PREOPERATIVE DIAGNOSES:,1. Right carpal tunnel syndrome.,2. Right index finger and middle fingers tenosynovitis.,POSTOPERATIVE DIAGNOSES:,1. Right carpal tunnel syndrome.,2. Right index finger and middle fingers tenosynovitis.,PROCEDURES PERFORMED:,1. Right carpal tunnel release.,2. Right index and middle fingers release A1 pulley.,TOURNIQUET TIME: ,70 minutes.,BLOOD LOSS: , Minimal.,GROSS INTRAOPERATIVE FINDINGS:,1. A compressed median nerve at the carpal tunnel, which was flattened.,2. A stenosing tenosynovitis of the A1 pulley of the right index as well as middle fingers. After the A1 pulley was released, there was evidence of some synovitis as well as some fraying of the flexor digitorum profundus as well as flexor digitorum superficialis tendons.,HISTORY: ,This is a 78-year-old male who is complaining of right hand pain and numbness with decreased range of the middle index finger and right middle finger complaining of catching and locking. The patient was diagnosed with carpal tunnel syndrome on bilateral hands the right being worse than the left. He had positive EMG findings as well as clinical findings. The patient did undergo an injection, which only provided him with temporary relief and is for this reason, he has consented to undergo the above-named procedure.,All risks as well as complications were discussed with the patient and consent was obtained.,PROCEDURE: ,The patient was wheeled back to the operating room #1 at ABCD General Hospital on 08/29/03. He was placed supine on the operating room table. Next, a non-sterile tourniquet was placed on the right forearm,

but not inflated. At this time, 8 cc of 0.25% Marcaine with epinephrine was instilled into the carpal tunnel region of the volar aspect of the wrist for anesthesia. In addition, an additional 2 cc were used on the superficial skin of the volar palm over the A1 pulley of the right index and right middle fingers. At this time, the extremity was then prepped and draped in usual sterile fashion for this procedure. First, we went for release of the carpal tunnel. Approximately 2.5 cm incision was made over the volar aspect of the wrist over the carpal tunnel region. First, dissection through the skin in the superficial fascia was performed with a self-retractor placed in addition to Ragnells retracting proximally and distally. The palmaris brevis muscle was then identified and sharply transected. At this time, we identified the transverse carpal tunnel ligament and a #15 blade was used to sharply and carefully release that fascia. Once the fascia of the transverse carpal ligament was transected, the identification of the median nerve was visualized. The resection of the ligament was taken both proximally and distally to assure complete release and it was checked thoroughly. At this time, a neurolysis was performed and no evidence of space-occupying lesions were identified within the carpal tunnel. At this time, copious irrigation was used to irrigate the wound. The wound was suctioned dry. At this time, we proceeded to the release of the A1 pulleys. Approximately, a 1.5 cm incision was made over the A1 pulley in the volar aspect of the palm of the right index and right middle fingers. First, we went for the index finger. Once the skin incision was

made, Metzenbaum scissor was used to longitudinally dissect the subcutaneous tissue and with Ragnell retractors we identified the A1 pulley. A #15 blade was used to make a longitudinal slit along with A1 pulley and the Littler scissors were used to release the A1 pulley proximally as well as distally. Once this was performed, a tendon hook was then used to wrap the tendon and release the tendons both proximally and distally and they were removed from the wound in order to check their integrity. There was some evidence of synovitis in addition to some fraying of the both the profundus as well as superficialis tendons. Once a thorough release was performed, copious irrigation was used to irrigate that wound. In the similar fashion, a 1.5 cm incision was made over the volar aspect of the A1 pulley of the right middle finger. A Littler scissor was used to bluntly dissect in the longitudinal fashion. With the Ragnell retractors, we identified the A1 pulley of the right middle finger.,Using a #15 blade, the A1 pulley was scored with the #15 blade and the Litter scissor was used to complete the release of the A1 pulley distally and proximally. We again placed the tendon hook around both the superficialis and the profundus tendons and they were extruded from the wound to check their integrity. Again, there was evidence of some synovitis as well as fraying of both tendons. The girth of both tendons and both wounds were within normal limits. At this time, copious irrigation was used to irrigate the wound. The patient was then asked to intraoperatively flex and extend his fingers and he was able to fully flex his fingers to make a close fit which he

was not able to do preoperatively. In addition, he was able to abduct his thumb indicating that the recurrent branch of the median nerve was intact. At this time, #5-0 nylon was used to approximate in a vertical mattress type fashion both the carpal tunnel incision as well as the both A1 pulley incisions of the right middle finger and right index finger. The wound closure took place after the tourniquet was released and hemostasis was obtained with Bovie cautery. At this time, a short-arm splint was placed on the volar aspect of the wrist after it was wrapped in a sterile dressing consisting of Adaptic and Kerlix roll. The patient was then carefully taken off of the operating room table to Recovery in stable condition.