PREOPERATIVE DIAGNOSIS:, Left elbow with retained hardware.,POSTOPERATIVE DIAGNOSIS: , Left elbow with retained hardware.,PROCEDURE: , ,1. Left elbow manipulation.,2. Hardware removal of left elbow.,ANESTHESIA: ,Surgery was performed under general anesthesia.,COMPLICATIONS:, There were no intraoperative complications.,DRAINS: , None.,SPECIMENS: , None.,INTRAOPERATIVE FINDING: , Preoperatively, the patient is 40 to 100 degrees range of motion with limited supination and pronation of about 20 degrees. We increased his extension and flexion to about 20 to 120 degrees and the pronation and supination to about 40 degrees.,LOCAL ANESTHETIC: ,10 mL of 0.25% Marcaine.,HISTORY AND PHYSICAL: , The patient is a 10-year-old right-hand dominant male, who threw himself off a quad on 10/10/2007. The patient underwent open reduction and internal fixation of his left elbow fracture dislocation. The patient also sustained a nondisplaced right glenoid neck fracture. The patient's fracture has healed without incident, although he had significant postoperative stiffness for which he is undergoing physical therapy, as well as use of a Dynasplint. The patient is neurologically intact distally. Given the fact that his fracture has healed, surgery was recommended for hardware removal to decrease his irritation with elbow extension from the hardware. Risks and benefits of the surgery were discussed. The risks of surgery included the risk of anesthesia, infection, bleeding, changes in sensation and motion of the extremities, failure to remove hardware, failure to relieve pain, continued

postoperative stiffness. All questions were answered and the parents agreed to the above plan.,PROCEDURE: ,The patient was taken to the operating room and placed supine on the operating table. General anesthesia was then administered. The patient's left upper extremity was then prepped and draped in a standard surgical fashion. Using fluoroscopy, the patient's K-wire was located. An incision was made over his previous scar. A subcutaneous dissection then took place in the plane between the subcutaneous fat and muscles. The K-wires were easily palpable. A small incision was made into the triceps, which allowed for visualization of the two pins, which were removed without incident. The wound was then irrigated. The triceps split was now closed using #2-0 Vicryl. The subcutaneous tissue was also closed using #2-0 Vicryl and the skin with #4-0 Monocryl. The wound was clean and dry and dressed with Steri-Strips, Xeroform, and 4 x 4s, as well as bias. A total of 10 mL of 0.25% Marcaine was injected into the incision, as well as the joint line. At the beginning of the case, prior to removal of the hardware, the arm was taken through some strenuous manipulations with improvement of his extension to 20 degrees, flexion to 130 degrees and pronation supination to about 40 degrees.,DIAGNOSTIC IMPRESSION: ,The postoperative films demonstrated no fracture, no retained hardware. The patient tolerated the procedure well and was subsequently taken to the recovery room in stable condition.,POSTOPERATIVE PLAN: , The patient will restart physical therapy and Dynasplint in 3 days. The patient is to follow up in 1 week's time for a wound check.

The patient was given Tylenol No. 3 for pain.