PREOPERATIVE DIAGNOSIS,1. Carpal tunnel syndrome.,2. de Quervain's stenosing tenosynovitis.,POSTOPERATIVE DIAGNOSIS,1. Carpal tunnel syndrome.,2. de Quervain's stenosing tenosynovitis.,TITLE OF PROCEDURE,1. Carpal tunnel release.,2. de Quervain's release.,ANESTHESIA: , MAC,COMPLICATIONS: , None.,PROCEDURE IN DETAIL: ,After administering appropriate antibiotics and MAC anesthesia, the upper extremity was prepped and draped in the usual standard fashion. The arm was exsanguinated with Esmarch and the tourniquet inflated to 250 mmHg.,A longitudinal incision was made in line with the 4th ray, from Kaplan's cardinal line proximally to 1 cm distal to the volar wrist crease. The dissection was carried down to the superficial aponeurosis. The subcutaneous fat was dissected radially from 2-3 mm and the superficial aponeurosis cut on this side to leave a longer ulnar leaf.,The ulnar leaf of the cut superficial aponeurosis was dissected ulnarly, and the distal edge of the transverse carpal ligament was identified with a hemostat. The hemostat was gently placed under the transverse carpal ligament to protect the contents of the carpal tunnel, and the ligament was cut on its ulnar side with a knife directly onto the hemostat. The antebrachial fascia was cut proximally under direct vision with scissors.,After irrigating the wound with copious amounts of normal saline, the radial leaf of the cut transverse carpal ligament was repaired to the ulnar leaf of the cut superficial aponeurosis with 4-0 Vicryl. Care was taken to avoid entrapping the motor branch of the median nerve in the suture. A hemostat was placed under the

repair to ensure that the median nerve was not compressed. The skin was repaired with 5-0 nylon interrupted stitches.,The first dorsal compartment was addressed through a transverse incision at the level of the radial styloid tip. Dissection was carried down with care taken to avoid and protect the superficial radial nerve branches. I released the compartment in a separate subsheath for the EPB on the dorsal side. Both ends of the sheath were released to lengthen them, and then these were repaired with 4-0 Vicryl. It was checked to make sure that there was significant room remaining for the tendons. This was done to prevent postoperative subluxation.,I then irrigated and closed the wounds in layers. Marcaine with epinephrine was placed into all wounds, and dressings and splint were placed. The patient was sent to the recovery room in good condition, having tolerated the procedure well.