PREOPERATIVE DIAGNOSES:,1. Metatarsus primus varus with bunion deformity, right foot.,2. Hallux abductovalgus with angulation deformity, right foot.,POSTOPERATIVE DIAGNOSES:,1. Metatarsus primus varus with bunion deformity, right foot.,2. Hallux abductovalgus with angulation deformity, right foot.,PROCEDURES:,1. Distal metaphyseal osteotomy and bunionectomy with internal screw fixation, right foot.,2. Reposition osteotomy with internal screw fixation to correct angulation deformity of proximal phalanx, right foot.,ANESTHESIA:,Local infiltrate with IV sedation.,INDICATION FOR SURGERY: , The patient has had a longstanding history of foot problems. The foot problem has been progressive in nature and has not been responsive to conservative treatment. The preoperative discussion with the patient included the alternative treatment options.,The procedure was explained in detail and risk factors such as infection, swelling, scarred tissue; numbness, continued pain, recurrence, and postoperative management were explained in detail. The patient has been advised, although no guaranty for success could be given, most patients have improved function and less pain. All questions were thoroughly answered. The patient requested surgical repair since the problem has reached a point that interferes with her normal daily activities. The purpose of the surgery is to alleviate the pain and discomfort.,DETAILS OF PROCEDURE: ,The patient was brought to the operating room and placed in a supine position. No tourniquet was utilized. IV sedation was administered and during that time local anesthetic consisting of approximately

10 mL total in a 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 #1: , Distal metaphyseal osteotomy with internal screw fixation with bunionectomy, right foot. A dorsal curvilinear incision medial to the extensor hallucis longus tendon was made, extending from the distal third of the shaft of the first metatarsal to a point midway on the shaft of the proximal phalanx. Care was taken to identify and retract the vital structures and when necessary, vessels were ligated via electrocautery. Sharp and blunt dissection was carried down through the subcutaneous tissue, superficial fascia, and then down to the capsular and periosteal layer, which was visualized. A linear periosteal capsular incision was made in line with the skin incision. The capsular tissue and periosteal layer were underscored, free from its underlying osseous attachments, and they refracted to expose the osseous surface. Inspection revealed increased first intermetatarsal angle and hypertrophic changes to the first metatarsal head. The head of the first metatarsal was dissected free from its attachment medially and dorsally, delivered dorsally and may be into the wound.,Inspection revealed the first metatarsophalangeal joint surface appeared to be in satisfactory condition. The sesamoid was in satisfactory condition. An oscillating saw was utilized to resect the hypertrophic portion of the first metatarsal head to remove the normal and functional configuration. Care was taken to

preserve the sagittal groove. The rough edges were then smoothed with a rasp.,Attention was then focused on the medial mid portion of the first metatarsal head where a K-wire access guide was positioned to define the apex and direction of displacement for the capital fragment. The access guide was noted to be in good position. A horizontally placed, through-and-through osteotomy with the apex distal and the base proximal was completed. The short plantar arm was from the access guide to proximal plantar and the long dorsal arm was from the access guide to proximal dorsal. The capital fragment was distracted off the first metatarsal, moved laterally to decrease the intermetatarsal angle to create a more anatomical and functional position of the first metatarsal head. The capital fragment was impacted upon the metatarsal.,Inspection revealed satisfactory reduction of the intermetatarsal angle and good alignment of the capital fragment. It was then fixated with 1 screw. A guide pin was directed from the dorsal aspect of the capital fragment to the plantar aspect of the shaft and first metatarsal in a distal dorsal to proximal plantar direction. The length was measured, _____ mm cannulated cortical screw was placed over the guide pin and secured in position. Compression and fixation were noted to be satisfactory. Inspection revealed good fixation and alignment at the operative site. Attention was then directed to the medial portion of the distal third of the shaft of the first metatarsal where an oscillating saw was used to resect the small portion of the bone that was created by shifting the capital fragment

laterally. All rough edges were rasped smooth. Examination revealed there was still lateral deviation of the hallux. A second procedure, the reposition osteotomy of the proximal phalanx with internal screw fixation to correct angulation deformity was indicated., ,PROCEDURE #2:, Reposition osteotomy with internal screw fixation to correct angulation deformity, proximal phalanx, right hallux. The original skin incision was extended from the point just distal to the interphalangeal joint. All vital structures were identified and retracted. Sharp and blunt dissection was carried down through the subcutaneous tissue, superficial fascia, and down to the periosteal layer, which was underscored, free from its underlying osseous attachments and reflected to expose the osseous surface. The focus of the deformity was noted to be more distal on the hallux. Utilizing an oscillating saw, a more distal, wedge-shaped transverse oblique osteotomy was made with the apex being proximal and lateral and the base medial distal was affected. The proximal phalanx was then placed in appropriate alignment and stabilized with a guide pin, which was then measured, _____ 14 mm cannulated cortical screw was placed over the guide pin and secured into position.,Inspection revealed good fixation and alignment at the osteotomy site. The alignment and contour of the first way was now satisfactorily improved. The entire surgical wound was flushed with copious amounts of sterile normal saline irrigation. The periosteal and capsular layer was closed with running sutures of #3-0 Vicryl. The subcutaneous tissue was closed with #4-0 Vicryl and the skin edges coapted

well with #4-0 nylon with running simples, reinforced with Steri-Strips.,Approximately 6 mL total in a 1:1 mixture of 0.25% Marcaine and 1% lidocaine plain was locally infiltrated proximal to the operative site for postoperative anesthesia. A dressing consisting of Adaptic and 4 x 4 was applied to the wound making sure the hallux was carefully splinted, followed by confirming bandages and an ACE wrap to provide mild compression. The patient tolerated the procedure and anesthesia well and left the operating room to recovery room in good postoperative condition with vital signs stable and arterial perfusion intact as evident by the normal capillary fill time.,A walker boot was dispensed and applied. The patient should wear it when walking or standing., ,The next office visit will be in 4 days. The patient was given prescriptions for Percocet 5 mg #40 one p.o. q.4-6h. p.r.n. pain, along with written and oral home instructions. The patient was discharged home with vital signs stable in no acute distress.