TITLE OF OPERATION:,1. Open reduction internal fixation (ORIF) with irrigation and debridement of open fracture including skin, muscle, and bone using a Synthes 3.5 mm locking plate on the lateral malleolus and two Synthes 4.5 mm cannulated screws medial malleolus.,2. Closed reduction and screw fixation of right femoral neck fracture using one striker Asnis 8.0 mm cannulated screw and two 6.5 mm cannulated screws.,3. Retrograde femoral nail using a striker T2 retrograde nail 10 x 340 with a 10 mm INCAP and two 5 mm distal locking screws and two 5 mm proximal locking screws.,4. Irrigation and debridement of right knee.,5. Irrigation and debridement of right elbow abrasions.,PREOP DIAGNOSIS:,1. Right open ankle fracture.,2. Right femoral shaft fracture.,3. Right femoral neck fracture.,4. Right open knee.,5. Right elbow abrasions.,POSTOP DIAGNOSIS:,1. Right open ankle fracture.,2. Right femoral shaft fracture.,3. Right femoral neck fracture.,4. Right open knee.,5. Right elbow abrasions.,INTRAVENOUS FLUIDS: , 650 packed red blood cells.,TOURNIQUET TIME: , 2 hours.,URINE OUTPUT: ,1600 cubic centimeters.,ESTIMATED BLOOD LOSS: , 250 cubic centimeters.,COMPLICATIONS:, None.,PLAN:, non-weightbearing right lower extremity, clindamycin x 48 hours.,OPERATIVE NARRATIVE:, The patient is a 53-year-old female who is a pedestrian struck, in a motor vehicle accident and sustained numerous injuries. She sustained a right open ankle fracture, right femur fracture, right femoral neck fracture, right open knee, and right elbow abrasions. Given the emergent nature of the right femoral

neck fracture and her young age as well as the open fracture, it was decided to proceed with an urgent operative intervention. The risks of surgery were discussed in detail and the consents were signed. The operative site was marked. The patient was taken to the operating room where she was given preoperative clindamycin. The patient had then general anesthetic performed by anesthesia.,A well-padded side tourniquet was placed. Attention was turned to the right ankle first. The large medical laceration was extended and the tissues were debrided. All dirty of the all injured bone, muscle, and tissues were debrided. Wound was then copiously irrigated with 8 liters of normal saline. At this point, the medial malleolus fracture was identified and was reduced. This was then fixed in with two 4.5 mm cannulated Synthes screws.,Next, the attention was turned to lateral malleolus. Incision was made over the distal fibula. It was carried down sharply through the skin in the subcutaneous issues. Care was taken to preserve the superficial peroneal nerve. The fracture was identified, and there was noted to be very comminuted distal fibula fracture. The fracture was reduced and confirmed with fluoroscopy. A 7 hole Synthes 3.5 mm locking plate was placed. This was placed in a bridging fashion with three screws above and three screws below the fracture. Appropriate reduction was confirmed under fluoroscopy. A cotton test was performed, and the ankle did not open up. Therefore, it was decided not to proceed with syndesmotic screw.,Next, the patient was then placed in the fracture table and all extremities were well padded. All

prominences were padded. The right leg was then prepped and draped in usual sterile fashion. A 2-cm incision was made just distal to the greater trochanter. This was carried down sharply through the skin to the fascia. The femur was identified. The guidewire for a striker Asnis 6.5 mm screw was placed in the appropriate position. The triangle guide was then used to ensure appropriate triangular formation of the remainder of the screws. A reduction of the fracture was performed prior to placing all the guide wires. A single 8 mm Asnis screw was placed inferiorly followed by two 6.5 mm screws superiorly.,Next, the abrasions on the right elbow were copiously irrigated. The necrotic and dead tissue was removed. The abrasions did not appear to enter the joints. They were wrapped with Xeroform 4 x 4 x 4 Kerlix and Ace wrap.,Next, the lacerations of the anterior knee were connected and were extended in the midline. They were carried down sharply to the skin and the retinacular issues to the joint. The intercondylar notch was identified. A guide wire for the striker T2 retrograde nail was placed and localized with fluoroscopy. The opening reamer was used following the bolted guide wire was then passed. The femur was then sequentially reamed using the flexible reamers. A T2 retrograde nail 10 x 340 was then passed. Two 5 mm distal locking screws and two 5 mm proximal locking screws were then placed.,Prior to reaming and passing the retrograde nail, the knee was copiously irrigated with 8 liters of normal saline. Any dead tissues in the knee were identified and were debrided using rongeurs and curettes.,The patient was placed

in the AO splints for the right ankle. The wounds were dressed with Xeroform 4 x 4 x 4s and IO band. The care was then transferred for the patient to Halstead Service.,The plan will be non-weightbearing right lower extremity and antibiotics for 48 hours.,Dr. X was present and scrubbed for the entirety of the procedure.