

PREOPERATIVE DIAGNOSIS: ,1. Left carpal tunnel syndrome.,2. de Quervain's tenosynovitis.,POSTOPERATIVE DIAGNOSIS:, ,1. Left carpal tunnel syndrome.,2. de Quervain's tenosynovitis.,OPERATIONS PERFORMED: ,1. Endoscopic carpal tunnel release.,2. de Quervain's release.,ANESTHESIA:, I.V. sedation and local (1% Lidocaine).,ESTIMATED BLOOD LOSS:, Zero.,COMPLICATIONS:, None.,PROCEDURE IN DETAIL: ,ENDOSCOPIC CARPAL TUNNEL RELEASE:, With the patient under adequate anesthesia, the upper extremity was prepped and draped in a sterile manner. The arm was exsanguinated. The tourniquet was elevated at 290 mm/Hg. Construction lines were made on the left palm to identify the ring ray. A transverse incision was made in the wrist, between FCR and FCU, one fingerbreadth proximal to the interval between the glabrous skin of the palm and normal forearm skin. Blunt dissection exposed the antebrachial fascia. Hemostasis was obtained with bipolar cautery. A distal-based window in the antebrachial fascia was then fashioned. Care was taken to protect the underlying contents. A proximal forearm fasciotomy was performed under direct vision. A synovial elevator was used to palpate the undersurface of the transverse carpal ligament, and synovium was elevated off this undersurface. Hamate sounds were then used to palpate the hook of hamate. The endoscopic instrument was then inserted into the proximal incision. The transverse carpal ligament was easily visualized through the portal. Using palmar pressure, the transverse carpal ligament was held

against the portal as the instrument was inserted down the transverse carpal ligament to the distal end.,The distal end of the transverse carpal ligament was then identified in the window. The blade was then elevated, and the endoscopic instrument was withdrawn, dividing the transverse carpal ligament under direct vision. After complete division o the transverse carpal ligament, the instrument was reinserted. Radial and ulnar edges of the transverse carpal ligament were identified, and complete release was confirmed.,The wound was then closed with running subcuticular stitch. Steri-Strips were applied, and sterile dressing was applied over the Steri-Strips. The tourniquet was deflated. The patient was awakened from anesthesia and returned to the Recovery Room in satisfactory condition, having tolerated the procedure well.,DE QUERVAIN'S RELEASE: , With the patient under adequate regional anesthesia applied by surgeon using 1% plain Xylocaine, the upper extremity was prepped and draped in a sterile manner. The arm was exsanguinated. The tourniquet was elevated to 290 mm/Hg. A transverse incision was then made over the radial aspect of the wrist overlying the first dorsal tunnel. Using blunt dissection, the radial sensory nerve branches were dissected and retracted out of the operative field. The first dorsal tunnel was then identified. The first dorsal tunnel was incised along the dorsal ulnar border, completely freeing the stenosing tenosynovitis (de Quervain's release). EPB and APL tendons were inspected and found to be completely free. The radial sensory nerve was inspected and found to be without damage.,The skin was

closed with a running 3-0 Prolene subcuticular stitch and Steri-Strips were applied and, over the Steri-Strips, a sterile dressing, and, over the sterile dressing, a volar splint with the hand in safe position. The tourniquet was deflated. The patient was returned to the holding area in satisfactory condition, having tolerated the procedure well.