PREOPERATIVE DIAGNOSIS:, Osteomyelitis, right hallux.,POSTOPERATIVE DIAGNOSIS: , Osteomyelitis, right hallux.,PROCEDURE PERFORMED:, Amputation distal phalanx and partial proximal phalanx, right hallux.,ANESTHESIA:, TIVA/local.,HISTORY:, This 44-year-old male patient was admitted to ABCD General Hospital on 09/02/2003 with a diagnosis of osteomyelitis of the right hallux and cellulitis of the right lower extremity. The patient has a history of diabetes and has had a chronic ulceration to the right hallux and has been on outpatient antibiotics, which he failed. The patient after a multiple conservative treatments such as wound care antibiotics, the patient was given the option of amputation as a treatment for the chronic resistant osteomyelitis. The patient desires to attempt a surgical correction. The risks versus benefits of the procedure were discussed with the patient in detail by Dr. X. The consent was available on the chart for review.,PROCEDURE IN DETAIL: , After patient was taken to the operating room via cart and placed on the operating table in the supine position, a safety strap was placed across his waist. Adequate IV sedation was administered by the Department of Anesthesia and a total of 3.5 cc of 1:1 mixture 1% lidocaine and 0.5% Marcaine plain were injected into the right hallux as a digital block. The foot was prepped and draped in the usual aseptic fashion lowering the operative field.,Attention was directed to the hallux where there was a full-thickness ulceration to the distal tip of the hallux measuring 0.5 cm x 0.5 cm. There was a _____ tract,

which probed through the distal phalanx and along the sides of the proximal phalanx laterally. The toe was 2.5 times to the normal size. There were superficial ulcerations in the medial arch of both feet secondary to history of a burn, which were not infected. The patient had dorsalis pedis and posterior tibial pulses that were found to be +2/4 bilaterally preoperatively. X-ray revealed complete distraction of the distal phalanx and questionable distraction of the lateral aspect of the proximal phalanx. A #10 blade was used to make an incision down the bone in a transverse fashion just proximal to the head of the proximal phalanx. The incision was carried mediolaterally and plantarly encompassing the toe leaving a large amount of plantar skin intact. Next, the distal phalanx was disarticulated at the interphalangeal joint and removed. The distal toe was amputated and sent to laboratory for bone culture and sensitivity as well as tissue pathology. Next, the head of the proximal phalanx was inspected and found to be soft on the distal lateral portion as suspected. Therefore, a sagittal saw was used to resect approximately 0.75 cm of the distal aspect of head of the proximal phalanx. This bone was also sent off for culture and was labeled proximal margin. Next, the flexor hallucis longus tendon was identified and retracted as far as possible distally and transected. The flexor tendon distally was gray discolored and was not viable. A hemostat was used to inspect the flexor sheath to ensure no infection tracking up the sheath proximally. None was found. No purulent drainage or abscess was found. The proximal margin of the surgical site tissue was viable and healthy. There was no malodor.

Anaerobic and aerobic cultures were taken and passed this as a specimen to microbiology. Next, copious amounts of gentamicin and impregnated saline were instilled into the wound.,A #3-0 Vicryl was used to reapproximate the deep subcutaneous layer to release skin tension. The plantar flap was viable and was debulked with Metzenbaum scissors. The flap was folded dorsally and reapproximated carefully with #3-0 nylon with a combination of simple interrupted and vertical mattress sutures. Iris scissors were used to modify and remodel the plantar flap. An excellent cosmetic result was achieved. No tourniquet was used in this case. The patient tolerated the above anesthesia and surgery without apparent complications. A standard postoperative dressing was applied consisting of saline-soaked Owen silk, 4x4s, Kerlix, and Coban. The patient was transported via cart to Postanesthesia Care Unit with vital signs able and vascular status intact to right foot. He will be readmitted to Dr. Katzman where we will continue to monitor his blood pressure and regulate his medications. Plan is to continue the antibiotics until further IV recommendations.,He will be nonweightbearing to the right foot and use crutches. He will elevate his right foot and rest the foot, keep it clean and dry. He is to follow up with Dr. X on Monday or Tuesday of next week.