PREOPERATIVE DIAGNOSES:,1. Hallux abductovalgus, right foot.,2. Hammertoe, bilateral third, fourth, and fifth toes.,POSTOPERATIVE DIAGNOSES:,1. Hallux abductovalgus, right foot.,2. Hammertoe, bilateral third, fourth, and fifth toes.,PROCEDURE PERFORMED:,1. Bunionectomy with distal first metatarsal osteotomy and internal screw fixation, right foot.,2. Proximal interphalangeal joint arthroplasty, bilateral fifth toes.,3. Distal interphalangeal joint arthroplasty, bilateral third and fourth toes.,4. Flexor tenotomy, bilateral third toes.,HISTORY:, This is a 36-year-old female who presented to ABCD preoperative holding area after keeping herself n.p.o. since mid night for surgery on her painful bunion to her right foot and her painful hammertoes to both feet. The patient has a history of sharp pain, which is aggravated by wearing shoes and ambulation. She has tried multiple conservative methods and treatment such as wide shoes and accommodative padding, all of which provided inadequate relief. At this time, she desires attempted surgical correction. The risks versus benefits of the procedure have been discussed in detail by Dr. Kaczander with the patient and the consent is available on the chart.,PROCEDURE IN DETAIL:, After IV was established by the Department of Anesthesia, the patient was taken to the operating room and placed on the operating table in supine position with a safety strap placed across her waist for her protection.,Copious amounts of Webril were applied about both ankles and a pneumatic ankle tourniquet was applied over the Webril. After adequate IV sedation was administered, a total of 18 cc of a

0.5% Marcaine plain was used to anesthetize the right foot, performing a Mayo block and a bilateral third, fourth, and fifth digital block. Next, the foot was prepped and draped in the usual aseptic fashion bilaterally. The foot was elevated off the table and an Esmarch bandage was used to exsanguinate the right foot. The pneumatic ankle tourniquet was elevated on the right foot to 200 mmHg. The foot was lowered into operative field and the sterile stockinet was reflected proximally. Attention was directed to the right first metatarsophalangeal joint, it was found to be contracted and there was lateral deviation of the hallux. There was decreased range of motion of the first metatarsophalangeal joint. A dorsolinear incision was made with a #10 blade, approximately 4 cm in length. The incision was deepened to the subcutaneous layer with a #15 blade. Any small veins traversing the subcutaneous layer were ligated with electrocautery. Next, the medial and lateral wound margins were undermined sharply. Care was taken to avoid the medial neurovascular bundle and the lateral extensor hallucis longus tendon. Next, the first metatarsal joint capsule was identified. A #15 blade was used to make a linear capsular incision down to the bone. The capsular periosteal tissues were elevated off the bone with a #15 blade and the metatarsal head was delivered into the wound. The PASA was found to be within normal limits. There was a hypertrophic medial eminence noted. A sagittal saw was used to remove the hypertrophic medial eminence. A 0.045 inch Kirschner wire was placed into the central medial aspect of the metatarsal head as an access

guide. A standard lateral release was performed. The fibular sesamoid was found to be in the interspace, but was relocated onto the metatarsal head properly. Next, a sagittal saw was used to perform a long arm Austin osteotomy. The K-wire was removed. The capital fragment was shifted laterally and impacted into the head. A 0.045 inch Kirschner wire was used to temporarily fixate the osteotomy. A 2.7 x 16 mm Synthes, fully threaded cortical screw was throne using standard AO technique. A second screw was throne, which was a 2.0 x 12 mm Synthes cortical screw. Excellent fixation was achieved and the screws tightly perched the bone. Next, the medial overhanging wedge was removed with a sagittal saw. A reciprocating rasp was used to smooth all bony prominences. The 0.045 inch Kirschner wire was removed. The screws were checked again for tightness and found to be very tight. The joint was flushed with copious amounts of sterile saline. A #3-0 Vicryl was used to close the capsular periosteal tissues with simple interrupted suture technique. A #4-0 Vicryl was used to close the subcutaneous layer in a simple interrupted technique. A #5-0 Monocryl was used to close the skin in a running subcuticular fashion.,Attention was directed to the right third digit, which was found to be markedly contracted at the distal interphalangeal joint. A #15 blade was used to make two convergent semi-elliptical incisions over the distal interphalangeal joint. The incision was deepened with a #15 blade. The wedge of skin was removed in full thickness. The long extensor tendon was identified and the distal and proximal borders of the wound were

undermined. The #15 blade was used to transect the long extensor tendon, which was reflected proximally. The distal interphalangeal joint was identified and the #15 blade was placed in the joint and the medial and lateral collateral ligaments were released. Crown and collar scissors were used to release the planar attachment to the head of the middle phalanx. Next, a double action bone cutter was used to resect the head of the middle phalanx. The toe was dorsiflexed and was found to have an excellent rectus position. A hand rasp was used to smooth all bony surfaces. The joint was flushed with copious amounts of sterile saline. The flexor tendon was found to be contracted, therefore, a flexor tenotomy was performed through the dorsal incision. Next, #3-0 Vicryl was used to close the long extensor tendon with two simple interrupted sutures. A #4-0 nylon was used to close the skin and excellent cosmetic result was achieved.,Attention was directed to the fourth toe, which was found to be contracted at the distal interphalangeal joint and abducted and varus rotated. An oblique skin incision with two converging semi-elliptical incisions was created using #15 blade. The rest of the procedure was repeated exactly the same as the above paragraph to the third toe on the right foot. All the same suture materials were used. However, there was no flexor tenotomy performed on this toe, only on the third toe bilaterally.,Attention was directed to the fifth right digit, which was found to be contracted at the proximal interphalangeal joint. A linear incision approximately 2 cm in length was made with a #15 blade over the proximal interphalangeal joint. Next,

a #15 blade was used to deepen the incision to the subcutaneous layer. The medial and lateral margins were undermined sharply to the level of the long extensor tendon. The proximal interphalangeal joint was identified and the tendon was transected with the #15 blade. The tendon was reflected proximally, off the head of the proximal phalanx. The medial and lateral collateral ligaments were released and the head of the proximal phalanx was delivered into the wound. A double action bone nibbler was used to remove the head of the proximal phalanx. A hand rasp was used to smooth residual bone. The joint was flushed with copious amounts of saline. A #3-0 Vicryl was used to close the long extensor tendon with two simple interrupted sutures. A #4-0 nylon was used to close the skin with a combination of simple interrupted and horizontal mattress sutures.,A standard postoperative dressing consisting of saline-soaked #0-1 silk, 4 x 4s, Kerlix, Kling, and Coban were applied. The pneumatic ankle tourniquet was released and immediate hyperemic flush was noted to the digits.,Attention was directed to the left foot. The foot was elevated off the table and exsanguinated with an Esmarch bandage and the pneumatic ankle tourniquet was elevated to 200 mmHg. Attention was directed to the left fifth toe, which was found to be contracted at the proximal interphalangeal joint. The exact same procedure, performed to the right fifth digit, was performed on this toe, with the same materials being used for suture and closure.,Attention was then directed to the left fourth digit, which was found to contracted and slightly abducted and varus rotated. The exact

same procedure as performed to the right fourth toe was performed, consisting of two semi-elliptical skin incisions in an oblique angle. The same suture material were used to close the incision.,Attention was directed to the left third digit, which was found to be contracted at the distal interphalangeal joint. The same procedure performed on the right third digit was also performed. The same suture materials were used to close the wound and the flexor tenotomy was also performed at this digit. A standard postoperative dressing was also applied to the left foot consisting of the same materials as described for the right foot. The pneumatic tourniquet was released and immediate hyperemic flush was noted to the digits. The patient tolerated the above anesthesia and procedure without complications. She was transported via cart to the Postanesthesia Care Unit with vital signs stable and vascular status intact to the foot. She was given postoperative shoes and will be partial weighbearing with crutches. She was admitted short-stay to Dr. Kaczander for pain control. She was placed on Demerol 50 and Vistaril 25 mg IM q3-4h. p.r.n. for pain. She will have Vicodin 5/500 one to two p.o. q.4-6h. p.r.n. for moderate pain. She was placed on Subq. heparin and given incentive spirometry 10 times an hour. She will be discharged tomorrow. She is to ice and elevate both feet today and rest as much as possible.,Physical Therapy will teach her crutch training today. X-rays were taken in the postoperative area and revealed excellent position of the screws and correction of bunion deformity as well as the hammertoe deformities.