TITLE OF OPERATION: , Youngswick osteotomy with internal screw fixation of the first right metatarsophalangeal joint of the right foot.,PREOPERATIVE DIAGNOSIS: , Hallux limitus deformity of the right foot.,POSTOPERATIVE DIAGNOSIS: , Hallux limitus deformity of the right foot.,ANESTHESIA:, Monitored anesthesia care with 15 mL of 1:1 mixture of 0.5% Marcaine and 1% lidocaine plain.,ESTIMATED BLOOD LOSS:, Less than 10 mL.,HEMOSTASIS:, Right ankle tourniquet set at 250 mmHg for 35 minutes.,MATERIALS USED: , 3-0 Vicryl, 4-0 Vicryl, and two partially threaded cannulated screws from 3.0 OsteoMed System for internal fixation.,INJECTABLES: ,Ancef 1 g IV 30 minutes preoperatively.,DESCRIPTION OF THE PROCEDURE: , The patient was brought to the operating room and placed on the operating table in the supine position. After adequate sedation was achieved by the anesthesia team, the above-mentioned anesthetic mixture was infiltrated directly into the patient's right foot to anesthetize the future surgical site. The right ankle was then covered with cast padding and an 18-inch ankle tourniquet was placed around the right ankle and set at 250 mmHg. The right ankle tourniquet was then inflated. The right foot was prepped, scrubbed, and draped in normal sterile technique. Attention was then directed on the dorsal aspect of the first right metatarsophalangeal joint where a 6-cm linear incision was placed just parallel and medial to the course of the extensor hallucis longus to the right great toe. The incision was deepened through the subcutaneous tissues. All the bleeders were identified, cut, clamped, and cauterized. The

incision was deepened to the level of the capsule and the periosteum of the first right metatarsophalangeal joint. All the tendinous and neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, all the capsular and periosteal attachments were mobilized from the base of the proximal phalanx of the right great toe and head of the first right metatarsal. Once the base of the proximal phalanx of the right great toe and the first right metatarsal head were adequately exposed, multiple osteophytes were encountered. Gouty tophi were encountered both intraarticularly and periarticularly for the first right metatarsophalangeal joint, which were consistent with a medical history that is positive for gout for this patient.,Using sharp and dull dissection, all the ligamentous and soft tissue attachments were mobilized and the right first metatarsophalangeal joint was freed from all adhesions. Using the sagittal saw, all the osteophytes were removed from the dorsal, medial, and lateral aspect of the first right metatarsal head as well as the dorsal, medial, and lateral aspect of the base of the proximal phalanx of the right great toe. Although some improvement of the range of motion was encountered after the removal of the osteophytes, some tightness and restriction was still present. The decision was thus made to perform a Youngswick-type osteotomy on the head of the first right metatarsal. The osteotomy consistent of two dorsal cuts and a plantar cut in a V-pattern with the apex of the osteotomy distal and the base of the osteotomy proximal. The two dorsal cuts were longer than the plantar cut

in order to accommodate for the future internal fixation. The wedge of bone that was formed between the two dorsal cuts was resected and passed off to Pathology for further examination. The head of the first right metatarsal was then impacted on the shaft of the first right metatarsal and provisionally stabilized with two wires from the OsteoMed System. The wires were inserted from a dorsal distal to plantar proximal direction through the dorsal osteotomy. The wires were also used as guidewires for the insertion of two 16-mm proximally threaded cannulated screws from the OsteoMed System. The 2 screws were inserted using AO technique. Upon insertion of the screws, the two wires were removed. Fixation of the osteotomy on the table was found to be excellent. The area was copiously flushed with saline and range of motion was reevaluated and was found to be much improved from the preoperative levels without any significant restriction. The cartilaginous surfaces on the base of the first right metatarsal and the base of the proximal phalanx were also fenestrated in order to induce some cartilaginous formation. The capsule and periosteal tissues were then reapproximated with 3-0 Vicryl suture material, 4-0 Vicryl was used to approximate the subcutaneous tissues. Steri-Strips were used to approximate and reinforce the skin edges. At this time, the right ankle tourniquet was deflated. Immediate hyperemia was noted in the entire right lower extremity upon deflation of the cuff. The patient's surgical site was then covered with Xeroform, copious amounts of fluff and Kling, stockinette, and Ace bandage. The patient's right foot was

placed in a surgical shoe and the patient was then transferred to the recovery room under the care of the anesthesia team with her vital signs stable and neurovascular status at appropriate levels. The patient was given instructions and education on how to continue caring for her right foot surgery at home. The patient was also given pain medication instructions on how to control her postoperative pain. The patient was eventually discharged from Hospital according to nursing protocol and was advised to follow up with Dr. X's office in one week's time for her first postoperative appointment.