PREOPERATIVE DIAGNOSIS: , Degenerative arthritis of left knee.,POSTOPERATIVE DIAGNOSIS:, Degenerative arthritis of left knee.,PROCEDURE PERFORMED: , NexGen left total knee replacement.,ANESTHESIA: , Spinal.,TOURNIQUET TIME: Approximately 66 minutes.,COMPLICATIONS:, None.,ESTIMATED BLOOD LOSS: , Approximately 50 cc.,COMPONENTS: , A NexGen stemmed tibial component size 5 was used, 10 mm cruciate retaining polyethylene surface, a NexGen cruciate retaining size E femoral component, and a size 38 9.5 mm thickness All-Poly Patella.,BRIEF HISTORY:, The patient is a 72-year-old female with a history of bilateral knee pain for years progressively worse and decreasing quality of life and ADLs. She wishes to proceed with arthroplasty at this time.,PROCEDURE: ,The patient was taken to the Operative Suite at ABCD General Hospital on 09/11/03. She was placed on the operating table. Department of Anesthesia administered a spinal anesthetic. Once adequately anesthetized, the left lower extremity was prepped and draped in the usual sterile fashion. An Esmarch was applied and a tourniquet was inflated to 325 mmHg on the left thigh. A longitudinal incision was made over the anterior portion of the knee and this was taken down through the subcutaneous tissue to the level of the patella retinaculum. A medial peripatellar arthrotomy was then made and taken down to the level of the tibial tubercle. Care was then ensured that the patellar tendon was not violated. The proximal tibia was then skeletonized both medially and laterally to the level of the axis

through the joint line. Again care was ensured that the patellar tendon was not avulsed from the insertion on the tibia. The intramedullary canal was then opened using a drill and the anterior sizing guide was then placed. Rongeur was used to take out any osteophytes and the size of approximately size E. At this point, the epicondyle axis guide was then inserted and aligned in a proper orientation. The anterior cutting guide was then placed. Care was checked for the amount of resection that the femur would be notched and the oscillating saw was used to cut the anterior portion of the femur. After this was performed, this was removed and the distal femoral cutting guide was then placed. The left knee placed in 5 degrees of valgus, guide was then placed, and a standard distal cut was then taken. After the cuts were ensured further to be leveled and they were, and we proceeded to place the finishing guide size E and distal femur. This was placed slightly in lateral position and secured in position with spring tense and head lift tense. Once adequately secured and placed in the appropriate orientation, the alignment was again verified with the epicondyle axis and appeared to be externally rotated appropriately. The chamfer cuts and anterior and posterior cuts were then made as well as the notch cut using the reciprocating and oscillating saws. After this was performed, the guide was removed and all bony fragments were then removed. Attention was then directed to the tibia. The external tibial alignment guide was then placed and pinned to the proximal tibia in a proper position. Care was ensured if it is was a varus or valgus and the appropriate. The

femur gauge was then used to provide us appropriate amount of bony resection. This was then pinned and secured into place. Ligament retractors were used to protect the collateral ligaments and the tip proximal tibial cut was then made. This bony portion was then removed and remaining meniscal fragments were removed as well as the ACL till adequate exposure was obtained. Trial components were then inserted into position and taken the range of motion and found to have good and full excellent range of motion stability. The trial components were then removed. The tibia was then stemmed in standard fashion after the tibial plate was placed in some degree of external rotation with appropriate alignment. After it was stemmed and broached, these were removed and the patella was then incised, a size 41 patella reamer blade was then used and was taken down, a size 38 patella button was then placed intact. Again the trial components were placed back into position. Patella button was placed and the tracking was evaluated. They tracked centrally with no touch technique. Again, all components were now removed and the knee was then copiously irrigated and suctioned dry. Once adequately suctioned dry, the tibial portion was cemented and packed into place. Also excess cement was removed. The femoral component was then cemented into position. All excess cement was removed. A size 12 poly was then inserted in trial to provide compression at cement adhered. The patella was then cemented and held into place. All components were held under compression until cement had adequately adhered all excess cement was then removed.

The knee was then taken through range of motion and size 12 felt to be slightly too big, this was removed and the size 10 trial was replaced, and again had excellent varus and valgus stability with full range of motion and felt to be the articulate surface of choice. The knee was again copiously irrigated and suctioned dry. One last check in the posterior aspect of the knee for any loose bony fragments or osteophytes was performed, there were none found and a final articulating surface was impacted and locked into place. After this, the knee was taken again for final range of motion and found to have excellent position, stability, and good alignment of the components. The knee was once again copiously irrigated, and the tourniquet was deflated. Bovie cautery was used to cauterize the knee bleeding that was seen until good hemostasis obtained. A drain was then placed deep to the retinaculum and the retinaculum repair was performed using #2-0 Ethibond and oversewn with a #1 Vicryl. This was flexed and the repair was found held securely. At this point, the knee was again copiously irrigated and suctioned dry. The subcutaneous tissue was closed with #2-0 Vicryl, and the skin was approximated with skin staples. Sterile dressing with Adaptic, 4x4s, ABDs, and Kerlix rolls was then applied. The patient was then transferred back to the gurney in a supine position.,DISPOSITION: , The patient tolerated well with no complications, to PACU in satisfactory condition.