PREOPERATIVE DIAGNOSES:,1. Hammertoe deformity, left fifth digit.,2. Ulceration of the left fifth digit plantolaterally.,POSTOPERATIVE DIAGNOSIS:,1. Hammertoe deformity, left fifth toe.,2. Ulceration of the left fifth digit plantolaterally.,PROCEDURE PERFORMED:,1. Arthroplasty of the left fifth digit proximal interphalangeal joint laterally.,2. Excision of plantar ulceration of the left fifth digit 3 cm x 1 cm in size.,OPERATIVE PROCEDURE IN DETAIL: , The patient is a 38-year-old female with longstanding complaint of painful hammertoe deformity of her left fifth toe. The patient had developed ulceration plantarly after being scheduled for removal of a plantar mass in the same area. The patient elects for surgical removal of this ulceration and correction of her hammertoe deformity at this time.,After an IV was instituted by the Department of Anesthesia, the patient was escorted to the OR where the patient was placed on the Operating Room table in the supine position. After adequate amount of IV sedation was administered by Anesthesia Department, the patient was given a digital block to the left fifth toe using 0.5% Marcaine plain with 1% lidocaine plain in 1:1 mixture totaling 6 cc. Following this, the patient was draped and prepped in a normal sterile orthopedic manner. An ankle tourniquet was placed on the left ankle and the left foot was elevated and Esmarch bandage applied to exsanguinate the foot. The ankle tourniquet was then inflated to 230 mmHg and then was brought back down to the level of the table. The stockinette was then cut and reflected and held in place using towel clamp.,The skin was then cleansed using

the wet and dry Ray-Tec sponge and then the plantar lesion was outlined. The lesion measured 1 cm in diameter at the level of the skin and a 3 cm elliptical incision line was drawn on the surface of the skin in the plantolateral aspect of the left fifth digit. Then using a fresh #15 blade, skin incision was made. Following this, the incision was then deepened using a fresh #15 blade down to the level of the subcutaneous tissue. Using a combination of sharp and blunt dissection, the skin was reflected distally and proximally to the lesion. The lesion appeared well encapsulated with fibrous tissue and through careful dissection using combination of sharp and drill instrumentation the ulceration was removed in its entirety. The next further exploration was performed to ensure that no residual elements of the fibrous capsular tissue remained within. The lesion extended from the level of the skin down to the periosteal tissue of the middle and distal phalanx, however, did not show any evidence of extending beyond the level of a periosteum. Remaining tissues were inspected and appeared healthy. The lesion was placed in the specimen container and sent to pathology for microanalysis as well as growth. Attention was then directed to the proximal interphalangeal joint of the left fifth digit and using further dissection with a #15 blade, the periosteum was reflected off the lateral aspect of the proximal _____ median phalanx. The capsule was also reflected to expose the prominent lateral osseous portion of this joint. Using a sagittal saw and #139 blade, the lateral osseous prominence was resected. This was removed in entirety. Then using power-oscillating

rasp, the sharp edges were smoothed and recontoured to the desirable anatomic condition. Then the incision and wound was flushed using copious amounts of sterile saline with gentamycin. Following this, the bone was inspected and appeared to be healthy with no evidence of involvement from the removed aforementioned lesion.,Following this, using #4-0 nylon in a combination of horizontal mattress and simple interrupted sutures, the lesion wound was closed and skin was approximated well without tension to the surface skin. Following this, the incision site was dressed using Owen silk, 4x4s, Kling, and Coban in a normal fashion. The tourniquet was then deflated and hyperemia was noted to return to digits one through five of the left foot. The patient was then escorted from the operative table into the Postanesthesia Care Unit. The patient tolerated the procedure and anesthesia well and was brought to the Postanesthesia Care Unit with vital signs stable and vascular status intact. In the recovery, the patient was given a surgical shoe as well as given instructions for postoperative care to include rest ice and elevation as well as the patient was given prescription for Naprosyn 250 mg to be taken three times daily as well as Vicodin ES to be taken q.6h. as needed.,The patient will follow-up on Friday with Dr. X in office for further evaluation. The patient was also given instructions as to signs of infection and to monitor her operative site. The patient was instructed to keep daily dressings intact, clean, dry, and to not remove them.