PREOPERATIVE DIAGNOSIS: , Bilateral knee degenerative arthritis.,POSTOPERATIVE DIAGNOSIS: , Bilateral knee degenerative arthritis.,PROCEDURE PERFORMED: , Bilateral knee arthroplasty.,Please note this procedure was done by Dr. X for the left total knee and Dr. Y for the right total knee. This operative note will discuss the right total knee arthroplasty.,ANESTHESIA: ,General.,COMPLICATIONS: , None.,BLOOD LOSS: , Approximately 150 cc.,HISTORY:, This is a 79-year-old female who has disabling bilateral knee degenerative arthritis. She has been unresponsive to conservative measures. All risks, complications, anticipated benefits, and postoperative course were discussed. The patient has agreed to proceed with surgery as described below.,GROSS FINDINGS: , There was noted to be eburnation and wear along the patellofemoral joint and femoral tibial articulation medially and laterally with osteophyte formation and sclerosis.,SPECIFICATIONS: , The Zimmer NexGen total knee system was utilized.,PROCEDURE: , The patient was taken to the operating room #2 and placed in supine position on the operating room table. She was administered spinal anesthetic by Dr. Z.,The tourniquet was placed about the proximal aspect of the right lower extremity. The right lower extremity was then sterilely prepped and draped in the usual fashion. An Esmarch bandage was used to exsanguinate the right lower extremity and the tourniquet was inflated to 325 mmHg. Longitudinal incision was made over the anterior aspect of the right knee. Subcutaneous tissue was carefully dissected. A

medial parapatellar retinacular incision was made. The patella was then everted and the above noted gross findings were appreciated. A drill hole was placed in the distal aspect of the femur and the distal femoral cutting guides were positioned in place. The appropriate cuts were made at the distal femur as well as with use of the chamfer guide. The trial femoral component was then positioned in place and noted to have good fit. Attention was then directed to proximal tibia, the external tibial alignment guide was positioned in place and the proximal tibial cut was made demonstrating satisfactory cut. The medial and lateral collateral ligaments remained intact throughout the procedure as well as the posterior cruciate ligaments. The remnants of the anterior cruciate ligament and menisci were resected. The tibial trial was positioned in place. Intraoperative radiographs were taken, demonstrating satisfactory alignment of the tibial cut. The tibial holes were then drilled. The patella was then addressed with the Bovie used to remove the soft tissue around the perimeter of the patella. The patellar cutting guide was positioned in place and the posterior aspect of the patella was resected to the appropriate thickness. Three drill holes were made within the patella after it was determined that 35 mm patella would be most appropriate. The knee was placed through range of motion with the trial components marked and then the appropriate components obtained. The tibial tray was inserted with cement, backed it into place, excess methylmethacrylate was removed. The femoral component was inserted with methylmethacrylate. Any excessive methylmethacrylate and

bony debris were removed from the joint. Trial Poly was positioned in place and the knee was held in full extension while the methylmethacrylate became firm. The methylmethacrylate was also used at the patella. The prosthesis was positioned in place. The patellar clamp held securely till the methylmethacrylate was firm. After all three components were in place, the knee was then again in placed range of motion and there appeared to be some torsion to the proximal tibial component and concerned regarding the alignment. This component was removed and revised to a stemmed component with better alignment and position. The previous component removed, the methylmethacrylate was removed. Further irrigation was performed and then a stemmed template was positioned in place with the intramedullary alignment guide positioned and the tibia drilled and broached. The trial tibial stemmed component was positioned in place. Knee was placed through range of motion and the tracking was better. Actual component was then obtained, methyl methacrylate was placed within the tibia. The stemmed tibial component was impacted into place with good fit. The Poly was then positioned in place. Knee held in full extension with compression longitudinally after methylmethacrylate was solidified. The trial Poly was removed. Wound was irrigated and the joint was inspected. There was no debris. Collateral ligaments and posterior cruciate ligaments remained intact. Soft tissue balancing was done and a 17 mm Poly was then inserted with the knee and tibial and femoral components with good tracking as well as

the patellar component. The tourniquet was deflated. Hemostasis was satisfactory. A drain was placed into the depths of the wound. The medial retinacular incision was closed with one Ethibond suture in interrupted fashion. The knee was placed through range of motion and there was no undue tissue tension, good patellar tracking, no excessive soft tissue laxity or constrain. The subcutaneous tissue was closed with #2-0 undyed Vicryl in interrupted fashion. The skin was closed with surgical clips. The exterior of the wound was cleansed as well padded dressing ABDs and ace wrap over the right lower extremity. At the completion of the procedure, distal pulses were intact. Toes were pink, warm, with good capillary refill. Distal neurovascular status was intact. Postoperative x-ray demonstrated satisfactory alignment of the prosthesis. Prognosis is good in this 79-year-old female with a significant degenerative arthritis.