PREOPERATIVE DIAGNOSIS: , Left medial compartment osteoarthritis of the knee.,POSTOPERATIVE DIAGNOSIS:, Left medial compartment osteoarthritis of the knee.,PROCEDURE PERFORMED:, Left unicompartmental knee replacement.,COMPONENTS USED:, Biomet size medium femoral component size B tibial tray and a 3 mm polyethylene component.,COMPLICATIONS:, None.,TOURNIQUET TIME: , 59 minutes.,BLOOD LOSS: , Minimal.,INDICATIONS FOR PROCEDURE: , A 55-year-old female who had previously undergone a Biomet Oxford unicompartmental knee replacement on the right side. She has done quite well with this. She now has had worsening left knee pain predominantly on the inside of her knee and has consented for unicompartmental knee replacement on the left.,DESCRIPTION OF PROCEDURE IN DETAIL: , The patient was brought to the operating room and placed supine on the operating room table. After appropriate anesthesia, the left lower extremity was identified with a time out procedure. Preoperative antibiotics were given. Left lower extremity was then prepped and draped in usual sterile fashion after applying a thigh tourniquet. The tourniquet was insufflated after elevation of the limb, and a standard medial parapatellar incision was used. Soft tissue dissection was carried down the retinaculum, was opened sharply to expose the joint, meniscus that was visible along the tibia was removed. The anterior fat pad was removed. The knee was then examined. The ACL was found to be intact. The lateral compartment had very minimal arthritis. There were some osteoarthritic

changes of the patellofemoral joint, but these were felt to be mild. Following this, the tibial external alignment guide was placed and pinned into place in the appropriate place. Tibial bone cut was made and checked with a feeler gauge and felt to be an adequate resection. Following this resection, the femoral intramedullary guide was placed without difficulty. The femoral cutting guide was then placed and referenced off of this femoral intramedullary guide. Once in the appropriate position, it was pinned and drilled. This was removed, and the posterior cutting block was inserted. It was impacted into place. Posterior bone cut was made for the medium femoral component. Next, a zero spigot was used and the distal femur was reamed. Following this, the check of the extension and flexion gaps revealed that an additional 1 mm needed to be reamed, so 1 spigot was used and this was reamed as well. Next, trial components were placed into the knee and the knee was taken through range of motion and felt to come out to full extension with a 3 mm poly with a good fit. Next, the tibia was prepared. The tibial tray was pinned into place, and the cuts for the keel of the tibia were made. These were removed with a small osteotome from the set. Following this, a trial tibial with the keel was placed and it did fit nicely. After this, all trial components were removed. The knee was copiously irrigated. Cement was begun mixing. Drill holes were used along the femur for cement interdigitation. The wound was cleaned and dried. Cement was placed on the tibia. Tibial tray was impacted into place. Excess cement was removed. Tibia was placed in the femur. Femoral component

was impacted into place. Excess cement was removed. It was held with a 4 mm trial insert and approximately 30 degrees of knee flexion until the cement had hardened. Following this, it was again trialed with a meniscal bearing implant and it was felt that 3 mm would be the appropriate size. A 3 mm polyethylene was chosen and inserted in the knee without difficulty, taken through range of motion and found to come out to full extension with no impingement and full flexion. The intramedullary rod removed from the femur. The wound was irrigated with normal saline. The retinaculum was closed with #1 PDS, 2-0 Monocryl was used for the subcutaneous tissue and staples used for the skin. A sterile dressing was placed. Tourniquet was then desufflated. Sponge and needle counts were correct at the end of the procedure. Dr. Jinnah was present for the surgery. The patient was transferred to the recovery room in stable condition. She will be weightbearing as tolerated in the left lower extremity and will be maintained on Lovenox for DVT prophylaxis. Prior to closure, the posterior capsule was injected with the joint cocktail.