PREOPERATIVE DIAGNOSIS: , Soft tissue mass, right foot.,POSTOPERATIVE DIAGNOSIS: , Soft tissue mass, right foot.,PROCEDURE PERFORMED: , Excision of soft tissue mass, right foot.,HISTORY: ,The patient is a 51-year-old female with complaints of soft tissue mass over the dorsum of the right foot. The patient has had previous injections to the site which have caused the mass to decrease in size, however, the mass continues to be present and is irritated and painful with shoes. The patient has requested surgical intervention at this time.,PROCEDURE: ,After an IV was instituted by the Department of Anesthesia, the patient was escorted from the preoperative holding area to the operating room. The patient was then placed on the operating room table in the supine position and a towel was placed around the patient's abdomen and secured her to the table. Using copious amounts of Webril, a pneumatic ankle tourniquet was applied to her right ankle. Using a Skin Skribe, the area of the soft tissue mass was outlined over the dorsum of her foot. After adequate amount of anesthesia was provided by the Department of Anesthesia, a local ankle block was given using 10 cc of 4.5 mL of 1% lidocaine plain, 4.5 mL of 0.5% Marcaine plain and 1.0 mL of Solu-Medrol and the foot was scrubbed and prepped in a normal sterile orthopedic manner. Following this, the ankle was elevated and Esmarch bandage applied to exsanguinate the foot and the ankle tourniquet was inflated to 250 mmHg. The foot was then brought back down to the table using bandage scissors. The stockinette was reflected and the right foot was exposed. Using a fresh #10

blade, a curvilinear incision was performed over the dorsum of the right foot. Then using a #15 blade, the incision was deepened with care taken to identify and avoid or cauterize any bleeders which were noted. Following this, the incision was deepened using a combination of sharp and blunt dissection and the muscle belly of the extensor digitorum brevis muscle was identified. Further dissection was then performed in the medial direction in the area of the soft tissue mass. The intermediate dorsal cutaneous nerve was identified and gently retracted laterally. Large amounts of adipose tissue were noted medial to the belly of the extensor digitorum brevis muscle. Using careful dissection, adipose tissue in this area was removed and saved for pathology. Following removal of adipose tissue in this area and identification of no more adipose tissue, attention was directed lateral to the belly of the extensor digitorum brevis muscle, which was also noted to have large amounts of adipose tissue in this area as well. Using careful dissection, from the lateral border of the foot as much adipose tissue as possible was removed from this area as well and saved for pathology. There was noted to be no other fluid-filled masses or lesions identifiable in this area then between the slits of the extensor digitorum brevis muscle, careful dissection was performed to examine the underside of the belly of the muscle as well as structures beneath and no abnormal structures were identified here as well. Following this, feeling adequately that no other mass remained in the area, the incision was flushed using copious amounts of sterile saline. The wound was then reinspected and all

remaining tissues appeared healthy including the subcutaneous tissue. The tendon and muscle belly of the extensor digitorum brevis muscle, the nerves of the intermediate dorsal cutaneous nerve and also the medial dorsal cutaneous nerve which were identified medially, all appeared intact. No deficits were noted. No abnormal appearing tissue was present within the surgical site. Following this, the skin edges were reapproximated using #4-0 Vicryl deep closure of the subcutaneous layer was performed. Then, using #4-0 nylon and simple interrupted suture, the skin was reapproximated and closed with care taken to ensure eversion of the skin edges and good approximation of the borders. The patient was also given 7 cc of 1% lidocaine plain throughout the procedure to augment local anesthesia. Following this, the wound was dressed using Xeroform gauze and 4x4s and was dressed using two ABD pads, dorsal and plantar for compression and using Kling, Kerlix and Coban. The patient then had the ankle tourniquet deflated with a total tourniquet time of 55 minutes at 250 mmHg and immediate hyperemia was noted to digits one through five of the right foot. The patient tolerated the procedure and anesthesia well and was noted to have vascular status intact. The patient was then escorted to the Postanesthesia Care Unit where she was placed in a surgical shoe. The patient was then given postoperative instructions to include ice and elevation to her right foot. The patient was cleared for ambulation as tolerated, but was instructed that with increased ambulation will come increased swelling and

pain. The patient will follow up with Dr. X in his office on Tuesday, 08/26/03 for further follow up. The patient was given prescription for Vicoprofen #25 taken one tablet q.4h. p.r.n., moderate to severe pain and also prescription for Keflex #20 500 mg tablets to be taken b.i.d. x10 days. The patient was given a number for the Emergency Room and instructed to return if any sign or symptom of infection should present and the patient was educated as to the nature of these. The patient had no further questions and recovered without any complications in the Postanesthesia Care Unit.