

PREOP DIAGNOSES:,1. Left pilon fracture.,2. Left great toe proximal phalanx fracture.,POSTOP DIAGNOSES:,1. Left pilon fracture.,2. Left great toe proximal phalanx fracture.,OPERATION PERFORMED:,1. External fixation of left pilon fracture.,2. Closed reduction of left great toe, T1 fracture.,ANESTHESIA: ,General.,BLOOD LOSS: ,Less than 10 mL.,Needle, instrument, and sponge counts were done and correct.,DRAINS AND TUBES: , None.,SPECIMENS:, None.,INDICATION FOR OPERATION: ,The patient is a 58-year-old female who was involved in an auto versus a tree accident on 6/15/2009. The patient suffered a fracture of a distal tibia and fibula as well as her great toe on the left side at that time. The patient was evaluated by the emergency room and did undergo further evaluation due to loss of consciousness. She underwent a provisional reduction and splinting in the emergency room followed by further evaluation for her heart and brain by the Medicine Service following this and she was appropriate for surgical intervention. Due to the comminuted nature of her tibia fracture as well as soft tissue swelling, the patient is in need of a staged surgery with the 1st stage external fixation followed by open treatment and definitive plate and screw fixation. The patient had swollen lower extremities, however, compartments were soft and she had no sign of compartment syndrome. Risks and benefits of procedure were discussed in detail with the patient and her husband. All questions were answered, and consent was obtained. The risks including damage to blood vessels and nerves with painful neuroma or numbness, limb altered

function, loss of range of motion, need for further surgery, infection, complex regional pain syndrome and deep vein thrombosis were all discussed as potential risks of the surgery.,FINDINGS:,1. There was a comminuted distal tibia fracture with a fibular shaft fracture. Following traction, there was adequate coronal and sagittal alignment of the fracture fragments and based on the length of the fibula, the fracture fragments were out to length.,2. The base of her proximal phalanx fracture was assessed and reduced with essentially no articular step-off and approximately 1-mm displacement. As the reduction was stable with buddy taping, no pinning was performed.,3. Her compartments were full, but not firm nor did she have any sign of compartment syndrome and no compartment releases were performed.,OPERATIVE REPORT IN DETAIL: ,The patient was identified in the preoperative holding area. The left leg was identified and marked at the surgical site of the patient. She was then taken to the operating room where she was transferred to the operating room in the supine position, placed under general anesthesia by the anesthesiology team. She received Ancel for antibiotic prophylaxis. A time-out was then undertaken verifying the correct patient, extremity, visibility of preoperative markings, availability of equipment, and administration of preoperative antibiotics. When all was verified by the surgeon, anesthesia and circulating personnel left lower extremity was prepped and draped in the usual fashion. At this point, intraoperative fluoroscopy was used to identify the fracture site as well as the appropriate starting

point both in the calcaneus for a transcalcaneal cross stent and in the proximal tibia with care taken to leave enough room for later plate fixation without contaminating the future operative site. A single centrally threaded calcaneal cross tunnel was then placed across the calcaneus parallel to the joint surface followed by placement of 2 Schantz pins in the tibia and a frame type external fixator was then applied in traction with attempts to get the fracture fragments out to length, but not overly distract the fracture and restore coronal and sagittal alignment as much as able. When this was adequate, the fixator apparatus was locked in place, and x-ray images were taken verifying correct placement of the hardware and adequate alignment of the fracture. Attention was then turned to the left great toe, where a reduction of the proximal phalanx fracture was performed and buddy taping as this provided good stability and was least invasive. X-rays were taken showing good reduction of the base of the proximal phalanx of the great toe fracture. At this point, the pins were cut short and capped to protect the sharp ends. The stab wounds for the Schantz pin and cross pin were covered with gauze with Betadine followed by dry gauze, and the patient was then awakened from anesthesia and transferred to the progressive care unit in stable condition. Please note there was no break in sterile technique throughout the case.,PLAN: ,The patient will require definitive surgical treatment in approximately 2 weeks when the soft tissues are amenable to plate and screw fixation with decreased risk of wound complication. She will maintain her buddy taping in

regards to her great toe fracture.