PREOPERATIVE DIAGNOSIS:, Soft tissue mass, right knee.,POSTOPERATIVE DIAGNOSES:,1. Soft tissue mass, right knee.,2. Osteophyte lateral femoral condyle, right knee.,PROCEDURES PERFORMED:, Excision of capsular mass and arthrotomy with ostectomy of lateral femoral condyle, right knee.,SPECIFICATION: , The entire operative procedure was done in Inpatient Operating Suite, room #1 at ABCD General Hospital. This was done under a local and IV sedation via the Anesthesia Department.,HISTORY AND GROSS FINDINGS:, This is a 37-year-old African-American male with a mass present at the posterolateral aspect of his right knee. On aspiration, it was originally attempted to no avail. There was a long-standing history of this including two different MRIs, one about a year ago and one very recently both of which did not delineate the mass present. During aspiration previously, the patient had experienced neuritic type symptoms down his calf, which have mostly resolved by the time that this had occurred. The patient continued to complain of pain and dysfunction to his calf. This was discussed with him at length. He wished this to be explored and the mass excised even though knowing the possibility that they would not change his pain pattern with the potential of reoccurrence as well as the potential of scar stiffness, swelling, and peroneal nerve palsy. With this, he decided to proceed.,Upon observation preoperatively, the patient was noted to have a hard mass present to the posterolateral aspect of the right knee. It was noted to be tender. It was marked preoperatively prior to an anesthetic. Upon dissection,

the patient was noted to have significant thickening of the posterior capsule. The posterolateral aspect of the knee above the posterolateral complex at the gastroc attachment to the lateral femoral condyle. There was also noted to be prominence of the lateral femoral condyle ridge. The bifurcation at the tibial and peroneal nerves were identified and no neuroma was present.,OPERATIVE PROCEDURE: ,The patient was laid supine upon the operating table. After receiving IV sedation, he was placed prone. Thigh tourniquet was placed. He was prepped and draped in the usual sterile manner. A transverse incision was carried down across the crease with a mass had been palpated through skin and subcutaneous tissue after exsanguination of the limb and tourniquet utilized. The nerve was identified and carefully retracted throughout the case. Both nerves were identified and carefully retracted throughout the case. There was noted to be no neuroma present. This was taken down until the gastroc was split. There was gross thickening of the joint capsule and after arthrotomy, a section of the capsule was excised. The lateral femoral condyle was then osteophied. We then smoothed off with a rongeur. After this, we could not palpate any mass whatsoever placing pressure upon the area of the nerve. Tourniquet was deflated. It was checked again. There was no excessive swelling. Swanson drain was placed to the depth of the wound and interrupted #2-0 Vicryl was utilized for subcutaneous fat closure and #4-0 nylon was utilized for skin closure. Adaptic, 4x4s, ABDs, and Webril were placed for compression dressing. Digits were warm _____

pulses distally at the end of the case. The tourniquet as stated has been deflated prior to closure and hemostasis was controlled. Expected surgical prognosis on this patient is guarded.