

PREOPERATIVE DIAGNOSIS:, Right hallux abductovalgus deformity.,POSTOPERATIVE DIAGNOSIS:, Right hallux abductovalgus deformity.,PROCEDURES PERFORMED:,1. Right McBride bunionectomy.,2. Right basilar wedge osteotomy with OrthoPro screw fixation.,ANESTHESIA: , Local with IV sedation.,HEMOSTASIS: , With pneumatic ankle cuff.,DESCRIPTION OF PROCEDURE: , The patient was brought to the operating room and placed in a supine position. The right foot was prepared and draped in usual sterile manner. Anesthesia was achieved utilizing a 50:50 mixture of 2% lidocaine plain with 0.5 Marcaine plain infiltrated just proximal to the first metatarsocuneiform joint. Hemostasis was achieved utilizing a pneumatic ankle Tourniquet placed above the right ankle and inflated to a pressure of 225 mmHg. At this time, attention was directed to the dorsal aspect of the right first metatarsophalangeal joint where dorsal linear incision approximately 3 cm in length was made. The incision was deepened within the same plane taking care of the Bovie and retracted all superficial nerves and vessels as necessary. The incision was then carried down to the underlying capsular structure once again taking care of the Bovie and retracted all superficial nerves and vessels as necessary. The capsular incision following the same outline as the skin incision was made and carried down to the underlying bony structure. The capsule was then freed from the underlying bony structure utilizing sharp and blunt dissection. Using a microsagittal saw, the medial and dorsal very prominent bony eminence were removed and the area was inspected for any remaining bony

prominences following resection of bone and those noted were removed using a hand rasp. At this time, attention was directed to the first inner space using sharp and blunt dissection. Dissection was carried down to the underlying level of the adductor hallucis tendon, which was isolated and freed from its phalangeal, sesamoidal, and metatarsal attachments. The tendon was noted to lap the length and integrity for transfer and at this time was tenotomized taking out resection of approximately 0.5 cm to help prevent any re-fibrous attachment. At this time, the lateral release was stressed and was found to be complete. The extensor hallucis brevis tendon was then isolated using blunt dissection and was tenotomized as well taking out approximately 0.5-cm resection. The entire area was copiously flushed 3 times using a sterile saline solution and was inspected for any bony prominences remaining and it was noted that the base of the proximal phalanx on the medial side due to the removal of the extensive buildup of the metatarsal head was going to be very prominent in nature and at this time was removed using a microsagittal saw. The area was again copiously flushed and inspected for any abnormalities and/or prominences and none were noted. At this time, attention was directed to the base of the first metatarsal where a second incision was made approximately 4 cm in length. The incision was deepened within the same plane taking care of Bovie and retracted all superficial nerves and vessels as necessary. The incision was then carried down to the level of the metatarsal and using sharp and blunt dissection periosteal capsule structures were

freed from the base of the metatarsal and taking care to retract the long extensive tendon and any neurovascular structures to avoid any disruption. At this time, there was a measurement made of 1 cm just distal to the metatarsocuneiform joint on the medial side and 2 cm distal to the metatarsocuneiform joint from the lateral aspect of the joint. At this time, 0.5 cm was measured distal to that lateral measurement and using microsagittal saw, a wedge osteotomy was taken from the base with the apex of the osteotomy being medial, taking care to keep the medial cortex intact as a hinge. The osteotomy site was feathered down until the osteotomy site could be closed with little tension on it and at this time using an OrthoPro screw 3.0 x 22 mm. The screw was placed following proper technique. The osteotomy site was found to be fixated with absolutely no movement and good stability upon manual testing. A very tiny gap on the lateral aspect of the osteotomy site was found and this was filled in packing it with the cancellous bone that was left over from the wedge osteotomy. The packing of the cancellous bone was held in place with bone wax. The entire area was copiously flushed 3 times using a sterile saline solution and was inspected and tested again for any movement of the osteotomy site or any gapping and then removed. At this time, a deep closure was achieved utilizing #2-0 Vicryl suture, subcuticular closure was achieved using #4-0 Vicryl suture, and skin repair was achieved at both surgical sites with #5-0 nylon suture in a running interlocking fashion. The hallux was found to have excellent movement upon completion of the

osteotomy and the second procedure of the McBride
bunionectomy and the metatarsal was found to stay in
excellent alignment with good stability at the proximal
osteotomy site. At this time, the surgical site was
postoperatively injected with 0.5 Marcaine plain as well as
dexamethasone 4 mg primarily. The surgical sites were then
dressed with sterile Xeroform, sterile 4x4s, cascading, and
Kling with a final protective layer of fiberglass in a
nonweightbearing cast fashion. The tourniquet was dropped
and color and temperature of all digits returned to normal. The
patient tolerated the anesthesia and the procedure well and
left the operating room in stable condition.,The patient has
been given written and verbal postoperative instructions and
has been instructed to call if she has any questions, problems,
or concerns at any time with the numbers provided. The
patient has also been warned a number of times the
importance of elevation and no weightbearing on the surgical
foot.,