PREOPERATIVE DIAGNOSIS: , Tailor's bunion, right foot.,POSTOPERATIVE DIAGNOSIS: , Tailor's bunion, right foot.,PROCEDURE: , Closing wedge osteotomy, fifth metatarsal with internal screw fixation, right foot.,ANESTHESIA: , Local infiltrate with IV sedation.,INDICATIONS FOR SURGERY: , The patient has had a longstanding history of foot problems. The problem has been progressive in nature. The preoperative discussion with the patient included alternative treatment options, the procedure was explained, and the risk factors such as infection, swelling, scar tissue, numbness, continued pain, recurrence, and the postoperative management were discussed. The patient has been advised, although no guarantee for success could be given, most of the patient have less pain and improved function, all questions were thoroughly answered. The patient requested for surgical repair since the problem has reached a point that interfere with normal daily activity. The purpose of the surgery is to alleviate pain and discomfort.,DETAILS OF PROCEDURE: ,The patient was given 1 g of Ancef IV for antibiotic prophylaxis 30 minutes prior to the procedure. The patient was brought to the operating room and placed in the supine position. No tourniquet was utilized. IV sedation was achieved followed by a local anesthetic consisting of approximately 10 mL total in 1:1 mixture of 0.25% Marcaine and 1% lidocaine with epinephrine was locally infiltrated proximal to the operative site. The lower extremity was prepped and draped in the usual sterile manner. Balanced anesthesia was

obtained.,PROCEDURE:, Closing wedge osteotomy, fifth metatarsal with internal screw fixation, right foot. A dorsal curvilinear incision was made extending from the base of the proximal phalanx fifth digit to a point 1.5 cm from the base of the fifth metatarsal. Care was taken to identify and retract all vital structures and when necessary, vessels were ligated via electrocautery. The extensor tendon was identified and retracted medially. Sharp and blunt dissection was carried down through the subcutaneous tissue down to the periosteal layer. A linear periosteal capsular incision was made in line with the skin incision. The capsular tissue and periosteal layer was underscored, free from its underlying osseous attachment, and then reflected to expose the osseous surface. Inspection of the fifth metatarsophalangeal joint revealed articular cartilage to be perverse and hypertrophic changes to the lateral and dorsolateral aspect of the fifth metatarsal head. An oscillating saw was utilized to carefully resect the hypertrophic portion of the fifth metatarsal head to a more normal configuration. The both edges were rasped smooth.,Attention was then focused on the fifth metatarsal. The periosteal layer proximal to the fifth metatarsal head was underscored, free from its underlying attachment, and then reflected to expose the osseous surface. An excess guide position perpendicular to the weightbearing surface was placed to define apex of the osteotomy.,Using an oscillating saw, a vertically placed, wedge-shaped oblique ostomy was made with the apex being proximal, lateral, and the base medial and distal. Generous amounts of lateral cortex were

preserved for the lateral hinge. The wedge was removed from the surgical field. The fifth metatarsal was placed in the appropriate position and stabilized with a guide pin, which was then countersunk and a 3-0 x 40 mm cannulated cortical screw was placed over the guide pin and secured into position. Good purchase was noted at the osteotomy site. Inspection revealed satisfactory reduction of the fourth intermetatarsal angle with the fifth metatarsal in good alignment and position. The surgical site was flushed with copious amounts of normal saline irrigation. The periosteal and capsular layers were closed with running sutures of 3-0 Vicryl. The subcutaneous tissues were closed with 4-0 Vicryl, and the skin edges were closed with 4-0 nylon in a running interrupted fashion. A dressing consisting of Adaptic, 4 x 4, confirming bandages, and ACE wrap to provide mild compression was applied. The patient tolerated the procedure and anesthesia well and left the operating room to the recovery room in good postoperative condition with vital signs stable and arterial perfusion intact as evident by normal capillary refill time, and all digits were warm and pink.,A walker boot was dispensed and applied. The patient should wear that all the time when standing or walking and be nonweightbearing with crutches and to clear by me.,Office visit will be in 4 days. The patient was given prescriptions for Keflex 500 mg one p.o. t.i.d. for 10 days and Ultram ER, #15 one p.o. daily along with written and oral home instructions including a number on which I can be reached 24 hours a day if any problem arises.,After short recuperative period, the

patient was discharged home with a vital sign stable in no acute distress.