administered to alleviate severe bone pain. The iliotibial band was released longitudinally, and the wound was closed with sutures. The patient's bone pain was effectively managed throughout the procedure.

9. Operative Note: Iliotibial band fractional lengthening with bone debridement and severe bone pain relief was performed on the patient's right knee under general anesthesia with controlled hypotension. A 5 cm incision was made over the lateral femoral condyle. The eroded bone was meticulously debrided, and local anesthetics were administered to manage severe bone pain. The iliotibial band was partially incised to alleviate tension. Hemostasis was achieved, and the incisions were closed.

10. Operative Note: Patient underwent endoscopic iliotibial band release with bone debridement and severe bone pain management under local anesthesia with monitored anesthesia care. Two small incisions were made, and an endoscope was inserted. The eroded bone was carefully debrided, and local anesthetics were applied to provide targeted pain relief. The iliotibial band was released, and the incisions were closed. The anesthesia dosage was adjusted to effectively manage the patient's severe bone pain throughout the procedure.

1. Operative Note: Patient underwent open iliotibial band release surgery with bone debridement and lateral patellar retinaculum repair under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released, and the eroded bone was meticulously debrided. Additionally, the lateral patellar retinaculum was repaired to improve patellar tracking. Hemostasis was achieved, and the wound was closed in layers.

2. Operative Note: Iliotibial band tenotomy and lateral release were performed on the patient's left knee under regional anesthesia. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was tenotomized, and a lateral release was carried out to alleviate tension. The procedure aimed to improve knee alignment and reduce friction. Hemostasis was ensured, and the incision was closed. Postoperative instructions for rehabilitation were provided.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band and lateral meniscectomy under spinal anesthesia. Standard portals were established, and a diagnostic arthroscopy was performed. The iliotibial band was meticulously debrided to alleviate friction. Concurrently, a lateral meniscectomy was performed to address any associated meniscal pathology. The knee was irrigated, and the portals were closed. The patient's postoperative course was closely monitored.

4. Operative Note: Iliotibial band release with Z-plasty and medial plication were performed on the patient's right knee under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released with a Z-plasty technique to lengthen it. Additionally, a medial plication was carried out to restore proper knee alignment. Hemostasis was achieved, and the wound was closed in layers.

5. Operative Note: Patient underwent minimally invasive endoscopic iliotibial band release with lateral patellar realignment under local anesthesia with intravenous sedation. Two small incisions were made over the lateral aspect of the knee. Endoscopic instruments were used to release the iliotibial band, and a lateral patellar realignment procedure was performed concurrently to improve patellar tracking. The incisions were closed, and the patient was provided with postoperative care instructions.

6. Operative Note: Arthroscopic bursectomy, iliotibial band release, and lateral tibial tubercle osteotomy were performed on the patient's left knee under monitored anesthesia care. Standard portals were established, and a thorough examination of the joint was conducted. The inflamed bursa was excised, and the iliotibial band was released using a shaver and radiofrequency device. A lateral tibial tubercle osteotomy was performed to correct malalignment. The knee was irrigated, and the portals were closed.

7. Operative Note: Iliotibial band stretching and lengthening procedure with lateral patellar facetectomy were performed on the patient's bilateral knees under general anesthesia. Medial and lateral incisions were made over each knee. The iliotibial band was dissected and lengthened to alleviate tension. Additionally, a lateral patellar facetectomy was performed to address patellar maltracking. The incisions were closed, and appropriate dressings were applied.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy and lateral collateral ligament reconstruction under local anesthesia with intravenous sedation. A curv

ilinear incision was made over the lateral femoral condyle. The iliotibial band was released, and the inflamed bursa was excised. Additionally, a lateral collateral ligament reconstruction was performed to stabilize the knee. Hemostasis was achieved, and the wound was closed with sutures.

9. Operative Note: Iliotibial band fractional lengthening with lateral meniscal repair was performed on the patient's right knee under general anesthesia with controlled hypotension. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was partially incised to reduce tension. Simultaneously, a lateral meniscal repair was carried out to address meniscal pathology. Hemostasis was achieved, and the incision was closed. The anesthesia dosage and blood pressure were carefully managed throughout the procedure.

10. Operative Note: Patient underwent endoscopic iliotibial band release with lateral collateral ligament augmentation and meniscal debridement under local anesthesia with monitored anesthesia care. Two small incisions were made, and an endoscope was inserted. The iliotibial band was released, and a lateral collateral ligament augmentation was performed to enhance knee stability. Concurrently, meniscal debridement was carried out to address any meniscal tears. The incisions were closed, and the anesthesia dosage was adjusted to maintain patient comfort and responsiveness.

1. Operative Note: Patient underwent open iliotibial band release surgery with bone debridement and lateral patellar facetectomy under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released to alleviate friction, and a lateral patellar facetectomy was performed to address patellar maltracking. Hemostasis was achieved, and the wound was closed in layers.

2. Operative Note: Iliotibial band tenotomy with lateral retinacular release and chondroplasty was performed on the patient's left knee under regional anesthesia. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was tenotomized, and a lateral retinacular release was carried out to reduce tension. Chondroplasty was performed to address any cartilage abnormalities. The incision was closed, and postoperative instructions for rehabilitation were provided.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band with lateral meniscal repair and chondroplasty under spinal anesthesia. Standard portals were established, and a diagnostic arthroscopy was performed. The iliotibial band was debrided to alleviate friction, and a lateral meniscal repair was performed to address meniscal pathology. Concurrently, chondroplasty was carried out to treat any cartilage lesions. The knee was irrigated, and the portals were closed.

4. Operative Note: Iliotibial band release with lateral patellar realignment and synovectomy was performed on the patient's right knee under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released to alleviate tension, and a lateral patellar realignment procedure was carried out to improve patellar tracking. Synovectomy was performed to remove inflamed synovial tissue. Hemostasis was achieved, and the wound was closed in layers.

5. Operative Note: Patient underwent minimally invasive endoscopic iliotibial band release with lateral patellar facetectomy and microfracture under local anesthesia with intravenous sedation. Two small incisions were made over the lateral aspect of the knee. Endoscopic instruments were used to release the iliotibial band, and a lateral patellar facetectomy was performed to address patellar maltracking. Microfracture was performed to promote cartilage healing. The incisions were closed, and postoperative care instructions were provided.

6. Operative Note: Arthroscopic bursectomy, iliotibial band release, and lateral meniscal debridement were performed on the patient's left knee under monitored anesthesia care. Standard portals were established, and a thorough examination of the joint was conducted. The inflamed bursa was excised, and the iliotibial band was released using a shaver and radiofrequency device. Lateral meniscal debridement was carried out to address meniscal tears. The knee was irrigated, and the portals were closed.

7. Operative Note: Iliotibial band stretching and lengthening procedure with lateral patellar tendon repair and chondroplasty were performed on the patient's bilateral knees under general anesthesia. Medial and lateral incisions were made over each knee. The iliotibial band was dissected and lengthened to reduce tension. Additionally, a lateral patellar tendon repair was carried out to improve patellar stability. Chondroplasty was performed to address cartilage defects. The incisions were closed, and appropriate dressings

were applied.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy, lateral retinacular lengthening, and meniscal repair under local anesthesia with intravenous sedation. A curvilinear incision was made over the lateral femoral condyle. The iliotibial band was released, and the inflamed bursa was excised. Lateral retinacular lengthening was performed to reduce tension, and meniscal repair was carried out to address meniscal tears. The wound was closed with sutures.

9. Operative Note: Iliotibial band fractional lengthening with lateral patellar realignment and autologous chondrocyte implantation were performed on the patient's right knee under general anesthesia with controlled hypotension. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was partially incised to alleviate tension. Lateral patellar realignment was performed to improve patellar tracking. Autologous chondrocyte implantation was carried out to promote cartilage regeneration. Hemostasis was achieved, and the incision was closed.

10. Operative Note: Patient underwent endoscopic iliotibial band release with lateral collateral ligament reconstruction and osteochondral autograft transplantation under local anesthesia with monitored anesthesia care. Two small incisions were made, and an endoscope was inserted. The iliotibial band was released using endoscopic instruments, and lateral collateral ligament reconstruction was performed to stabilize the knee. Osteochondral autograft transplantation was carried out to repair cartilage defects. The incisions were closed, and the anesthesia dosage was adjusted to maintain patient comfort and responsiveness.

1. Operative Note: Patient underwent urgent open iliotibial band release surgery with extensive debridement and joint irrigation for severe infection on the right knee under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released, and extensive debridement was performed to remove infected tissues. The joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and a drain was placed. The wound was closed in layers.

2. Operative Note: Iliotibial band tenotomy and joint washout were performed on the patient's left knee under regional anesthesia for severe joint infection. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was tenotomized, and the joint was washed out with antibiotic solution to remove infectious material. A drain was placed, and the incision was closed. Postoperative antibiotic therapy and close monitoring were initiated.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band and extensive joint lavage for severe infection on the right knee under spinal anesthesia. Standard portals were established, and a diagnostic arthroscopy was performed. The infected iliotibial band was meticulously debrided, and the joint was lavaged with antibiotic solution. Additional cultures were obtained, and appropriate antibiotic therapy was initiated. The portals were closed, and the patient was closely monitored postoperatively.

4. Operative Note: Iliotibial band release with joint debridement and extensive irrigation was performed on the patient's right knee under general anesthesia for severe infection. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released, and extensive debridement of infected tissues was carried out. The joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and a drain was placed. The wound was closed in layers.

5. Operative Note: Patient underwent minimally invasive endoscopic iliotibial band release with joint washout and debridement for severe infection on the left knee under local anesthesia with intravenous sedation. Two small incisions were made over the lateral aspect of the knee. Endoscopic instruments were used to release the iliotibial band, and the joint was washed out and debrided to remove infected tissues. A drain was placed, and the incisions were closed. Intravenous antibiotics were initiated.

6. Operative Note: Arthroscopic bursectomy, iliotibial band release, and joint debridement were performed on the patient's right knee under monitored anesthesia care for severe joint infection. Standard portals were established, and a thorough examination of the joint was conducted. The inflamed bursa was excised, the iliotibial band was released, and extensive debridement of infected tissues was carried out. The joint was irrigated with antibiotic solution. The portals were closed, and appropriate antibiotic therapy was initiated.

7. Operative Note: Iliotibial band stretching and lengthening procedure with joint washout and debridement were performed on the patient's bilateral knees under general anesthesia for severe infection. Medial and lateral incisions were made over each knee. The iliotibial band was dissected and lengthened, and the joints were thoroughly washed out and debrided to remove infected tissues. A drain was placed, and the incisions were closed. Intravenous antibiotics were administered.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy, joint irrigation, and

debridement for severe infection on the right knee under local anesthesia with intravenous sedation. A curvilinear incision was made over the lateral femoral condyle. The iliotibial band was released, the inflamed bursa was excised, and the joint was irrigated and debrided to remove infected tissues. A drain was placed, and the wound was closed with sutures.

9. Operative Note: Iliotibial band fractional lengthening with joint washout and debridement was performed on the patient's left knee under general anesthesia for severe infection. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was partially incised to reduce tension, and the joint was washed out and debrided to remove infected tissues. A drain was placed, and the incision was closed. Intravenous antibiotic therapy was initiated.

10. Operative Note: Patient underwent endoscopic iliotibial band release with joint lavage, debridement, and irrigation for severe infection on the right knee under local anesthesia with monitored anesthesia care. Two small incisions were made, and an endoscope was inserted. The iliotibial band was released using endoscopic instruments, and the joint was lavaged, debrided, and irrigated to remove infected tissues. A drain was placed, and the incisions were closed. Intravenous antibiotics were administered.

1. Operative Note: Patient underwent open iliotibial band release surgery with bursectomy, extensive debridement, and joint irrigation for severe inflammation and infection on the right knee under general anesthesia. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released, and an inflamed bursa was excised. Extensive debridement was performed to remove infected and inflamed tissues. The joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and a drain was placed. The wound was closed in layers.

2. Operative Note: Iliotibial band tenotomy and joint washout were performed on the patient's left knee under regional anesthesia for severe inflammation and effusion. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was tenotomized, and the joint was washed out with saline solution to reduce inflammation and remove excess fluid. A drain was placed, and the incision was closed. Postoperative instructions included elevation and ice application.

3. Operative Note: Patient underwent arthroscopic debridement of the iliotibial band and lateral patellar facetectomy for chronic inflammation and patellar maltracking on the right knee under spinal anesthesia. Standard portals were established, and a diagnostic arthroscopy was performed. The inflamed iliotibial band was meticulously debrided, and a lateral patellar facetectomy was performed to address maltracking. The joint was irrigated with saline solution, and the portals were closed. Postoperative rehabilitation plan was provided.

4. Operative Note: Iliotibial band release with joint debridement and corticosteroid injection was performed on the patient's right knee under general anesthesia for severe inflammation and recurrent symptoms. A 6 cm incision was made over the lateral femoral condyle. The iliotibial band was released, and extensive debridement of inflamed tissues was carried out. A corticosteroid injection was administered intraoperatively to reduce inflammation. Hemostasis was achieved, and the wound was closed in layers.

5. Operative Note: Patient underwent minimally invasive endoscopic iliotibial band release with lateral retinacular release and joint lavage for chronic inflammation and lateral knee pain on the left knee under local anesthesia with intravenous sedation. Two small incisions were made over the lateral aspect of the knee. Endoscopic instruments were used to release the iliotibial band, and a lateral retinacular release was performed to alleviate tension. The joint was lavaged to reduce inflammation. The incisions were closed, and postoperative instructions included activity modification and anti-inflammatory medication.

6. Operative Note: Arthroscopic bursectomy, iliotibial band release, and joint debridement were performed on the patient's right knee under monitored anesthesia care for severe inflammation and recurrent bursitis. Standard portals were established, and a thorough examination of the joint was conducted. The inflamed bursa was excised, the iliotibial band was released, and debridement of inflamed tissues was performed. The joint was irrigated with saline solution. The portals were closed, and postoperative instructions included rest and icing.

7. Operative Note: Iliotibial band stretching and lengthening procedure with lateral patellar realignment and synovectomy were performed on the patient's bilateral knees under general anesthesia for severe inflammation and synovitis. Medial and lateral incisions were made over each knee. The iliotibial band was dissected and lengthened

, a lateral patellar realignment was performed, and synovectomy was carried out to remove inflamed synovial tissue. The incisions were closed, and appropriate dressings were applied.

8. Operative Note: Patient underwent open iliotibial band release with bursectomy, joint irrigation, and corticosteroid injection for chronic inflammation and symptomatic bursitis on the right knee under local anesthesia with intravenous sedation. A curvilinear incision was made over the lateral femoral condyle. The iliotibial band was released, the inflamed bursa was excised, and the joint was irrigated with saline solution. A corticosteroid injection was administered intraoperatively. The wound was closed with sutures.

9. Operative Note: Iliotibial band fractional lengthening with joint washout and debridement was performed on the patient's left knee under general anesthesia for severe inflammation and intra-articular adhesions. A 5 cm incision was made over the lateral femoral condyle. The iliotibial band was partially incised, and the joint was washed out and debrided to remove inflamed tissues and adhesions. A drain was placed, and the incision was closed. Postoperative rehabilitation plan was provided.

10. Operative Note: Patient underwent endoscopic iliotibial band release with joint lavage, debridement, and corticosteroid injection for chronic inflammation and recurrent symptoms on the right knee under local anesthesia with monitored anesthesia care. Two small incisions were made, and an endoscope was inserted. The iliotibial band was released using endoscopic instruments, and the joint was lavaged, debrided, and injected with a corticosteroid to reduce inflammation. A drain was placed, and the incisions were closed. Postoperative instructions included activity modification and pain management.

1. Operative Note: Patient underwent arthroscopic iliotibial band release and lateral retinacular release on the left knee under general anesthesia. The procedure was performed to address moderate iliotibial band syndrome. Postoperative follow-up will include physical therapy and a gradual return to activity, with a follow-up appointment scheduled in six weeks to assess progress and determine the need for further intervention.

2. Operative Note: Iliotibial band stretching and lengthening procedure with lateral patellar realignment were performed on the patient's right knee under regional anesthesia. The surgery was done to manage severe iliotibial band syndrome. The patient will require close follow-up to monitor their progress and response to treatment. Physical therapy and pain management will be initiated, and a follow-up appointment is scheduled in two weeks for further evaluation.

3. Operative Note: Patient underwent open iliotibial band release and bursectomy on the left knee under general anesthesia. The surgery was performed to treat mild iliotibial band syndrome. The patient will be started on a rehabilitation program and advised to modify their activities. A follow-up appointment is scheduled in four weeks to assess the response to treatment and provide further guidance.

4. Operative Note: Iliotibial band tenotomy and debridement of the lateral femoral condyle were performed on the patient's right knee under local anesthesia. The procedure was done to manage advanced iliotibial band syndrome. The patient will require close postoperative monitoring and follow-up appointments to assess their pain levels, range of motion, and overall recovery progress. Further interventions, such as physical therapy or additional surgical procedures, will be determined based on the patient's response.

5. Operative Note: Patient underwent minimally invasive endoscopic iliotibial band release and joint washout on the left knee under monitored anesthesia care. The surgery was performed to address recurrent iliotibial band syndrome with mild inflammation. The patient will be advised to gradually resume their activities and will have a follow-up appointment in six weeks to evaluate the response to treatment and provide further recommendations.

6. Operative Note: Arthroscopic bursectomy, iliotibial band release, and synovectomy were performed on the patient's right knee under general anesthesia. The surgery was done to manage severe iliotibial band syndrome with significant inflammation and synovial involvement. The patient will require frequent follow-up visits for wound care, pain management, and assessment of their recovery progress. Further interventions, such as corticosteroid injections or additional surgeries, may be considered based on the patient's response.

7. Operative Note: Iliotibial band release with lateral retinacular lengthening and joint irrigation were performed on the patient's left knee under regional anesthesia. The surgery was performed to treat moderate iliotibial band syndrome. The patient will be started on a comprehensive rehabilitation program and closely monitored during the recovery process. A follow-up appointment is scheduled in four weeks to assess the response to treatment and make further recommendations.

8. Operative Note: Patient underwent open iliotibial band release and lateral patellar realignment on the right knee under general anesthesia. The surgery was performed to manage advanced iliotibial band syndrome with patellar malalignment. Postoperative follow-up will include physical therapy and regular monitoring of the patient's knee alignment and function. Additional interventions, such as bracing or further surgical procedures, will be determined based on the patient's progress.

9. Operative Note: Iliotibial band fractional lengthening with joint debridement and corticosteroid injection were performed on

the patient's left knee under local anesthesia. The surgery was done to treat moderate iliotibial band syndrome with significant inflammation. The patient will undergo regular follow-up appointments for wound care, pain management, and assessment of their response to treatment. Further interventions or adjustments to the treatment plan will be made accordingly.

10. Operative Note: Patient underwent endoscopic iliotibial band release and joint debridement on the right knee under monitored anesthesia care. The surgery was performed to manage mild iliotibial band syndrome. The patient will receive postoperative instructions regarding activity modification, pain management, and the use of assistive devices if necessary. A follow-up appointment is scheduled in six weeks to evaluate the patient's progress and determine the need for further intervention or rehabilitation.

## M76.4 Tibial collateral bursitis [Pellegrini-Stieda]

1. Operative Note - Tibial Collateral Bursitis Excision: A 5 cm incision was made over the tibial collateral bursa. The bursa was identified, dissected, and excised completely. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and no intraoperative complications were encountered.

2. Operative Note - Arthroscopic Debridement of Tibial Collateral Bursitis: A standard arthroscopic technique was employed. The tibial collateral bursa was visualized, and excessive synovial tissue was meticulously debrided. Any loose bodies were removed, and the bursal cavity was thoroughly irrigated. The arthroscope was removed, and the incisions were closed. The patient's postoperative course was uneventful.

3. Operative Note - Bursectomy for Tibial Collateral Bursitis: A curvilinear incision was made along the medial aspect of the knee. The tibial collateral bursa was identified and excised in its entirety. Careful attention was given to preserving adjacent structures. Hemostasis was ensured, and the wound was closed in layers. The patient's pain and swelling significantly improved following the procedure.

4. Operative Note - Open Drainage of Tibial Collateral Bursitis: A longitudinal incision was made over the tibial collateral bursa. The bursal fluid was drained, and copious irrigation was performed. The cavity was packed with sterile gauze to promote continued drainage. The wound was left open for secondary intention healing. The patient was instructed on wound care and scheduled for follow-up.

5. Operative Note - Ultrasound-Guided Aspiration of Tibial Collateral Bursitis: Under ultrasound guidance, a 21-gauge needle was inserted into the tibial collateral bursa. Aspiration was performed to evacuate the fluid. Sterile dressings were applied, and the patient was advised to monitor for any signs of infection. Follow-up imaging was recommended to ensure resolution of the bursitis.

6. Operative Note - Corticosteroid Injection for Tibial Collateral Bursitis: Following sterile preparation, a local anesthetic was administered. Under fluoroscopic guidance, a needle was advanced into the tibial collateral bursa, and a mixture of corticosteroid and local anesthetic was injected. The patient tolerated the procedure well, and immediate pain relief was reported. Post-injection instructions were provided.

7. Operative Note - Endoscopic Bursectomy for Tibial Collateral Bursitis: Utilizing an endoscope, the tibial collateral bursa was visualized. Careful dissection and electrocautery were employed to remove the bursal lining. Hemostasis was achieved, and the wound was closed with absorbable sutures. The patient experienced improved range of motion postoperatively and was referred for physical therapy.

8. Operative Note - Percutaneous Bursectomy for Tibial Collateral Bursitis: Under sterile conditions, a percutaneous approach was utilized. A small incision was made, and specialized instruments were used to remove the bursal tissue. Hemostasis was ensured, and the incision was closed with adhesive strips. The patient was instructed to avoid activities that could irritate the area.

9. Operative Note - Laser Ablation of Tibial Collateral Bursitis: A minimally invasive approach was employed. The laser fiber was introduced into the tibial collateral bursa, and laser energy was delivered to ablate the inflamed tissue. The bursa was thoroughly irrigated, and a drain was placed. The patient reported reduced pain and swelling

postoperatively, with no complications encountered.

10. Operative Note - Radiofrequency Ablation for Tibial Collateral Bursitis: Utilizing fluoroscopic guidance, a radiofrequency probe was inserted into the tibial collateral bursa. Radiofrequency energy was applied to ablate the bursal tissue. Hemostasis was achieved, and the wound was closed. The patient's symptoms improved significantly, and they were advised to follow up for further evaluation.

1. Operative Note - Bursectomy with Partial Bursal Wall Resection: A longitudinal incision was made over the tibial collateral bursa. The bursal wall was partially excised to promote drainage and prevent recurrence. Careful dissection was performed to preserve adjacent structures. Hemostasis was achieved, and the wound was closed in layers. The patient's pain and swelling showed marked improvement postoperatively.

2. Operative Note - Arthroscopic Bursectomy and Synovectomy for Tibial Collateral Bursitis: Using arthroscopic instruments, the tibial collateral bursa was accessed. The bursa was meticulously excised, and synovial tissue was debrided. Any adhesions were released, and thorough irrigation was performed. The arthroscope was withdrawn, and the portals were closed. The patient was instructed on rehabilitation exercises.

3. Operative Note - Excision and Cauterization of Tibial Collateral Bursitis: A curvilinear incision was made over the bursa. The bursal sac was excised, and any remaining tissue was carefully cauterized to minimize the risk of recurrence. Hemostasis was ensured, and the wound was closed. The patient was advised on postoperative care and scheduled for follow-up evaluation.

4. Operative Note - Endoscopic Bursal Wall Fenestration for Tibial Collateral Bursitis: Using an endoscope, the tibial collateral bursa was visualized. A fenestration was created in the bursal wall to promote drainage and prevent fluid accumulation. The bursa was thoroughly irrigated, and the incisions were closed. The patient reported improved symptoms in the early postoperative period.

5. Operative Note - Percutaneous Lavage and Steroid Injection for Tibial Collateral Bursitis: Following aseptic preparation, a needle was inserted into the bursa. Lavage was performed using a saline solution to flush out inflammatory debris. Subsequently, a mixture of corticosteroid and local anesthetic was injected. The patient experienced relief of pain and was counseled on the potential benefits and risks of the procedure.

6. Operative Note - Open Debridement and Capsulectomy of Tibial Collateral Bursitis: An incision was made over the tibial collateral bursa. The bursa was opened, and extensive debridement of inflamed tissue was performed. The surrounding capsule was excised to reduce the risk of recurrence. Hemostasis was achieved, and the wound was closed. The patient was advised on postoperative care and follow-up.

7. Operative Note - Bursectomy with Continuous Passive Motion (CPM) Therapy for Tibial Collateral Bursitis: The bursa was accessed through a longitudinal incision. The bursal tissue was excised, and thorough irrigation was performed. Subsequently, a CPM device was applied to the patient's knee to promote early mobilization and prevent stiffness. The patient tolerated the procedure well, and postoperative rehabilitation was initiated.

8. Operative Note - Mini-Open Bursectomy and Partial Bursal Excision for Tibial Collateral Bursitis: A mini-open approach was utilized, and a limited incision was made over the bursa. The bursal tissue was excised partially to preserve the integrity of nearby structures. Hemostasis was achieved, and the wound was closed with sutures. The patient's symptoms improved gradually, and physiotherapy was recommended.

9. Operative Note - Excision of Tibial Collateral Bursitis with Fascial Closure: A curvilinear incision was made over the bursa. The bursal sac was excised completely, and meticulous closure of the underlying fascia was performed. The wound was closed in layers, and a sterile dressing was applied. The patient experienced relief of symptoms postoperatively and was advised on wound care instructions.

10. Operative Note - Percutaneous Ultrasound-Guided Alcohol Injection for Tibial Collateral Bursitis: Under ultrasound guidance, a needle was inserted into the bursa. Alcohol was injected to induce sclerosis and subsequent reduction of bursal inflammation. The needle was removed, and sterile dressings were applied. The patient reported improvement in pain and was instructed on post-injection care.

1. Operative Note - Bursectomy with Local Anesthesia for Tibial Collateral Bursitis: A longitudinal incision was made over the tibial collateral bursa under local anesthesia. The bursa was excised completely, and meticulous hemostasis was achieved. The wound was closed, and the patient reported minimal discomfort during the procedure.

2. Operative Note - Arthroscopic Debridement with Regional Anesthesia for Tibial Collateral Bursitis: Regional anesthesia was administered to the patient. Arthroscopic instruments were used to perform debridement of the tibial collateral bursa. The procedure was well-tolerated, and the patient experienced satisfactory pain control postoperatively.

3. Operative Note - Excision and Cauterization with General Anesthesia for Tibial Collateral Bursitis: The patient underwent general anesthesia. A curvilinear incision was made, and the bursal sac was excised with meticulous cauterization. The wound was closed, and the patient recovered smoothly from anesthesia.

4. Operative Note - Percutaneous Lavage and Steroid Injection with Moderate Sedation for Tibial Collateral Bursitis: Moderate sedation was administered to the patient. Percutaneous lavage of the bursa was performed, followed by a corticosteroid and local anesthetic injection. The patient remained comfortable throughout the procedure, and postoperative pain was effectively managed.

5. Operative Note - Endoscopic Bursectomy with Spinal Anesthesia for Tibial Collateral Bursitis: The patient received spinal anesthesia. An endoscope was utilized to visualize and perform bursectomy of the tibial collateral bursa. The procedure was successfully completed, and the patient did not experience any intraoperative discomfort.

6. Operative Note - Open Debridement with General Anesthesia and Nerve Block for Tibial Collateral Bursitis: The patient was placed under general anesthesia with an additional nerve block. An open debridement of the bursa was performed, ensuring complete removal of inflamed tissue. The patient remained stable throughout the procedure, and postoperative pain was effectively controlled.

7. Operative Note - Bursectomy with Local Anesthesia and Conscious Sedation for Tibial Collateral Bursitis: Local anesthesia was administered with conscious sedation. The bursa was excised completely, and the patient remained relaxed and comfortable throughout the procedure. Adequate pain relief was achieved postoperatively.

8. Operative Note - Arthroscopic Bursectomy with General Anesthesia and Regional Nerve Block for Tibial Collateral Bursitis: The patient underwent general anesthesia with a regional nerve block. Arthroscopic bursectomy was performed, ensuring thorough removal of inflamed tissue. The patient had stable vital signs throughout the procedure, and postoperative pain was effectively managed.

9. Operative Note - Excision and Cauterization with Spinal Anesthesia and Sedation for Tibial Collateral Bursitis: Spinal anesthesia was administered along with sedation. The bursal sac was excised and cauterized meticulously. The patient remained comfortable and cooperative during the procedure, and pain control was satisfactory in the postoperative period.

10. Operative Note - Percutaneous Lavage and Steroid Injection with Local Anesthesia for Tibial Collateral Bursitis: Local anesthesia was administered to the patient. Percutaneous lavage of the bursa was performed, followed by a corticosteroid and local anesthetic injection. The patient tolerated the procedure well, and pain relief was achieved without any complications.

1. Operative Note - Bursectomy with Bone Erosion Evaluation for Tibial Collateral Bursitis: A longitudinal incision was made over the tibial collateral bursa. During the bursectomy, bone erosion was noted in the adjacent tibia. The bursa was excised completely, and the extent of bone erosion was assessed. The wound was closed, and the patient was referred for further imaging and orthopedic evaluation.

2. Operative Note - Arthroscopic Debridement and Bone Erosion Repair for Tibial Collateral Bursitis: Arthroscopic instruments were utilized to access the tibial collateral bursa. Significant bone erosion was observed, and careful debridement was performed. The eroded area was filled with bone graft material and secured with sutures. The patient tolerated the procedure well, and postoperative imaging showed successful bone erosion repair.

3. Operative Note - Excision, Bone Erosion Assessment, and Bone Stimulator Placement for Tibial Collateral Bursitis: The bursal sac was excised through a curvilinear incision. Intraoperatively, bone erosion was detected in the adjacent tibia. After meticulous assessment, a bone stimulator was placed to promote bone healing. The wound was closed, and the patient was advised on proper bone stimulator usage.

4. Operative Note - Open Debridement, Bone Erosion Evaluation, and Bone Grafting for Tibial Collateral Bursitis: An open debridement was performed, revealing bone erosion in the tibial region. The eroded area was thoroughly evaluated, and a bone graft was placed to support bone regeneration. The wound was closed, and the patient was instructed on weight-bearing restrictions and follow-up care.

5. Operative Note - Bone Erosion Repair with Arthroscopic Bone Anchors for Tibial Collateral Bursitis: Arthroscopic evaluation of the tibial collateral bursa revealed extensive bone erosion. Bone anchors were inserted into the eroded area to provide stability and promote bone healing. The procedure was successful, and the patient's postoperative course was uneventful.

6. Operative Note - Bursectomy, Bone Erosion Assessment, and Antibiotic Spacer Placement for Tibial Collateral Bursitis: Following bursa excision, bone erosion was noted in the adjacent tibia. The eroded area was thoroughly evaluated, and an antibiotic spacer was placed to address potential infection and facilitate bone regeneration. The wound was closed, and the patient was prescribed a course of antibiotic therapy.

7. Operative Note - Bone Erosion Repair with Autograft and Internal Fixation for Tibial Collateral Bursitis: Intraoperative assessment revealed significant bone erosion associated with the bursitis. Autograft material was harvested and used to repair the eroded bone. Internal fixation devices were employed for stabilization. The patient's pain and swelling gradually resolved postoperatively.

8. Operative Note - Arthroscopic Debridement, Bone Erosion Evaluation, and Bone Substitute Placement for Tibial Collateral Bursitis: Arthroscopic debridement of the bursa was performed, exposing underlying bone erosion. The eroded area was assessed, and a bone substitute material was applied to promote bone regeneration. The patient's symptoms improved, and follow-up imaging was recommended to monitor bone healing.

9. Operative Note - Excision, Bone Erosion Evaluation, and Allograft Implantation for Tibial Collateral Bursitis: The bursal sac was excised, and bone erosion was identified during the procedure. Thorough evaluation of the eroded area was conducted, and an allograft was implanted to facilitate bone healing. The wound was closed, and the patient was instructed on postoperative care and rehabilitation.

10. Operative Note - Bone Erosion Repair with Bone Morphogenetic Protein (BMP) and External Fixation for Tibial Collateral Bursitis: Significant bone erosion was observed during the procedure. Bone morphogenetic protein (BMP) was applied to promote bone regeneration, and an external fixation device was employed to stabilize the affected area. The patient's progress was monitored closely, and gradual improvement was noted in subsequent follow-up visits.

1. Operative Note - Bursectomy with Bone Erosion Evaluation for Tibial Collateral Bursitis and Severe Bone Pain: A longitudinal incision was made over the tibial collateral bursa. During the bursectomy, severe bone pain was reported by the patient. Bone erosion was observed in the adjacent tibia. The bursa was excised completely, and meticulous assessment of the eroded bone was performed. The wound was closed, and the patient was referred for pain management and further orthopedic evaluation.

2. Operative Note - Arthroscopic Debridement and Bone Erosion Repair for Tibial Collateral Bursitis with Severe Bone Pain: Arthroscopic instruments were utilized to access the tibial collateral bursa. The patient experienced severe bone pain during the procedure. Significant bone erosion was noted, and thorough debridement was performed. The eroded area was repaired using bone graft material. The patient's pain was adequately managed postoperatively.

3. Operative Note - Excision, Bone Erosion Assessment, and Bone Stimulator Placement for Tibial Collateral Bursitis with Severe Bone Pain: The bursal sac was excised through a curvilinear incision. Severe bone pain was reported by the patient during the operation. Intraoperatively, bone erosion was detected in the adjacent tibia. After meticulous assessment, a bone stimulator was placed to promote bone healing and alleviate the severe bone pain. The wound was closed, and the patient was provided with appropriate pain management.

4. Operative Note - Open Debridement, Bone Erosion Evaluation, and Bone Grafting for Tibial Collateral Bursitis with Severe Bone Pain: An open debridement was performed, revealing severe bone pain associated with extensive bone erosion. The eroded area was thoroughly evaluated, and a bone graft was placed to support bone regeneration and alleviate the severe bone pain. The wound was closed, and the patient received adequate postoperative pain control.

5. Operative Note - Bone Erosion Repair with Arthroscopic Bone Anchors for Tibial Collateral Bursitis and Severe Bone Pain: Arthroscopic evaluation of the tibial collateral bursa revealed severe bone pain experienced by the patient. Extensive bone erosion was observed. Bone anchors were inserted into the eroded area to provide stability and alleviate the severe bone pain. The procedure was successful, and the patient reported significant pain relief postoperatively.

6. Operative Note - Bursectomy, Bone Erosion Assessment, and Antibiotic Spacer Placement for Tibial Collateral Bursitis with Severe Bone Pain: Following the bursa excision, the patient experienced severe bone pain associated with bone erosion in the adjacent tibia. The eroded area was thoroughly evaluated, and an antibiotic spacer was placed to address potential infection and alleviate the severe bone pain. The wound was closed, and the patient was prescribed appropriate pain medications.

7. Operative Note - Bone Erosion Repair with Autograft and Internal Fixation for Tibial Collateral Bursitis with Severe Bone Pain: The patient presented with severe bone pain in relation to the bone erosion associated with the bursitis. Autograft material was harvested and used to repair the eroded bone, providing stability and relief from the severe bone pain. Internal fixation devices were employed to ensure proper alignment. The patient experienced gradual pain reduction postoperatively.

8. Operative Note - Arthroscopic Debridement, Bone Erosion Evaluation, and Bone Substitute Placement for Tibial Collateral Bursitis with Severe Bone Pain: Severe

bone pain was reported by the patient during the arthroscopic debridement. Bone erosion was observed, and thorough evaluation was conducted. A bone substitute material was applied to promote bone regeneration and alleviate the severe bone pain. The patient's pain level significantly decreased in the postoperative period.

9. Operative Note - Excision, Bone Erosion Evaluation, and Allograft Implantation for Tibial Collateral Bursitis with Severe Bone Pain: The bursal sac was excised, and the patient experienced severe bone pain related to the bone erosion. Thorough evaluation of the eroded area was conducted, and an allograft was implanted to facilitate bone healing and alleviate the severe bone pain. The wound was closed, and the patient was provided with appropriate pain management strategies.

10. Operative Note - Bone Erosion Repair with Bone Morphogenetic Protein (BMP) and External Fixation for Tibial Collateral Bursitis with Severe Bone Pain: Severe bone pain was reported by the patient during the bone erosion repair procedure. Extensive bone erosion was noted. Bone morphogenetic protein (BMP) was applied to promote bone regeneration and alleviate the severe bone pain. External fixation was utilized for stabilization. The patient experienced significant pain relief postoperatively.

1. Operative Note - Arthroscopic Bursectomy and Debridement for Tibial Collateral Bursitis: Arthroscopic instruments were used to access the tibial collateral bursa. The bursa was excised, and thorough debridement was performed to remove inflamed tissues. Hemostasis was achieved, and the wound was closed. The patient tolerated the procedure well, and postoperative pain was managed effectively.

2. Operative Note - Open Bursectomy with Bursal Wall Resection for Tibial Collateral Bursitis: A curvilinear incision was made over the tibial collateral bursa. The bursal sac was excised, and a portion of the bursal wall was resected to prevent recurrence. The wound was meticulously closed, and the patient was provided with postoperative care instructions.

3. Operative Note - Endoscopic Bursectomy and Cauterization for Tibial Collateral Bursitis: Endoscopic instruments were introduced into the tibial collateral bursa. The bursa was excised, and careful cauterization was performed to ensure complete removal and reduce the risk of recurrence. The patient's symptoms improved postoperatively, and appropriate wound care was advised.

4. Operative Note - Bursectomy with Bone Erosion Repair for Tibial Collateral Bursitis: A longitudinal incision was made over the tibial collateral bursa. The bursal sac was excised, and concurrent evaluation of bone erosion was conducted. The eroded area was repaired using bone graft material. The wound was closed, and the patient was referred for further orthopedic evaluation.

5. Operative Note - Percutaneous Lavage and Drainage for Tibial Collateral Bursitis: Under local anesthesia, percutaneous lavage of the bursa was performed. A drain was inserted to facilitate postoperative drainage. The patient experienced relief of symptoms and was instructed on drain care and removal.

6. Operative Note - Arthroscopic Synovectomy for Tibial Collateral Bursitis: Arthroscopic access to the tibial collateral bursa was obtained. Synovectomy was performed to remove the inflamed synovial tissue. The procedure was successful, and the patient reported a decrease in pain and swelling postoperatively.

7. Operative Note - Open Excision and Suturing of Tibial Collateral Bursitis: A longitudinal incision was made over the bursa, and the bursal sac was excised. The wound was thoroughly irrigated, and layered suturing was performed to achieve primary closure. The patient's symptoms improved, and appropriate wound care instructions were given.

8. Operative Note - Percutaneous Aspiration and Corticosteroid Injection for Tibial Collateral Bursitis: Local anesthesia was administered, and percutaneous aspiration of the bursa was performed. Corticosteroid medication was then injected to alleviate inflammation. The procedure was well-tolerated, and the patient reported symptomatic relief.

9. Operative Note - Bursectomy with Arthroscopic Joint Debridement for Tibial Collateral Bursitis: Arthroscopic instruments were used to access the tibial collateral bursa and perform bursectomy. Additionally, joint debridement was carried out to address any associated intra-articular pathology. The patient's symptoms improved postoperatively, and appropriate rehabilitation was advised.

10. Operative Note - Open Excision with Bursal Wall Reconstruction for Tibial Collateral Bursitis: A curvilinear incision was made, and the bursal sac was excised. Reconstruction of the bursal wall was performed using local tissue flaps. The wound was closed meticulously, and the patient was provided with postoperative instructions for wound care and follow-up.

1. Operative Note - Arthroscopic Bursectomy and Capsular Release for Tibial Collateral Bursitis: Arthroscopic instruments were used to access the tibial collateral bursa. The bursa was excised, and concurrent capsular release was performed to address joint contracture. Hemostasis was achieved, and the wounds were closed. The patient's range of motion improved postoperatively, and physical therapy was recommended.

2. Operative Note - Open Excision with Tendon Repair for Tibial Collateral Bursitis: A longitudinal incision was made over the tibial collateral bursa. The bursal sac was excised, and concomitant repair of the affected tendon was performed. The wound was closed meticulously, and the patient was advised on postoperative rehabilitation.

3. Operative Note - Endoscopic Bursectomy and Synovial Biopsy for Tibial Collateral Bursitis: Endoscopic instruments were introduced into the tibial collateral bursa. The bursa was excised, and a synovial biopsy was obtained for further evaluation. The procedure was successful, and the patient was referred to a rheumatologist for further management.

4. Operative Note - Bursectomy with Joint Lavage and Steroid Injection for Tibial Collateral Bursitis: A longitudinal incision was made over the bursa, and the bursal sac was excised. Joint lavage was performed to remove debris, followed by the injection of a corticosteroid for anti-inflammatory effect. The patient reported significant improvement in pain and mobility postoperatively.

5. Operative Note - Arthroscopic Bursectomy with Loose Body Removal for Tibial Collateral Bursitis: Arthroscopic access to the tibial collateral bursa was obtained. The bursa was excised, and loose bodies within the joint were meticulously removed. The patient's symptoms improved, and follow-up imaging confirmed resolution of loose bodies.

6. Operative Note - Open Bursectomy with Tenodesis for Tibial Collateral Bursitis: A curvilinear incision was made over the bursa, and the bursal sac was excised. Tenodesis of the affected tendon was performed to stabilize the joint. The wound was closed, and the patient was instructed on postoperative immobilization and rehabilitation.

7. Operative Note - Excision with Cryotherapy for Tibial Collateral Bursitis: The bursa was excised through a longitudinal incision, and cryotherapy was applied to the surrounding tissues to reduce inflammation and pain. The wound was closed meticulously, and the patient was advised on cryotherapy follow-up sessions.

8. Operative Note - Arthroscopic Bursectomy and Partial Meniscectomy for Tibial Collateral Bursitis: Arthroscopic instruments were used to access the tibial collateral bursa. The bursa was excised, and partial meniscectomy was performed to address concurrent meniscal pathology. The patient's symptoms significantly improved, and rehabilitation was initiated.

9. Operative Note - Open Excision with Fasciotomy for Tibial Collateral Bursitis: A curvilinear incision was made, and the bursal sac was excised. Fasciotomy was performed to relieve pressure and improve circulation. The wounds were closed, and the patient's pain and swelling subsided postoperatively.

10. Operative Note - Bursectomy with Joint Arthrodesis for Tibial Collateral Bursitis: A longitudinal incision was made over the bursa, and the bursal sac was excised. Joint arthrodes

is was performed to stabilize the affected joint and alleviate symptoms. The wound was closed, and the patient was referred to an orthopedic specialist for long-term management.

1. Operative Note - Emergency Debridement and Washout for Tibial Collateral Bursitis with Severe Joint Infection: The patient presented with severe infection in the extreme moving joint associated with tibial collateral bursitis. Emergency debridement and washout were performed to remove infected tissues and debris. Copious irrigation with antimicrobial solution was carried out. The wound was left open for ongoing drainage, and appropriate antibiotic therapy was initiated.

2. Operative Note - Open Excision and Joint Exploration for Tibial Collateral Bursitis with Severe Joint Infection: An open excision was performed to remove the bursal sac. Joint exploration was conducted to assess the extent of the severe infection in the extreme moving joint. Pus was drained, and infected tissues were debrided. The joint was irrigated thoroughly with antibiotic solution. The wound was closed, and intravenous antibiotics were administered postoperatively.

3. Operative Note - Bursectomy with Debridement and Joint Lavage for Tibial Collateral Bursitis with Severe Joint Infection: The bursa was excised, and extensive debridement was performed to remove necrotic tissue and control the severe joint infection. The joint was lavaged with antimicrobial solution, and a drain was placed for ongoing drainage. The patient was started on intravenous antibiotics and closely monitored for any signs of worsening infection.

4. Operative Note - Arthroscopic Bursectomy with Joint Debridement and Irrigation for Tibial Collateral Bursitis with Severe Joint Infection: Arthroscopic access to the joint was obtained. The infected bursa was excised, and thorough debridement of infected tissues was carried out. The joint was irrigated with antimicrobial solution, and multiple fluid samples were sent for culture analysis. The patient was initiated on broad-spectrum antibiotics and closely monitored for clinical response.

5. Operative Note - Open Excision with Abscess Drainage and Joint Stabilization for Tibial Collateral Bursitis with Severe Joint Infection: An open excision of the bursa was performed. Abscesses within the joint were drained, and infected tissues were debrided. Joint stabilization procedures were undertaken to address joint instability caused by the severe infection. The wounds were closed, and intravenous antibiotics were administered.

6. Operative Note - Emergency Joint Washout with Capsulectomy for Tibial Collateral Bursitis with Severe Joint Infection: An emergency joint washout was performed to address the severe joint infection associated with tibial collateral bursitis. Capsulectomy was performed to improve access to infected areas. Copious irrigation with antimicrobial solution was carried out, and the wound was left open for ongoing drainage. The patient was started on intravenous antibiotics.

7. Operative Note - Bursectomy with Extensive Debridement and Vacuum-Assisted Closure for Tibial Collateral Bursitis with Severe Joint Infection: The bursa was excised, and extensive debridement of infected tissues was performed. Vacuum-assisted closure (VAC) therapy was initiated to facilitate wound healing and control the severe joint infection. The patient was administered intravenous antibiotics and closely monitored for response.

8. Operative Note - Arthroscopic Joint Debridement with Abscess Drainage for Tibial Collateral Bursitis with Severe Joint Infection: Arthroscopic access to the joint was obtained. Extensive joint debridement was performed to remove infected tissues. Abscesses were drained, and the joint was irrigated with antimicrobial solution. The patient received intravenous

antibiotics and appropriate wound care instructions.

9. Operative Note - Open Excision with Joint Flushing and Antibiotic Impregnated Spacer Implantation for Tibial Collateral Bursitis with Severe Joint Infection: An open excision of the bursa was performed, followed by thorough joint flushing with antibiotic solution. An antibiotic impregnated spacer was implanted to provide local antibiotic release and aid in infection control. The wound was closed, and intravenous antibiotics were continued postoperatively.

10. Operative Note - Bursectomy with Joint Resection and Antibiotic Bead Placement for Tibial Collateral Bursitis with Severe Joint Infection: The bursa was excised, and joint resection was performed to remove infected bone and tissue. Antibiotic-impregnated beads were placed to provide local antibiotic release. The wound was closed, and the patient was administered intravenous antibiotics for infection management.

1. Operative Note - Arthroscopic Bursectomy and Synovectomy for Acutely Inflamed Tibial Collateral Bursitis: Arthroscopic access to the tibial collateral bursa was obtained. The acutely inflamed bursa was excised, and synovectomy was performed to remove inflamed synovial tissue. The procedure was successful in alleviating symptoms, and postoperative anti-inflammatory medications were prescribed.

2. Operative Note - Open Excision and Debridement for Chronic Inflammatory Tibial Collateral Bursitis: A longitudinal incision was made over the tibial collateral bursa. The chronically inflamed bursal sac was excised, and meticulous debridement was performed to remove fibrotic and inflamed tissue. The wound was closed, and postoperative physical therapy was recommended.

3. Operative Note - Bursectomy with Anti-inflammatory Local Drug Delivery for Recurrent Inflammatory Tibial Collateral Bursitis: The bursa was excised, and a local drug delivery system was utilized to administer anti-inflammatory medication directly to the inflamed area. The procedure aimed to provide sustained relief from recurrent inflammation. The wound was closed, and the patient was instructed on follow-up care.

4. Operative Note - Arthroscopic Bursectomy with Corticosteroid Injection for Moderately Inflamed Tibial Collateral Bursitis: Arthroscopic instruments were used to access the tibial collateral bursa. The moderately inflamed bursa was excised, and a corticosteroid injection was administered to reduce inflammation. The patient experienced relief of symptoms, and appropriate postoperative rehabilitation was advised.

5. Operative Note - Open Excision with Intraoperative Anti-inflammatory Irrigation for Severe Inflammatory Tibial Collateral Bursitis: A curvilinear incision was made over the bursa, and the severely inflamed bursal sac was excised. Intraoperative irrigation with anti-inflammatory solution was performed to reduce inflammation. The wound was closed, and the patient was prescribed oral anti-inflammatory medications.

6. Operative Note - Bursectomy with Cryotherapy for Inflammatory Tibial Collateral Bursitis: The bursa was excised through a longitudinal incision, and cryotherapy was applied to the surrounding tissues to reduce inflammation. The cryotherapy technique aimed to alleviate symptoms and minimize postoperative inflammatory response. The wound was closed, and the patient was instructed on cryotherapy follow-up sessions.

7. Operative Note - Arthroscopic Bursectomy and Platelet-Rich Plasma (PRP) Injection for Mildly Inflamed Tibial Collateral Bursitis: Arthroscopic access to the bursa was obtained. The mildly inflamed bursa was excised, and a platelet-rich plasma (PRP) injection was administered to promote tissue healing and reduce inflammation. The patient's symptoms improved postoperatively, and postoperative activity modification was recommended.

8. Operative Note - Open Excision with Topical Anti-inflammatory Gel Application for Inflammatory Tibial Collateral Bursitis: An open excision of the bursa was performed, and topical anti-inflammatory gel was applied to the surgical site to reduce inflammation. The wound was closed, and the patient was advised on postoperative wound care and anti-inflammatory medication usage.

9. Operative Note - Bursectomy with Intraoperative Steroid Soaked Sponge Placement for Moderately Inflamed Tibial Collateral Bursitis: The bursa was excised, and intraoperative placement of a steroid soaked sponge was performed to provide localized anti-inflammatory effect. The procedure

aimed to minimize postoperative inflammation and promote symptom relief. The wound was closed, and appropriate postoperative follow-up was scheduled.

10. Operative Note - Arthroscopic Bursectomy with Biologic Modifiers Injection for Chronic Inflammatory Tibial Collateral Bursitis: Arthroscopic instruments were used to access the tibial collateral bursa. The chronically inflamed bursa was excised, and an injection of biologic modifiers was administered to modulate the inflammatory response. The patient experienced improvement in symptoms, and postoperative rehabilitation was initiated.

1. Operative Note - Arthroscopic Bursectomy for Mild Tibial Collateral Bursitis: Arthroscopic access to the tibial collateral bursa was obtained. The mildly inflamed bursa was excised, and thorough irrigation was performed. The patient was advised on postoperative pain management and instructed to follow up in 2 weeks for a reevaluation of symptoms.

2. Operative Note - Open Excision and Debridement for Moderate Tibial Collateral Bursitis: An open excision of the bursa was performed, followed by meticulous debridement of inflamed tissues. The wound was closed, and the patient was scheduled for a follow-up appointment in 4 weeks to assess wound healing and monitor symptom improvement.

3. Operative Note - Bursectomy with Joint Lavage and Steroid Injection for Severe Tibial Collateral Bursitis: The bursa was excised, and joint lavage was performed to remove debris. A steroid injection was administered to reduce inflammation. The patient was instructed to follow up in 1 week for a postoperative evaluation and to assess the response to treatment.

4. Operative Note - Arthroscopic Bursectomy and Synovectomy for Chronic Tibial Collateral Bursitis: Arthroscopic instruments were used to access the tibial collateral bursa. The chronically inflamed bursa was excised, and synovectomy was performed to remove inflamed synovial tissue. The patient was advised to schedule a follow-up appointment in 6 weeks to monitor long-term symptom improvement and assess the need for additional treatment.

5. Operative Note - Open Excision with Tenodesis for Recurrent Tibial Collateral Bursitis: A curvilinear incision was made over the bursa, and the bursal sac was excised. Tenodesis of the affected tendon was performed to address recurrent symptoms. The patient was scheduled for a follow-up visit in 3 weeks to evaluate the surgical outcome and consider further interventions if necessary.

6. Operative Note - Bursectomy with Joint Arthrodesis for Refractory Tibial Collateral Bursitis: A longitudinal incision was made over the bursa, and the bursal sac was excised. Joint arthrodesis was performed to stabilize the affected joint due to refractory symptoms. The patient was advised to follow up in 8 weeks to monitor the fusion process and assess overall symptom improvement.

7. Operative Note - Arthroscopic Bursectomy and Biologic Modifiers Injection for Inflammatory Tibial Collateral Bursitis: Arthroscopic access to the bursa was obtained. The inflamed bursa was excised, and an injection of biologic modifiers was administered to modulate the inflammatory response. The patient was scheduled for a follow-up appointment in 4 weeks to evaluate the efficacy of the biologic treatment and determine the need for further interventions.

8. Operative Note - Open Excision with Abscess Drainage for Infected Tibial Collateral Bursitis: A curvilinear incision was made over the bursa, and the infected bursal sac was excised. Abscesses were drained, and the wound was thoroughly irrigated. The patient was instructed to follow up in 2 weeks for wound assessment and to monitor for signs of infection recurrence.

9. Operative Note - Bursectomy with Joint Resection for Advanced Tibial Collateral Bursitis: The bursa was excised, and joint resection was performed to remove inflamed and damaged joint tissues. The patient was scheduled

for a follow-up visit in 6 weeks to evaluate the surgical outcome, assess joint stability, and discuss potential rehabilitation options.

10. Operative Note - Arthroscopic Bursectomy with Capsulectomy for Acute Tibial Collateral Bursitis: Arthroscopic access to the bursa was obtained. The acutely inflamed bursa was excised, and capsulectomy was performed to improve joint mobility. The patient was advised to follow up in 3 weeks to assess postoperative joint function and monitor for any recurrent symptoms.

## M76.5 Patellar tendinitis

1. Operative Note: Patient underwent arthroscopic debridement and resection of patellar tendon adhesions. The affected area was meticulously explored, and fibrotic tissue was excised. Hemostasis was achieved, and the wound was closed in layers. Postoperative instructions provided.

2. Operative Note: Patient underwent ultrasound-guided percutaneous needle tenotomy for patellar tendinitis. A 21-gauge needle was inserted under local anesthesia, and multiple punctures were made along the tendon. Careful monitoring of the needle path was ensured to prevent complications. Post-procedure, the patient was instructed to rest and apply ice packs.

3. Operative Note: Patient underwent extracorporeal shockwave therapy (ESWT) for patellar tendinitis. A high-energy shockwave generator was used to deliver acoustic pulses to the affected area. Treatment parameters were adjusted to the patient's tolerance. Post-treatment, the patient was advised to avoid strenuous activities and follow a rehabilitation program.

4. Operative Note: Patient underwent platelet-rich plasma (PRP) injection for patellar tendinitis. A syringe containing autologous PRP was prepared, and under ultrasound guidance, the PRP was injected into the affected tendon. The injection site was covered with a sterile dressing. The patient was advised to limit physical activity and follow up for further treatment.

5. Operative Note: Patient underwent open patellar tendon release surgery for chronic patellar tendinitis. A longitudinal incision was made, and the patellar tendon was exposed. Partial release of the tendon was performed to relieve tension. The wound was closed meticulously, and a knee immobilizer was applied. Postoperatively, the patient was advised to use crutches and follow a rehabilitation program.

6. Operative Note: Patient underwent arthroscopic patellar tendon debridement with bursectomy. The knee joint was accessed, and the inflamed bursa was carefully excised. Subsequently, meticulous debridement of the patellar tendon was performed to remove degenerated tissue. Hemostasis was achieved, and the incisions were closed. Postoperatively, the patient was advised to undergo physical therapy.

7. Operative Note: Patient underwent minimally invasive needle aspiration of the prepatellar bursa for patellar tendinitis. Under sterile conditions, a 16-gauge needle was inserted into the bursa, and the fluid was aspirated. The area was then cleaned, and a sterile dressing was applied. Post-procedure, the patient was advised to rest and monitor for signs of infection.

8. Operative Note: Patient underwent autologous tenocyte implantation (ATI) for chronic patellar tendinitis. A small tissue sample was harvested from the patient's healthy tendon, and tenocytes were isolated and expanded in culture. The cultured cells were then implanted into the damaged tendon under ultrasound guidance. Postoperatively, the patient was instructed to protect the tendon and follow a rehabilitation program.

9. Operative Note: Patient underwent endoscopic patellar tendon release for recalcitrant patellar tendinitis. Two small incisions were made, and an endoscope and specialized instruments were inserted. The patellar tendon was visualized, and partial release was performed to relieve tension. The wounds were closed, and the patient was advised to follow a gradual return-to-activity program.

10. Operative Note: Patient underwent ultrasound-guided high-volume saline injection for patellar tendinitis. Under local anesthesia, a large volume of sterile saline was injected into the affected tendon. The injection helped to mechanically disrupt scar tissue and stimulate healing. The patient was advised to rest and gradually increase activity levels under supervision.

1. Operative Note: Patient underwent percutaneous ultrasonic tenotomy for the management of chronic patellar tendinitis. Ultrasonic energy was applied to the degenerative tissue within the tendon, promoting its breakdown and removal. The procedure was performed under local anesthesia, and the patient tolerated it well. Postoperatively, the patient was advised to follow a structured rehabilitation program.

2. Operative Note: Patient underwent minimally invasive radiofrequency ablation (RFA) for patellar tendinitis. A specialized RFA probe was inserted near the affected tendon, and radiofrequency energy was used to ablate the pain fibers and promote tissue healing. The procedure was performed under fluoroscopic guidance, and the patient experienced immediate pain relief. Post-procedure, the patient was instructed to gradually resume activities.

3. Operative Note: Patient underwent open patellar tendon repair surgery for severe patellar tendinitis. The damaged portion of the tendon was identified and carefully excised. The remaining healthy tendon ends were then sutured together using non-absorbable sutures. The incision was closed in layers, and a knee immobilizer was applied. Postoperatively, the patient was prescribed a rehabilitation program.

4. Operative Note: Patient underwent autologous hamstring tendon grafting for patellar tendinitis with chronic patellar instability. The hamstring tendon was harvested, prepared, and then secured within the patellar tendon using bone tunnels and sutures. The knee was immobilized, and the patient was advised to use crutches. A rehabilitation program was initiated to restore strength and stability.

5. Operative Note: Patient underwent arthroscopic subcutaneous patellar tendon release for patellar tendinitis. A small incision was made, and the subcutaneous tissues overlying the patellar tendon were released using specialized instruments. The procedure was performed under arthroscopic visualization, ensuring minimal disruption to surrounding structures. Postoperatively, the patient was instructed to use a knee brace and engage in physical therapy.

6. Operative Note: Patient underwent shockwave-guided percutaneous needle tenotomy and platelet-rich plasma (PRP) injection for patellar tendinitis. Shockwave therapy was first administered to the affected tendon, followed by percutaneous needle tenotomy to induce controlled microtrauma. Subsequently, PRP was injected into the tendon to stimulate healing. The patient was advised to rest and gradually increase activity levels.

7. Operative Note: Patient underwent minimally invasive laser therapy for patellar tendinitis. A laser probe was inserted near the affected tendon, and laser energy was delivered to stimulate tissue healing and reduce inflammation. The procedure was performed under ultrasound guidance, ensuring accurate placement. Post-treatment, the patient was advised to follow a rehabilitation program and avoid excessive strain on the knee.

8. Operative Note: Patient underwent arthroscopic debridement and microfracture technique for patellar tendinitis. The knee joint was accessed using arthroscopic portals, and the degenerative tissue within the tendon was meticulously debrided. Microfracture was then performed by creating small holes in the bone beneath the tendon, promoting the formation of new cartilage. The patient was instructed to follow a structured rehabilitation protocol.

9. Operative Note: Patient underwent percutaneous needle tenotomy combined with hyaluronic acid injection for patellar tendinitis. Under ultrasound guidance, a needle was used to perform tenotomy on the affected tendon, followed by the injection of hyaluronic acid to improve lubrication and reduce pain. The procedure was well-tolerated, and the patient was advised to limit high-impact activities during the recovery period.

10. Operative Note: Patient underwent open patellar tendon lengthening surgery for patellar tendinitis

with associated patellar contracture. The tight patellar tendon was released by making a longitudinal incision, and careful lengthening was performed to improve joint mechanics. The wound was closed, and a knee immobilizer was applied. Postoperatively, the patient was prescribed a rehabilitation program focused on regaining flexibility and strength.

1. Operative Note: Patient underwent arthroscopic debridement and resection of patellar tendon adhesions under general anesthesia. The affected area was meticulously explored, and fibrotic tissue was excised. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and appropriate postoperative pain management was provided.

2. Operative Note: Patient underwent ultrasound-guided percutaneous needle tenotomy for patellar tendinitis under local anesthesia with sedation. A 21-gauge needle was inserted, and multiple punctures were made along the tendon. The patient remained comfortable throughout the procedure, and post-procedure pain was managed with analgesics. Instructions regarding postoperative care were provided.

3. Operative Note: Patient underwent extracorporeal shockwave therapy (ESWT) for patellar tendinitis under local anesthesia. The high-energy shockwave generator was used to deliver acoustic pulses to the affected area. The patient experienced minimal discomfort during the procedure. Post-treatment, the patient was advised on pain management strategies and rehabilitation exercises.

4. Operative Note: Patient underwent platelet-rich plasma (PRP) injection for patellar tendinitis under local anesthesia and conscious sedation. A syringe containing autologous PRP was prepared, and under ultrasound guidance, the PRP was injected into the affected tendon. The patient remained calm and pain-free during the procedure. Postoperatively, pain relief measures were discussed.

5. Operative Note: Patient underwent open patellar tendon release surgery for chronic patellar tendinitis under regional anesthesia. A longitudinal incision was made, and the patellar tendon was exposed. Partial release of the tendon was performed to relieve tension. The patient was comfortable throughout the procedure, and postoperative pain was managed accordingly.

6. Operative Note: Patient underwent arthroscopic patellar tendon debridement with bursectomy under general anesthesia with reduced dosage. The knee joint was accessed, and the inflamed bursa was carefully excised. Meticulous debridement of the patellar tendon was performed to remove degenerated tissue. The patient tolerated the procedure well, and postoperative pain was effectively controlled.

7. Operative Note: Patient underwent minimally invasive needle aspiration of the prepatellar bursa for patellar tendinitis under local anesthesia. A 16-gauge needle was inserted into the bursa, and the fluid was aspirated. The patient reported minimal discomfort during the procedure. Post-procedure, the patient was instructed on pain management and follow-up care.

8. Operative Note: Patient underwent autologous tenocyte implantation (ATI) for chronic patellar tendinitis under general anesthesia with increased dosage. The cultured cells were implanted into the damaged tendon under ultrasound guidance. The patient was comfortably sedated throughout the procedure, and appropriate postoperative pain management was provided.

9. Operative Note: Patient underwent endoscopic patellar tendon release for recalcitrant patellar tendinitis under regional anesthesia. Two small incisions were made, and an endoscope and specialized instruments were inserted. The patient remained pain-free throughout the procedure. Postoperatively, pain control measures were discussed, and the patient was advised on rehabilitation protocols.

10. Operative Note: Patient underwent ultrasound-guided high-volume saline injection for patellar tendinitis under local anesthesia with monitored anesthesia care. A large volume of sterile saline was injected into the affected tendon. The patient experienced minimal discomfort during the procedure. Postoperatively, pain management strategies were discussed, and the patient was educated on activity modification.

1. Operative Note: Patient underwent arthroscopic debridement and resection of patellar tendon adhesions with bone erosion due to patellar tendinitis. The affected area was meticulously explored, and fibrotic tissue as well as eroded bone fragments were excised. Careful attention was given to restore the integrity of the patellar tendon and address the bone erosion. Postoperatively, the patient was prescribed a comprehensive rehabilitation program.

2. Operative Note: Patient underwent open patellar tendon repair surgery for severe patellar tendinitis with extensive bone erosion. The damaged portion of the tendon was excised, and the eroded bone was carefully debrided. The remaining healthy tendon ends were then sutured together, and bone grafting was performed to reconstruct the eroded area. The patient was instructed on postoperative care and rehabilitation.

3. Operative Note: Patient underwent autologous hamstring tendon grafting with bone augmentation for patellar tendinitis and significant bone erosion. The hamstring tendon graft was harvested and secured within the patellar tendon using bone tunnels and screws. Additional bone grafting was performed to address the erosion. Postoperatively, the patient was advised on weight-bearing restrictions and followed up closely.

4. Operative Note: Patient underwent arthroscopic microfracture technique combined with bone grafting for patellar tendinitis with substantial bone erosion. Microfracture was performed to create channels in the eroded bone, and bone grafting was subsequently done to stimulate cartilage regeneration. The patient was advised on protected weight-bearing and participated in a structured rehabilitation program.

5. Operative Note: Patient underwent open patellar tendon lengthening surgery with bone reconstruction for chronic patellar tendinitis and bone erosion. The tight patellar tendon was released, and careful lengthening was performed. Bone grafting and fixation were carried out to address the eroded bone. Postoperatively, the patient was prescribed a specialized rehabilitation protocol to ensure optimal healing.

6. Operative Note: Patient underwent arthroscopic debridement and bone erosion repair for patellar tendinitis. The patellar tendon was carefully examined, and the eroded bone fragments were meticulously removed. The remaining healthy tendon was preserved, and the eroded bone was reconstructed using bone grafting techniques. The patient was instructed on postoperative care and the importance of adhering to the rehabilitation program.

7. Operative Note: Patient underwent open patellar tendon release surgery with bone reconstruction for severe patellar tendinitis and significant bone erosion. The tight tendon was released, and the eroded bone was addressed by using bone grafts and fixation devices. The patient tolerated the procedure well, and appropriate pain management and rehabilitation strategies were implemented.

8. Operative Note: Patient underwent autologous tenocyte implantation (ATI) with bone grafting for chronic patellar tendinitis and associated bone erosion. The tenocytes were implanted into the damaged tendon, and bone grafts were carefully placed to promote the restoration of eroded bone. The patient was closely monitored postoperatively and provided with specific guidelines for rehabilitation and weight-bearing.

9. Operative Note: Patient underwent arthroscopic subcutaneous patellar tendon release with bone erosion repair for patellar tendinitis. The subcutaneous tissues overlying the patellar tendon were released, and meticulous attention was given to address the bone erosion. Bone grafts were used to fill the eroded areas and facilitate bone healing. The patient received postoperative instructions for pain management and rehabilitation.

10. Operative Note: Patient underwent minimally invasive needle aspiration of the prepatellar bursa with bone erosion repair for patellar tendinitis. The bursa fluid was aspirated, and the eroded bone was carefully treated using bone grafting

techniques. The patient experienced minimal discomfort during the procedure, and appropriate postoperative care was discussed, including pain management and activity modification.

1. Operative Note: Patient with severe bone pain due to patellar tendinitis underwent arthroscopic debridement and resection of adhesions. The procedure aimed to alleviate the pain by removing fibrotic tissue and addressing underlying bone pathology. Careful attention was given to the eroded bone, and appropriate measures were taken to promote healing and reduce pain. Postoperatively, the patient was provided with pain management strategies and scheduled for follow-up assessments.

2. Operative Note: Patient with severe bone pain associated with patellar tendinitis underwent open patellar tendon repair surgery. The procedure aimed to address the underlying tendon pathology and the eroded bone causing pain. The damaged tendon was excised, and bone grafting was performed to promote healing and alleviate pain. The patient was instructed on postoperative pain management and rehabilitation exercises.

3. Operative Note: Patient with severe bone pain from patellar tendinitis underwent autologous hamstring tendon grafting with bone augmentation. The procedure aimed to address the eroded bone and reconstruct the damaged tendon, relieving pain. Bone grafting was performed to promote bone healing and reduce pain. Postoperatively, the patient was prescribed pain medications and initiated on a structured rehabilitation program.

4. Operative Note: Patient with severe bone pain associated with patellar tendinitis underwent arthroscopic microfracture technique combined with bone grafting. The procedure aimed to alleviate pain by promoting cartilage regeneration and addressing the eroded bone. Microfracture was performed to create channels for cartilage growth, and bone grafts were placed to stimulate healing. Postoperatively, the patient received pain management strategies and instructions for rehabilitation.

5. Operative Note: Patient with severe bone pain due to patellar tendinitis and bone erosion underwent open patellar tendon lengthening surgery with bone reconstruction. The procedure aimed to relieve pain by releasing the tight tendon and addressing the eroded bone. Bone grafting and fixation were performed to promote bone healing and reduce pain. Postoperatively, the patient was provided with pain medications and initiated on a specialized rehabilitation protocol.

6. Operative Note: Patient with severe bone pain associated with patellar tendinitis and bone erosion underwent arthroscopic debridement and bone erosion repair. The procedure aimed to alleviate pain by removing damaged tissue and addressing the eroded bone. Careful attention was given to reconstruct the bone and promote healing. Postoperatively, the patient was prescribed pain management medications and instructed on rehabilitation exercises.

7. Operative Note: Patient with severe bone pain due to patellar tendinitis underwent open patellar tendon release surgery with bone reconstruction. The procedure aimed to alleviate pain by releasing the tight tendon and addressing the eroded bone. Bone grafts and fixation were utilized to promote healing and reduce pain. Postoperatively, the patient received pain management strategies and was initiated on a structured rehabilitation program.

8. Operative Note: Patient with severe bone pain associated with patellar tendinitis and bone erosion underwent autologous tenocyte implantation (ATI) with bone grafting. The procedure aimed to address the underlying tendon pathology and relieve bone pain. Tenocytes were implanted into the damaged tendon, and bone grafts were used to promote healing and reduce pain. Postoperatively, the patient received pain management medications and was scheduled for follow-up assessments.

9. Operative Note: Patient with severe bone pain due to patellar tendinitis underwent arthroscopic subcutaneous patellar tendon release with bone erosion repair. The procedure aimed to alleviate pain by releasing the tight tendon and addressing the eroded bone. Bone grafts were used to fill the eroded areas and promote healing. The patient received postoperative pain management strategies and was instructed on rehabilitation exercises.

10. Operative Note: Patient with severe

bone pain associated with patellar tendinitis and bone erosion underwent minimally invasive needle aspiration of the prepatellar bursa with bone erosion repair. The procedure aimed to alleviate pain by removing excess fluid from the bursa and addressing the eroded bone. Bone grafting techniques were employed to stimulate healing and reduce pain. Postoperatively, the patient received pain management instructions and was scheduled for follow-up evaluations.

1. Operative Note: Patient with severe bone pain and refractory patellar tendinitis underwent surgical intervention in the form of open patellar tendon debridement and bone resurfacing. The procedure involved meticulous removal of degenerated tissue and recontouring of the eroded bone surface. The aim was to alleviate pain and promote tendon healing. Postoperatively, the patient was prescribed a comprehensive rehabilitation program.

2. Operative Note: Patient with severe bone pain and recalcitrant patellar tendinitis underwent surgical intervention in the form of arthroscopic patellar tendon repair with bone augmentation. The procedure involved reattaching the damaged tendon using sutures and reinforcing it with bone grafts to enhance stability and alleviate pain. Postoperatively, the patient received pain management strategies and was instructed on a tailored rehabilitation protocol.

3. Operative Note: Patient with severe bone pain and chronic patellar tendinitis underwent surgical intervention in the form of minimally invasive percutaneous tenotomy with bone erosion repair. The procedure involved making small incisions and using specialized instruments to release the tight tendon and address the eroded bone. Postoperatively, the patient received pain medication and was advised on appropriate rehabilitation exercises.

4. Operative Note: Patient with severe bone pain and extensive patellar tendinitis underwent surgical intervention in the form of open patellar tendon lengthening with bone grafting. The procedure aimed to relieve pain by lengthening the tight tendon and addressing the eroded bone with bone grafts. Postoperatively, the patient received pain management interventions and was enrolled in a structured rehabilitation program.

5. Operative Note: Patient with severe bone pain and advanced patellar tendinitis underwent surgical intervention in the form of arthroscopic debridement with bone erosion repair. The procedure involved meticulous removal of degenerated tissue and bone fragments, followed by reconstruction of the eroded bone areas. Postoperatively, the patient received pain control measures and was instructed on postoperative care and rehabilitation exercises.

6. Operative Note: Patient with severe bone pain and symptomatic patellar tendinitis underwent surgical intervention in the form of open patellar tendon release with bone reconstruction. The procedure involved releasing the tight tendon and addressing the eroded bone with bone grafts and fixation devices. Postoperatively, the patient received pain management interventions and was scheduled for regular follow-up assessments.

7. Operative Note: Patient with severe bone pain and refractory patellar tendinitis underwent surgical intervention in the form of autologous tenocyte implantation (ATI) with bone grafting. The procedure involved implanting cultured tenocytes into the damaged tendon and reconstructing the eroded bone using bone grafts. Postoperatively, the patient received pain medication and was advised on a customized rehabilitation program.

8. Operative Note: Patient with severe bone pain and persistent patellar tendinitis underwent surgical intervention in the form of arthroscopic microfracture technique combined with bone grafting. The procedure involved creating microfractures in the eroded bone to stimulate cartilage regeneration and augmenting it with bone grafts. Postoperatively, the patient received pain management interventions and participated in a structured rehabilitation program.

9. Operative Note: Patient with severe bone pain and chronic patellar tendinitis underwent surgical intervention in the form of open patellar tendon repair with bone reconstruction. The procedure involved excision of the damaged tendon, reconstruction of the eroded bone using bone grafts, and reattachment of the tendon with sutures. Postoperatively, the patient received pain control measures and was instructed on rehabilitation exercises.

10. Operative Note: Patient with severe bone pain and extensive patellar tendinitis underwent surgical intervention in the form of arthroscopic subcutaneous patellar tendon release with bone erosion

repair. The procedure involved releasing the tight tendon and addressing the eroded bone with bone grafts. Postoperatively, the patient received pain medication and was provided with a comprehensive rehabilitation plan.

1. Operative Note: Patient with severe bone pain and debilitating patellar tendinitis underwent surgical intervention in the form of open patellar tendon transfer with bone realignment. The procedure involved transferring a healthy tendon to replace the damaged patellar tendon and realigning the eroded bone to restore proper joint mechanics. Postoperatively, the patient received pain management interventions and commenced a progressive rehabilitation program.

2. Operative Note: Patient with severe bone pain and extensive patellar tendinitis underwent surgical intervention in the form of arthroscopic microfracture technique with bone augmentation. The procedure involved creating small fractures in the eroded bone and filling the defects with bone grafts to stimulate healing and alleviate pain. Postoperatively, the patient received pain medication and was advised on activity modification and rehabilitation exercises.

3. Operative Note: Patient with severe bone pain and chronic patellar tendinitis underwent surgical intervention in the form of autologous platelet-rich plasma (PRP) injection combined with bone erosion repair. The procedure involved injecting concentrated platelets into the damaged tendon and addressing the eroded bone with bone grafts. Postoperatively, the patient received pain management interventions and was scheduled for PRP follow-up treatments.

4. Operative Note: Patient with severe bone pain and persistent patellar tendinitis underwent surgical intervention in the form of open patellar tendon debridement and bone resection. The procedure involved meticulous removal of degenerated tissue and resecting the eroded bone to relieve pain and restore normal tendon function. Postoperatively, the patient received pain control measures and was instructed on a tailored rehabilitation protocol.

5. Operative Note: Patient with severe bone pain and refractory patellar tendinitis underwent surgical intervention in the form of arthroscopic patellar tendon release with bone grafting. The procedure involved releasing the tight tendon and reconstructing the eroded bone using bone grafts to alleviate pain and promote healing. Postoperatively, the patient received pain medication and commenced a progressive rehabilitation program.

6. Operative Note: Patient with severe bone pain and recalcitrant patellar tendinitis underwent surgical intervention in the form of minimally invasive percutaneous tenotomy with bone erosion repair and stem cell injection. The procedure involved releasing the tight tendon, addressing the eroded bone with bone grafts, and injecting stem cells to promote tissue regeneration and reduce pain. Postoperatively, the patient received pain management interventions and was advised on post-procedure care.

7. Operative Note: Patient with severe bone pain and chronic patellar tendinitis underwent surgical intervention in the form of open patellar tendon lengthening with bone augmentation. The procedure involved lengthening the tight tendon and addressing the eroded bone using bone grafts to alleviate pain and restore proper tendon function. Postoperatively, the patient received pain control measures and was enrolled in an intensive rehabilitation program.

8. Operative Note: Patient with severe bone pain and persistent patellar tendinitis underwent surgical intervention in the form of arthroscopic debridement with bone erosion repair and high-energy shockwave therapy. The procedure involved removing degenerated tissue, reconstructing the eroded bone with bone grafts, and administering shockwave therapy to promote healing and reduce pain. Postoperatively, the patient received pain medication and was scheduled for shockwave therapy sessions.

9. Operative Note: Patient with severe bone pain and extensive patellar tendinitis underwent surgical intervention in the form of open patellar tendon repair with bone reconstruction using allograft. The procedure involved excising the damaged tendon, reconstructing the eroded bone with allograft, and reattaching the tendon using sutures to alleviate pain and restore function. Postoperatively, the patient received pain management interventions and was scheduled for follow-up assessments.

10

. Operative Note: Patient with severe bone pain and chronic patellar tendinitis underwent surgical intervention in the form of arthroscopic subcutaneous patellar tendon release with bone erosion repair and iliac crest bone grafting. The procedure involved releasing the tight tendon, reconstructing the eroded bone with bone grafts, and utilizing iliac crest bone grafts for added stability and pain relief. Postoperatively, the patient received pain medication and was instructed on rehabilitation exercises.

1. Operative Note: Patient presented with severe infection and limited range of motion in the patellar joint due to patellar tendinitis. Surgical intervention was performed, including extensive debridement of infected tissue and thorough irrigation of the joint. Intraoperative cultures were obtained for targeted antibiotic therapy. The aim was to control the infection and alleviate the patient's symptoms. Postoperatively, appropriate antibiotic therapy was initiated, and close monitoring for signs of recurrence or further complications was implemented.

2. Operative Note: Patient with severe infection and restricted joint mobility secondary to patellar tendinitis underwent surgical intervention involving open incision and drainage of the infected joint. Copious irrigation with antimicrobial solution was performed to ensure thorough cleansing. The infected tissue was debrided, and tissue samples were sent for culture analysis. Postoperatively, the patient received intravenous antibiotics and was closely monitored for signs of infection resolution.

3. Operative Note: Patient presented with severe infection and significant joint impairment due to patellar tendinitis. Surgical intervention included arthroscopic debridement of the infected joint, meticulous irrigation, and removal of necrotic tissue. Multiple tissue samples were sent for microbial analysis. Postoperatively, the patient was started on targeted intravenous antibiotic therapy and scheduled for regular follow-up evaluations to assess the response to treatment.

4. Operative Note: Patient with severe infection and profound joint dysfunction resulting from patellar tendinitis underwent emergent surgical intervention. Open joint exploration revealed extensive infection involving the patellar joint. Thorough debridement was performed, followed by irrigation with antibiotic solution. Intraoperative cultures were obtained for sensitivity testing. Postoperatively, the patient was started on aggressive intravenous antibiotic therapy and closely monitored for signs of infection control.

5. Operative Note: Patient with severe infection and severely compromised joint function due to patellar tendinitis underwent surgical intervention involving extensive joint debridement and irrigation. The infected tissue was meticulously excised, and multiple samples were collected for microbial analysis. Postoperatively, the patient received intravenous antibiotics based on culture results and was closely monitored for signs of improvement or persistence of infection.

6. Operative Note: Patient presented with severe infection and profound joint immobility secondary to patellar tendinitis. Surgical intervention was performed, including arthroscopic lavage and debridement of the infected joint. Copious irrigation with antibiotic solution was carried out to remove infectious material. Tissue samples were obtained for culture and sensitivity testing. Postoperatively, the patient received appropriate intravenous antibiotics and close clinical monitoring.

7. Operative Note: Patient with severe infection and limited joint mobility resulting from patellar tendinitis underwent surgical intervention consisting of open joint debridement and irrigation. The infected tissues were meticulously removed, and the joint was thoroughly irrigated with antibiotic solution. Cultures were obtained intraoperatively for targeted antibiotic therapy. Postoperatively, the patient was initiated on intravenous antibiotics and closely followed up for signs of infection resolution.

8. Operative Note: Patient presented with severe infection and significant joint dysfunction associated with patellar tendinitis. Surgical intervention involved open joint exploration, debridement of infected tissue, and irrigation with antibiotic solution. Multiple tissue samples were sent for microbial analysis. Postoperatively, the patient received intravenous antibiotics and was closely monitored for signs of infection control and improved joint function.

9. Operative Note: Patient with severe infection and extreme joint impairment due to patellar tendinitis underwent surgical intervention involving thorough arthroscopic debridement and irrigation of the infected joint. The joint was lavaged with antibiotic solution to eliminate the infectious material. Intraoperative cultures were obtained for targeted antibiotic therapy. Postoperatively, the patient was started on intravenous antibiotics and closely monitored for signs of infection resolution and functional improvement.

10. Operative Note: Patient with severe infection and restricted joint mobility secondary to patellar tendinitis underwent emergent surgical intervention. Open joint debridement and irrigation were performed, ensuring meticulous removal of infected tissue and thorough cleansing of the joint. Cultures were obtained intraoperatively for targeted antibiotic therapy. Postoperatively, the patient received intravenous antibiotics and underwent regular evaluations to assess the response to treatment and control of the infection.

1. Operative Note: Patient with severe inflammation and limited joint mobility due to patellar tendinitis underwent surgical intervention involving arthroscopic debridement of the inflamed tissues. The procedure aimed to alleviate inflammation by removing diseased tissue and promoting healing. Postoperatively, the patient received anti-inflammatory medications and was advised on a structured rehabilitation program.

2. Operative Note: Patient presented with severe inflammation and significant joint impairment secondary to patellar tendinitis. Surgical intervention included open incision and drainage of the inflamed joint, meticulous irrigation, and removal of inflammatory tissue. The aim was to control the inflammation and restore joint function. Postoperatively, the patient received anti-inflammatory medications and was closely monitored for signs of inflammation resolution.

3. Operative Note: Patient with severe inflammation and profound joint dysfunction resulting from patellar tendinitis underwent surgical intervention involving arthroscopic lavage and debridement of the inflamed joint. The procedure aimed to reduce inflammation and improve joint function. Postoperatively, the patient received anti-inflammatory medications and commenced a tailored rehabilitation program.

4. Operative Note: Patient with severe inflammation and restricted joint mobility due to patellar tendinitis underwent surgical intervention involving open joint exploration and debridement of the inflamed tissues. The inflamed tissue was meticulously excised, and the joint was thoroughly irrigated. Postoperatively, the patient received anti-inflammatory medications and was instructed on appropriate rehabilitation exercises.

5. Operative Note: Patient presented with severe inflammation and significantly compromised joint function secondary to patellar tendinitis. Surgical intervention included arthroscopic debridement and irrigation of the inflamed joint, aiming to alleviate inflammation and promote healing. Postoperatively, the patient received anti-inflammatory medications and was enrolled in a structured rehabilitation program.

6. Operative Note: Patient with severe inflammation and profound joint immobility resulting from patellar tendinitis underwent surgical intervention involving extensive joint debridement and irrigation. The inflamed tissue was meticulously removed, and the joint was thoroughly irrigated with anti-inflammatory solution. Postoperatively, the patient received anti-inflammatory medications and was closely monitored for signs of inflammation control and improved joint mobility.

7. Operative Note: Patient presented with severe inflammation and limited joint mobility due to patellar tendinitis. Surgical intervention was performed, including open joint debridement and irrigation of the inflamed joint. The inflamed tissues were meticulously excised, and the joint was thoroughly irrigated with anti-inflammatory solution. Postoperatively, the patient received anti-inflammatory medications and was instructed on a customized rehabilitation program.

8. Operative Note: Patient with severe inflammation and restricted joint mobility associated with patellar tendinitis underwent surgical intervention consisting of arthroscopic lavage and debridement of the inflamed joint. The inflamed tissues were carefully removed, and the joint was irrigated with anti-inflammatory solution. Postoperatively, the patient received anti-inflammatory medications and was closely followed up for signs of inflammation resolution and improved joint function.

9. Operative Note: Patient presented with severe inflammation and significant joint dysfunction due to patellar tendinitis. Surgical intervention involved open joint exploration, debridement of inflamed tissue, and irrigation with anti-inflammatory solution. The aim was to alleviate inflammation and restore joint function. Postoperatively, the patient received anti-inflammatory medications and was scheduled for regular follow-up assessments.

10. Operative Note: Patient with severe inflammation and extreme joint impairment secondary to patellar tendinitis underwent surgical intervention involving thorough arthroscopic debridement and irrigation of the inflamed joint. The joint was lavaged with anti-inflammatory solution to reduce inflammation and alleviate symptoms. Postoperatively, the patient received anti-inflammatory medications and was advised on post-procedure care and rehabilitation exercises.

1. Operative Note: Patient diagnosed with mild patellar tendinitis underwent surgical intervention involving arthroscopic debridement and irrigation. Postoperatively, the patient was scheduled for a follow-up examination in four weeks to assess response to conservative management and determine the need for further intervention.

2. Operative Note: Patient diagnosed with moderate patellar tendinitis underwent surgical intervention consisting of open patellar tendon repair. The patient was scheduled for postoperative follow-ups at two weeks, six weeks, and three months to monitor pain levels, range of motion, and progression of healing.

3. Operative Note: Patient diagnosed with severe patellar tendinitis underwent surgical intervention involving arthroscopic debridement, bone erosion repair, and platelet-rich plasma injection. The patient's follow-up visits were scheduled at two weeks, four weeks, and eight weeks to assess pain, functional improvement, and response to treatment.

4. Operative Note: Patient diagnosed with chronic patellar tendinitis underwent surgical intervention with open patellar tendon lengthening and autograft reconstruction. The patient's follow-up appointments were arranged at three weeks, six weeks, and three months to evaluate pain levels, joint stability, and rehabilitation progress.

5. Operative Note: Patient diagnosed with recurrent patellar tendinitis underwent surgical intervention involving arthroscopic debridement, extensive bone erosion repair, and high-energy shockwave therapy. The patient's follow-up visits were scheduled at four weeks, eight weeks, and six months to monitor pain reduction, joint function, and response to shockwave therapy.

6. Operative Note: Patient diagnosed with bilateral patellar tendinitis underwent staged surgical interventions. The first procedure involved arthroscopic debridement and injection of corticosteroids. Subsequent follow-up appointments were scheduled at two weeks and six weeks to assess pain relief and determine the need for further intervention.

7. Operative Note: Patient diagnosed with unilateral patellar tendinitis and mild bone erosion underwent surgical intervention involving arthroscopic debridement and bone augmentation. The patient's follow-up visits were scheduled at four weeks, eight weeks, and four months to evaluate pain levels, joint stability, and the progression of bone healing.

8. Operative Note: Patient diagnosed with bilateral severe patellar tendinitis and significant bone erosion underwent bilateral open patellar tendon repair with allograft reconstruction. The patient's follow-up appointments were arranged at two weeks, six weeks, and six months to monitor pain, joint function, and the incorporation of the allograft.

9. Operative Note: Patient diagnosed with moderate patellar tendinitis and early signs of bone erosion underwent surgical intervention involving arthroscopic debridement, bone grafting, and platelet-rich plasma injection. The patient's follow-up visits were scheduled at three weeks, three months, and one year to assess pain relief, joint stability, and long-term outcome.

10. Operative Note: Patient diagnosed with severe patellar tendinitis and extensive bone erosion underwent surgical intervention with open patellar tendon repair, bone reconstruction, and autologous stem cell therapy. The patient's follow-up appointments were arranged at two weeks, four weeks, six months, and one year to evaluate pain levels, joint function, and the regenerative effects of stem cell therapy.

## M76.6 Achilles tendinitis

1. Patient presented with chronic Achilles tendinitis. Examination revealed tenderness, swelling, and limited range of motion. Conservative treatment initiated with rest, ice, NSAIDs, and physical therapy. A heel lift was recommended to offload the tendon. Patient advised to avoid high-impact activities. Follow-up scheduled in four weeks.

2. Operative note: Patient underwent Achilles tendon debridement for chronic tendinitis. A longitudinal incision was made, and the tendon was carefully dissected. Degenerated tissue and adhesions were excised. The tendon was repaired using non-absorbable sutures. The wound was closed, and a compression dressing was applied. Postoperative instructions given for rest, elevation, and rehabilitation.

3. Operative note: Patient underwent percutaneous ultrasonic tenotomy for chronic Achilles tendinitis. The area was sterilized, and a local anesthetic was administered. A small incision was made, and an ultrasonic tenotome was inserted to break up scar tissue and stimulate healing. The procedure was performed under ultrasound guidance. Postoperative care included immobilization and gradual return to activity.

4. Operative note: Patient underwent platelet-rich plasma (PRP) injection for Achilles tendinitis. The area was cleaned, and local anesthesia was administered. Using ultrasound guidance, PRP was injected into the affected tendon. The patient tolerated the procedure well. Post-injection instructions provided, including rest and gradual return to activity. Follow-up scheduled in two weeks to assess response.

5. Operative note: Patient underwent extracorporeal shockwave therapy (ESWT) for Achilles tendinitis. The area was marked, and a coupling gel was applied. ESWT was delivered using a specialized device, targeting the affected tendon. The patient experienced mild discomfort during the procedure. Post-ESWT instructions given, including limited weight-bearing and gradual increase in activity level.

6. Operative note: Patient underwent minimally invasive Achilles tendon release for chronic tendinitis. A small incision was made, and a specialized instrument was used to release the tight and inflamed tendon fibers. The procedure was performed under local anesthesia. The incision was closed with sutures, and a compression dressing was applied. Postoperative care included rest and physical therapy.

7. Operative note: Patient underwent autologous tenocyte implantation for recalcitrant Achilles tendinitis. A small biopsy of healthy tendon tissue was obtained. The tenocytes were isolated, expanded in culture, and then injected into the damaged tendon. The patient tolerated the procedure well. Postoperative instructions included immobilization and a progressive rehabilitation program.

8. Operative note: Patient underwent endoscopic Achilles tendon debridement and repair for chronic tendinitis. Two small incisions were made, and an endoscope was inserted to visualize the tendon. Degenerated tissue was excised, and the tendon was repaired using suture anchors. The incisions were closed with sutures. Postoperative care included immobilization and a gradual return to weight-bearing.

9. Operative note: Patient underwent arthroscopic debridement of the retrocalcaneal bursa for Achilles tendinitis. Two small incisions were made, and an arthroscope was inserted to visualize the bursa. The bursal tissue was carefully excised using specialized instruments. The incisions were closed with sutures, and a compression dressing was applied. Postoperative instructions given for rest, ice, and elevation.

10. Operative note: Patient underwent open Achilles tendon lengthening for chronic tendinitis with tightness. A longitudinal incision was made, and the tendon was exposed. A Z-lengthening technique was used to lengthen the tendon and relieve tension. The incision was closed with sutures, and a bulky

dressing was applied. Postoperative care included immobilization and a gradual return to activity.

1. Operative note: Patient underwent eccentric training for Achilles tendinitis. A customized exercise program was designed to target the eccentric loading of the affected tendon. The patient was instructed on proper technique and provided with a progressive exercise plan. Regular follow-up appointments scheduled to monitor progress and make necessary adjustments.

2. Operative note: Patient underwent corticosteroid injection for acute exacerbation of Achilles tendinitis. The area was prepared, and local anesthesia was administered. A corticosteroid solution was injected into the inflamed tendon sheath. The patient experienced immediate relief. Post-injection instructions given, including rest, ice, and activity modification. Follow-up scheduled in two weeks to evaluate response.

3. Operative note: Patient underwent shockwave therapy for refractory Achilles tendinitis. The area was marked, and coupling gel was applied. Shockwave therapy was administered using a specialized device, targeting the affected tendon. The patient reported mild discomfort during the procedure. Post-therapy instructions given, including rest, gradual return to activity, and physical therapy.

4. Operative note: Patient underwent ultrasound-guided needle tenotomy for Achilles tendinitis. The area was sterilized, and local anesthesia was administered. Under ultrasound guidance, a needle was inserted into the tendon, and multiple perforations were made to stimulate healing. The procedure was well-tolerated by the patient. Post-tenotomy care included rest, immobilization, and rehabilitation.

5. Operative note: Patient underwent arthroscopic bursectomy for Achilles tendinitis with associated retrocalcaneal bursitis. Two small incisions were made, and an arthroscope was inserted to visualize the bursa. The bursa was excised using specialized instruments. The incisions were closed with sutures, and a compression dressing was applied. Postoperative instructions given for rest, ice, and elevation.

6. Operative note: Patient underwent regenerative medicine therapy for Achilles tendinitis. Adipose-derived mesenchymal stem cells were harvested and processed. The concentrated stem cell solution was injected into the damaged tendon under ultrasound guidance. The patient tolerated the procedure well. Post-treatment care included activity modification and rehabilitation.

7. Operative note: Patient underwent Tenex procedure for chronic Achilles tendinitis. The area was prepared, and local anesthesia was administered. A small incision was made, and a specialized instrument was inserted to mechanically debride the damaged tendon. The procedure was performed under ultrasound guidance. The incision was closed, and a compression dressing was applied. Postoperative care included rest, elevation, and physical therapy.

8. Operative note: Patient underwent radiofrequency ablation (RFA) for Achilles tendinitis. The area was sterilized, and local anesthesia was administered. Using an RFA device, targeted radiofrequency energy was delivered to the affected tendon to promote healing and reduce pain. The patient experienced mild discomfort during the procedure. Post-RFA instructions given, including rest and gradual return to activity.

9. Operative note: Patient underwent high-volume saline injection (HVSI) for chronic Achilles tendinitis. The area was marked, and local anesthesia was administered. A large volume of sterile saline solution was injected into the damaged tendon, causing distension and promoting healing. The patient tolerated the procedure well. Post-injection instructions included rest, ice, and activity modification.

10. Operative note: Patient underwent arthroscopic debridement and repair of Haglund's deformity with concomitant Achilles tendinitis. Multiple small incisions were made, and an arthroscope was inserted to visualize the bony prominence and the tendon. The deformity was resected, and the damaged tendon was repaired using suture anchors. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization and a gradual return to weight-bearing.

1. Operative note: Patient underwent Achilles tendon debridement for chronic tendinitis under local anesthesia. A longitudinal incision was made, and the tendon was carefully dissected. Degenerated tissue and adhesions were excised. The tendon was repaired using non-absorbable sutures. The wound was closed, and a compression dressing was applied. Postoperative instructions given for rest, elevation, and rehabilitation.

2. Operative note: Patient underwent percutaneous ultrasonic tenotomy for chronic Achilles tendinitis under regional anesthesia. The area was sterilized, and a nerve block was performed to numb the lower leg. A small incision was made, and an ultrasonic tenotome was inserted to break up scar tissue and stimulate healing. The procedure was performed under ultrasound guidance. Postoperative care included immobilization and gradual return to activity.

3. Operative note: Patient underwent platelet-rich plasma (PRP) injection for Achilles tendinitis under conscious sedation. The area was cleaned, and local anesthesia was administered. The patient was also given sedative medication to induce a relaxed state. Using ultrasound guidance, PRP was injected into the affected tendon. Post-injection instructions provided, including rest and gradual return to activity. Follow-up scheduled in two weeks to assess response.

4. Operative note: Patient underwent endoscopic Achilles tendon debridement and repair for chronic tendinitis under general anesthesia. Two small incisions were made, and an endoscope was inserted to visualize the tendon. Degenerated tissue was excised, and the tendon was repaired using suture anchors. The incisions were closed with sutures. Postoperative care included immobilization and a gradual return to weight-bearing.

5. Operative note: Patient underwent open Achilles tendon lengthening for chronic tendinitis with tightness under regional anesthesia. A longitudinal incision was made, and the tendon was exposed. A Z-lengthening technique was used to lengthen the tendon and relieve tension. The incision was closed with sutures, and a bulky dressing was applied. Postoperative care included immobilization and a gradual return to activity.

6. Operative note: Patient underwent autologous tenocyte implantation for recalcitrant Achilles tendinitis under local anesthesia with sedation. A small biopsy of healthy tendon tissue was obtained. The tenocytes were isolated, expanded in culture, and then injected into the damaged tendon. The patient tolerated the procedure well. Postoperative instructions included immobilization and a progressive rehabilitation program.

7. Operative note: Patient underwent arthroscopic debridement of the retrocalcaneal bursa for Achilles tendinitis under regional anesthesia. Two small incisions were made, and an arthroscope was inserted to visualize the bursa. The bursal tissue was carefully excised using specialized instruments. The incisions were closed with sutures, and a compression dressing was applied. Postoperative instructions given for rest, ice, and elevation.

8. Operative note: Patient underwent eccentric training for Achilles tendinitis under local anesthesia with minimal sedation. A customized exercise program was designed to target the eccentric loading of the affected tendon. The patient was instructed on proper technique and provided with a progressive exercise plan. Regular follow-up appointments scheduled to monitor progress and make necessary adjustments.

9. Operative note: Patient underwent corticosteroid injection for acute exacerbation of Achilles tendinitis under topical anesthesia. The area was prepared, and a topical anesthetic cream was applied to numb the skin. A corticosteroid solution was injected into the inflamed tendon sheath. The patient experienced immediate relief. Post-injection instructions given, including rest, ice, and activity modification. Follow-up scheduled in two weeks to evaluate response.

10. Operative note: Patient underwent shockwave

therapy for refractory Achilles tendinitis under conscious sedation. The area was marked, and coupling gel was applied. Shockwave therapy was administered using a specialized device, targeting the affected tendon. The patient reported mild discomfort during the procedure. Post-therapy instructions given, including rest, gradual return to activity, and physical therapy.

1. Operative note: Patient underwent Achilles tendon debridement with bone erosion management for severe tendinitis and bone erosion. A longitudinal incision was made, exposing the affected tendon and eroded bone. The eroded bone was carefully debrided and smoothed. Degenerated tendon tissue was excised, and the tendon was repaired using non-absorbable sutures. The wound was closed, and a compression dressing was applied. Postoperative instructions given for rest, elevation, and rehabilitation.

2. Operative note: Patient underwent arthroscopic debridement of retrocalcaneal bursa with bone erosion repair for Achilles tendinitis and bone erosion. Two small incisions were made, and an arthroscope was inserted to visualize the bursa and eroded bone. The bursal tissue was excised, and the eroded bone was addressed using bone grafting and fixation techniques. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization and a gradual return to weight-bearing.

3. Operative note: Patient underwent open Achilles tendon repair with bone erosion reconstruction for chronic tendinitis and significant bone erosion. A longitudinal incision was made, exposing the damaged tendon and eroded bone. The eroded bone was reconstructed using bone grafts and fixation hardware. The tendon was repaired using non-absorbable sutures. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization and a gradual return to activity.

4. Operative note: Patient underwent autograft augmentation of Achilles tendon with bone erosion repair for severe tendinitis and bone erosion. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Autograft tendon tissue was harvested and used to augment the weakened tendon. The eroded bone was addressed with bone grafting and fixation. The incision was closed, and a compression dressing was applied. Postoperative instructions included rest, elevation, and rehabilitation.

5. Operative note: Patient underwent endoscopic Achilles tendon debridement with bone erosion management for chronic tendinitis and associated bone erosion. Two small incisions were made, and an endoscope was inserted to visualize the tendon and eroded bone. Degenerated tissue was excised, and the eroded bone was carefully smoothed and addressed with appropriate techniques. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization and a gradual return to weight-bearing.

6. Operative note: Patient underwent bone grafting and tendon repair for Achilles tendinitis with significant bone erosion. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone grafts were obtained and meticulously placed to restore the eroded bone. The tendon was repaired using non-absorbable sutures. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization and a progressive rehabilitation program.

7. Operative note: Patient underwent bone erosion debridement and repair of Haglund's deformity with concomitant Achilles tendinitis. Multiple small incisions were made, and the bony prominence and eroded bone were visualized. The deformity was resected, and the eroded bone was addressed using bone grafting and fixation techniques. The incisions were closed with sutures, and a compression dressing was applied. Postoperative instructions given for rest, ice, and elevation.

8. Operative note: Patient underwent open Achilles tendon lengthening with bone erosion management for chronic tendinitis and extensive bone erosion. A longitudinal incision was made, exposing the damaged tendon and eroded bone. The eroded bone was carefully addressed with bone grafts and fixation. The tendon was lengthened using appropriate techniques. The incision was closed with sutures, and

a bulky dressing was applied. Postoperative care included immobilization and a gradual return to activity.

9. Operative note: Patient underwent Achilles tendon repair with bone erosion reconstruction using allograft material for severe tendinitis and significant bone erosion. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Allograft tissue was used to reconstruct the weakened tendon, while the eroded bone was reconstructed using bone grafting and fixation methods. The incision was closed, and a compression dressing was applied. Postoperative instructions included rest, elevation, and rehabilitation.

10. Operative note: Patient underwent arthroscopic debridement of retrocalcaneal bursa with bone erosion repair and stem cell therapy for Achilles tendinitis and bone erosion. Two small incisions were made, and an arthroscope was inserted to visualize the bursa and eroded bone. The bursal tissue was excised, and the eroded bone was addressed using bone grafting and fixation techniques. Stem cells were injected into the tendon and eroded bone for enhanced healing. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization and a gradual return to weight-bearing.

1. Operative note: Patient underwent Achilles tendon debridement with bone erosion management for severe tendinitis, bone erosion, and accompanying severe bone pain. A longitudinal incision was made, exposing the damaged tendon and eroded bone. The eroded bone was carefully addressed, and any loose fragments were removed. The tendon was repaired using non-absorbable sutures. The incision was closed, and a compression dressing was applied. Postoperative instructions given for rest, elevation, pain management, and rehabilitation.

2. Operative note: Patient underwent arthroscopic debridement of retrocalcaneal bursa with bone erosion repair for Achilles tendinitis, bone erosion, and severe bone pain. Two small incisions were made, and an arthroscope was inserted to visualize the bursa and eroded bone. The bursal tissue was excised, and the eroded bone was addressed using bone grafting and fixation techniques. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and gradual return to weight-bearing.

3. Operative note: Patient underwent open Achilles tendon repair with bone erosion reconstruction for chronic tendinitis, significant bone erosion, and severe bone pain. A longitudinal incision was made, exposing the damaged tendon and eroded bone. The eroded bone was reconstructed using bone grafts and fixation hardware. The tendon was repaired using non-absorbable sutures. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to activity.

4. Operative note: Patient underwent autograft augmentation of Achilles tendon with bone erosion repair for severe tendinitis, bone erosion, and severe bone pain. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Autograft tendon tissue was harvested and used to augment the weakened tendon. The eroded bone was addressed with bone grafting and fixation. The incision was closed, and a compression dressing was applied. Postoperative instructions included rest, elevation, pain management, and rehabilitation.

5. Operative note: Patient underwent endoscopic Achilles tendon debridement with bone erosion management for chronic tendinitis, associated bone erosion, and severe bone pain. Two small incisions were made, and an endoscope was inserted to visualize the tendon and eroded bone. Degenerated tissue was excised, and the eroded bone was carefully smoothed and addressed with appropriate techniques. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to weight-bearing.

6. Operative note: Patient underwent bone grafting and tendon repair for Achilles tendinitis with significant bone erosion and severe bone pain. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone grafts were obtained and meticulously placed to restore the eroded bone. The tendon was repaired using non-absorbable sutures. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a progressive rehabilitation program.

7. Operative note: Patient underwent bone erosion debridement and repair of Haglund's deformity with concomitant Achilles tendinitis and severe bone pain. Multiple small incisions were made, and the bony prominence and eroded bone were visualized. The deformity was resected, and the eroded bone was addressed using bone grafting and fixation techniques. The incisions were closed with sutures, and a compression dressing was applied. Postoperative instructions given for rest, ice, pain management, and elevation.

8. Operative note: Patient underwent open Achilles tendon lengthening with bone erosion management for chronic tendinitis,

extensive bone erosion, and severe bone pain. A longitudinal incision was made, exposing the damaged tendon and eroded bone. The eroded bone was carefully addressed with bone grafts and fixation. The tendon was lengthened using appropriate techniques. The incision was closed with sutures, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to activity.

9. Operative note: Patient underwent Achilles tendon repair with bone erosion reconstruction using allograft material for severe tendinitis, significant bone erosion, and severe bone pain. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Allograft tissue was used to reconstruct the weakened tendon, while the eroded bone was reconstructed using bone grafting and fixation methods. The incision was closed, and a compression dressing was applied. Postoperative instructions included rest, elevation, pain management, and rehabilitation.

10. Operative note: Patient underwent arthroscopic debridement of retrocalcaneal bursa with bone erosion repair and stem cell therapy for Achilles tendinitis, bone erosion, and severe bone pain. Two small incisions were made, and an arthroscope was inserted to visualize the bursa and eroded bone. The bursal tissue was excised, and the eroded bone was addressed using bone grafting and fixation techniques. Stem cells were injected into the tendon and eroded bone for enhanced healing. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to weight-bearing.

1. Operative note: Patient underwent Achilles tendon debridement and osteotomy for severe tendinitis and bone erosion. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Degenerated tissue was excised, and an osteotomy was performed to address the bone erosion. The osteotomy was stabilized using fixation hardware. The tendon was repaired using non-absorbable sutures. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization and a gradual return to weight-bearing.

2. Operative note: Patient underwent Achilles tendon repair with bone grafting and augmentation for chronic tendinitis, significant bone erosion, and surgical intervention. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone grafts were obtained and meticulously placed to reconstruct the eroded bone. The tendon was repaired using non-absorbable sutures and augmented with a biological scaffold. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization and a progressive rehabilitation program.

3. Operative note: Patient underwent open Achilles tendon reconstruction with bone allograft and surgical intervention for severe tendinitis, extensive bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone allografts were utilized to reconstruct the eroded bone. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to activity.

4. Operative note: Patient underwent Achilles tendon lengthening with osteotomy and surgical intervention for chronic tendinitis, bone erosion, and contracture. A longitudinal incision was made, exposing the damaged tendon and eroded bone. An osteotomy was performed to address the bone erosion and allow for adequate tendon lengthening. The tendon was then lengthened using appropriate techniques. The incision was closed with sutures, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a progressive rehabilitation program.

5. Operative note: Patient underwent Achilles tendon reconstruction with autograft and surgical intervention for severe tendinitis, extensive bone erosion, and functional deficit. A longitudinal incision was made, exposing the damaged tendon and eroded bone. An autograft tendon was harvested and used to reconstruct the weakened tendon. The eroded bone was addressed with bone grafting and fixation. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to activity.

6. Operative note: Patient underwent Achilles tendon repair with bone grafting and surgical intervention for chronic tendinitis, significant bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone grafts were obtained and meticulously placed to reconstruct the eroded bone. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a progressive rehabilitation program.

7. Operative note: Patient underwent endoscopic Achilles tendon debridement with osteotomy and surgical intervention for Achilles tendinitis, bone erosion, and limited range of motion. Two small incisions were made, and an endoscope was inserted to visualize the tendon and eroded bone. Degenerated tissue was excised, and an osteotomy was performed to address the bone erosion and improve range of motion. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to weight-bearing.

8. Operative

note: Patient underwent Achilles tendon repair with bone erosion reconstruction and surgical intervention for chronic tendinitis, extensive bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. The eroded bone was reconstructed using bone grafts and fixation hardware. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a progressive rehabilitation program.

9. Operative note: Patient underwent Achilles tendon debridement and bone erosion repair with surgical intervention for severe tendinitis, bone erosion, and functional deficit. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Degenerated tissue was excised, and the eroded bone was carefully addressed with bone grafting and fixation techniques. The tendon was repaired using non-absorbable sutures. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a gradual return to weight-bearing.

10. Operative note: Patient underwent open Achilles tendon reconstruction with bone grafting and surgical intervention for chronic tendinitis, significant bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone grafts were obtained and meticulously placed to reconstruct the eroded bone. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a progressive rehabilitation program.

1. Operative note: Patient underwent Achilles tendon repair with bone erosion reconstruction and extensive surgical intervention for severe tendinitis, extensive bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. The eroded bone was reconstructed using a combination of bone grafting, osteotomy, and fixation methods. The tendon was meticulously repaired using non-absorbable sutures and reinforced with a biological scaffold. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a comprehensive rehabilitation program.

2. Operative note: Patient underwent Achilles tendon debridement with bone erosion reconstruction and surgical intervention for chronic tendinitis, significant bone erosion, and limited mobility. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Degenerated tissue was excised, and the eroded bone was carefully reconstructed using bone grafts and fixation techniques. The tendon was repaired using non-absorbable sutures and augmented with a tendon transfer procedure. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a progressive range of motion exercises.

3. Operative note: Patient underwent open Achilles tendon reconstruction with bone allograft and extensive surgical intervention for severe tendinitis, extensive bone erosion, and functional deficit. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone allografts were utilized to reconstruct the eroded bone, while the tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. Additional procedures, including osteotomy and bursal excision, were performed to address associated pathologies. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a comprehensive rehabilitation program.

4. Operative note: Patient underwent Achilles tendon repair with bone grafting and surgical intervention for chronic tendinitis, significant bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone grafts were obtained and meticulously placed to reconstruct the eroded bone, while the tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. Intraoperative assessment revealed the presence of a concomitant bursa, which was excised. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a progressive rehabilitation program.

5. Operative note: Patient underwent Achilles tendon debridement with bone erosion repair and surgical intervention for severe tendinitis, extensive bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Degenerated tissue was excised, and the eroded bone was meticulously addressed using bone grafting and fixation techniques. A concomitant Haglund's deformity was identified and surgically corrected. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a comprehensive rehabilitation program.

6. Operative note: Patient underwent Achilles tendon reconstruction with autograft and surgical intervention for chronic tendinitis, extensive bone erosion, and functional deficit. A longitudinal incision was made, exposing the damaged tendon and eroded bone. An autograft tendon was harvested and meticulously used to reconstruct the weakened tendon. The eroded bone was addressed with bone grafting and fixation methods. Additional surgical interventions, including debridement of calcific deposits and synovectomy, were performed to optimize the outcome. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization,

pain management, and a progressive rehabilitation program.

7. Operative note: Patient underwent endoscopic Achilles tendon debridement with bone erosion repair and surgical intervention for chronic tendinitis, significant bone erosion, and functional impairment. Two small incisions were made, and an endoscope was inserted to visualize the tendon and eroded bone. Degenerated tissue was excised, and the eroded bone was meticulously addressed using bone grafting and fixation techniques. A concomitant retrocalcaneal bursa was identified and excised. The tendon was repaired using non-absorbable sutures and reinforced with a biological scaffold. The incisions were closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a comprehensive rehabilitation program.

8. Operative note: Patient underwent Achilles tendon repair with bone grafting and extensive surgical intervention for severe tendinitis, extensive bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone grafts were obtained and meticulously placed to reconstruct the eroded bone. A concomitant Haglund's deformity and retrocalcaneal bursitis were identified and treated surgically. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a comprehensive rehabilitation program.

9. Operative note: Patient underwent open Achilles tendon lengthening with bone erosion repair and surgical intervention for chronic tendinitis, significant bone erosion, and functional impairment. A longitudinal incision was made, exposing the damaged tendon and eroded bone. An osteotomy was performed to address the bone erosion, and the tendon was lengthened using appropriate techniques. The eroded bone was meticulously addressed using bone grafting and fixation methods. A concomitant retrocalcaneal bursa was identified and excised. The incision was closed, and a compression dressing was applied. Postoperative care included immobilization, pain management, and a comprehensive rehabilitation program.

10. Operative note: Patient underwent Achilles tendon reconstruction with bone allograft and extensive surgical intervention for severe tendinitis, extensive bone erosion, and functional deficit. A longitudinal incision was made, exposing the damaged tendon and eroded bone. Bone allografts were utilized to reconstruct the eroded bone, while the tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. Additional surgical interventions, including Haglund's deformity correction and retrocalcaneal bursa excision, were performed to optimize the outcome. The incision was closed, and a bulky dressing was applied. Postoperative care included immobilization, pain management, and a comprehensive rehabilitation program.

1. Operative note: Patient underwent emergency Achilles tendon debridement and bone erosion repair with surgical intervention for severe tendinitis, extensive bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Aggressive debridement of necrotic tissue was performed, and thorough irrigation with antibiotic solution was done. The eroded bone was reconstructed using bone grafting and fixation methods. The tendon was repaired using non-absorbable sutures. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and close monitoring of the joint infection.

2. Operative note: Patient underwent Achilles tendon reconstruction with bone grafting and extensive surgical intervention for chronic tendinitis, significant bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. The infected tissues were thoroughly debrided, and the eroded bone was meticulously addressed using bone grafting and fixation techniques. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and regular wound care.

3. Operative note: Patient underwent open Achilles tendon repair with bone erosion reconstruction and surgical intervention for severe tendinitis, extensive bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Debridement of infected tissues was performed, and the eroded bone was reconstructed using bone grafts and fixation hardware. The tendon was repaired using non-absorbable sutures and reinforced with a biological scaffold. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and regular monitoring of the joint infection.

4. Operative note: Patient underwent Achilles tendon debridement and bone erosion repair with surgical intervention for chronic tendinitis, significant bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Thorough debridement of necrotic tissue was performed, and the eroded bone was reconstructed using bone grafting and fixation methods. The infected joint was irrigated and thoroughly cleaned. The tendon was repaired using non-absorbable sutures. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and close monitoring of the joint infection.

5. Operative note: Patient underwent Achilles tendon reconstruction with bone grafting and surgical intervention for severe tendinitis, extensive bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Debridement of infected tissues was performed, and the eroded bone was meticulously addressed using bone grafting and fixation techniques. The infected joint was thoroughly irrigated and debrided. The tendon was repaired using non-absorbable sutures and augmented with a biological scaffold. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and regular wound care.

6. Operative note: Patient underwent open Achilles tendon lengthening with bone erosion repair and surgical intervention for chronic tendinitis, significant bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Thorough debridement of infected tissues was performed, and the eroded bone was

reconstructed using bone grafting and fixation methods. The infected joint was irrigated, debrided, and treated with antibiotic solutions. The tendon was repaired using non-absorbable sutures. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and regular monitoring of the joint infection.

7. Operative note: Patient underwent Achilles tendon repair with bone grafting and extensive surgical intervention for severe tendinitis, extensive bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Debridement of necrotic tissue and infected material was performed, and the eroded bone was meticulously addressed using bone grafting and fixation techniques. The infected joint was thoroughly irrigated, debrided, and treated with antimicrobial solutions. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and close monitoring of the joint infection.

8. Operative note: Patient underwent Achilles tendon debridement with bone erosion reconstruction and surgical intervention for chronic tendinitis, significant bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Extensive debridement of infected tissues was performed, and the eroded bone was reconstructed using bone grafting and fixation methods. The infected joint was meticulously irrigated, debrided, and treated with appropriate antimicrobial agents. The tendon was repaired using non-absorbable sutures and augmented with a biological scaffold. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and regular wound care.

9. Operative note: Patient underwent open Achilles tendon reconstruction with bone allograft and surgical intervention for severe tendinitis, extensive bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Debridement of infected tissues was performed, and the eroded bone was reconstructed using bone allografts and fixation hardware. The infected joint was thoroughly irrigated, debrided, and treated with appropriate antibiotics. The tendon was repaired using non-absorbable sutures and reinforced with a biological scaffold. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and regular monitoring of the joint infection.

10. Operative note: Patient underwent Achilles tendon repair with bone grafting and surgical intervention for chronic tendinitis, significant bone erosion, and a severe infection on the extreme moving joint. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and infected joint. Thorough debridement of infected tissues was performed, and the eroded bone was meticulously addressed using bone grafting and fixation techniques. The infected joint was extensively irrigated, debrided, and treated with appropriate antimicrobial agents. The tendon was repaired using non-absorbable sutures and augmented with a tendon augmentation technique. The incision was closed, and a sterile dressing was applied. Postoperative care included intravenous antibiotics, immobilization, and close monitoring of the joint infection.

1. Operative note: Patient underwent Achilles tendon repair with bone erosion reconstruction and surgical intervention for severe tendinitis, extensive bone erosion, and inflammation of the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Thorough debridement of necrotic tissue and inflamed synovium was performed. The eroded bone was meticulously reconstructed using bone grafting and fixation methods. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and a comprehensive rehabilitation program.

2. Operative note: Patient underwent Achilles tendon debridement with bone erosion repair and surgical intervention for chronic tendinitis, significant bone erosion, and severe inflammation of the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Degenerated tissue and inflamed synovium were thoroughly excised. The eroded bone was addressed using bone grafting and fixation techniques. The tendon was repaired using non-absorbable sutures and augmented with a biological scaffold. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular wound care.

3. Operative note: Patient underwent open Achilles tendon reconstruction with bone allograft and extensive surgical intervention for severe tendinitis, extensive bone erosion, and inflammatory changes in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Inflamed synovium was excised, and the eroded bone was reconstructed using bone allografts and fixation hardware. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular monitoring of the inflammatory response.

4. Operative note: Patient underwent Achilles tendon repair with bone grafting and surgical intervention for chronic tendinitis, significant bone erosion, and localized inflammation in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Inflamed synovium was excised, and the eroded bone was reconstructed using bone grafts and fixation methods. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular wound care.

5. Operative note: Patient underwent Achilles tendon debridement with bone erosion reconstruction and surgical intervention for severe tendinitis, extensive bone erosion, and increased inflammation in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Thorough debridement of necrotic tissue and inflamed synovium was performed. The eroded bone was meticulously addressed using bone grafting and fixation techniques. The tendon was repaired using non-absorbable sutures and augmented with a biological scaffold. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and a comprehensive rehabilitation program.

6. Operative note: Patient underwent Achilles tendon repair with bone grafting and extensive surgical intervention for chronic tendinitis, significant bone erosion, and pronounced inflammation in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Inflamed synovium was excised, and the eroded bone was meticulously reconstructed using bone grafting and fixation methods. The

tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular wound care.

7. Operative note: Patient underwent open Achilles tendon reconstruction with bone allograft and surgical intervention for severe tendinitis, extensive bone erosion, and significant inflammation in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Thorough debridement of inflamed synovium was performed, and the eroded bone was reconstructed using bone allografts and fixation hardware. The tendon was repaired using non-absorbable sutures and reinforced with a biological scaffold. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular monitoring of the inflammatory response.

8. Operative note: Patient underwent Achilles tendon debridement with bone erosion repair and surgical intervention for chronic tendinitis, significant bone erosion, and localized inflammation in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Inflamed synovium was thoroughly excised, and the eroded bone was meticulously addressed using bone grafting and fixation techniques. The tendon was repaired using non-absorbable sutures and augmented with a biological scaffold. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular wound care.

9. Operative note: Patient underwent open Achilles tendon repair with bone grafting and extensive surgical intervention for severe tendinitis, extensive bone erosion, and increased inflammation in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Thorough debridement of inflamed synovium was performed, and the eroded bone was reconstructed using bone grafts and fixation methods. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular wound care.

10. Operative note: Patient underwent Achilles tendon repair with bone grafting and surgical intervention for chronic tendinitis, significant bone erosion, and pronounced inflammation in the surrounding tissues. A longitudinal incision was made, exposing the damaged tendon, eroded bone, and inflamed tissues. Inflamed synovium was excised, and the eroded bone was meticulously reconstructed using bone grafting and fixation techniques. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. The incision was closed, and a compression dressing was applied. Postoperative care included anti-inflammatory medications, immobilization, and regular wound care.

1. Operative note: Patient underwent Achilles tendon debridement and bone erosion repair with surgical intervention for mild Achilles tendinitis, minimal bone erosion, and no significant complications observed during the procedure. The tendon was thoroughly debrided, and the eroded bone was addressed with conservative measures. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, physical therapy, and close monitoring of the patient's symptoms.

2. Operative note: Patient underwent Achilles tendon reconstruction with bone grafting and extensive surgical intervention for moderate Achilles tendinitis, moderate bone erosion, and limited complications observed during the procedure. The damaged tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. Bone grafting and fixation methods were employed to address the bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, immobilization, and a comprehensive rehabilitation program.

3. Operative note: Patient underwent open Achilles tendon repair with bone erosion reconstruction and surgical intervention for severe Achilles tendinitis, extensive bone erosion, and moderate complications observed during the procedure. The tendon was repaired using non-absorbable sutures and reinforced with a biological scaffold. Extensive bone grafting and fixation techniques were utilized to address the significant bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, immobilization, and regular monitoring of the patient's progress.

4. Operative note: Patient underwent Achilles tendon debridement with bone erosion repair and surgical intervention for mild Achilles tendinitis, minimal bone erosion, and no significant complications observed during the procedure. The damaged tendon was thoroughly debrided, and conservative measures were employed to address the minimal bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, activity modification, and follow-up assessment to monitor the patient's response.

5. Operative note: Patient underwent Achilles tendon repair with bone grafting and surgical intervention for moderate Achilles tendinitis, moderate bone erosion, and limited complications observed during the procedure. The tendon was repaired using non-absorbable sutures and augmented with a tendon augmentation technique. Bone grafting and fixation methods were employed to address the moderate bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, immobilization, and a tailored rehabilitation program based on the severity of the diagnosis.

6. Operative note: Patient underwent open Achilles tendon reconstruction with bone allograft and extensive surgical intervention for severe Achilles tendinitis, extensive bone erosion, and moderate complications observed during the procedure. The damaged tendon was repaired using non-absorbable sutures and reinforced with a biological scaffold. Extensive bone allografting and fixation hardware were utilized to address the significant bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, immobilization, and regular monitoring of the patient's progress.

7. Operative note: Patient underwent Achilles tendon debridement with bone erosion reconstruction and surgical intervention for mild Achilles tendinitis, minimal bone erosion, and no significant complications observed during the procedure. The damaged tendon was thoroughly debrided, and conservative measures were employed to address the minimal bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, activity modification, and close follow-up to assess the patient's response to treatment.

8. Operative note: Patient underwent Achilles tendon repair with bone grafting and extensive surgical intervention for moderate Achilles tendinitis, moderate bone erosion, and limited complications observed during the procedure. The tendon was repaired using non-absorbable sutures and reinforced with a tendon augmentation technique. Bone grafting and

fixation methods were employed to address the moderate bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, immobilization, and a tailored rehabilitation program based on the severity of the diagnosis.

9. Operative note: Patient underwent open Achilles tendon reconstruction with bone allograft and surgical intervention for severe Achilles tendinitis, extensive bone erosion, and moderate complications observed during the procedure. The damaged tendon was repaired using non-absorbable sutures and reinforced with a biological scaffold. Extensive bone allografting and fixation hardware were utilized to address the significant bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, immobilization, and regular monitoring of the patient's progress.

10. Operative note: Patient underwent Achilles tendon debridement with bone erosion repair and surgical intervention for mild Achilles tendinitis, minimal bone erosion, and no significant complications observed during the procedure. The damaged tendon was thoroughly debrided, and conservative measures were employed to address the minimal bone erosion. The incision was closed, and a sterile dressing was applied. Postoperative care included pain management, activity modification, and regular follow-up visits to assess the patient's response and ensure proper healing.

## 