PREOPERATIVE DIAGNOSES:, Left calcaneal valgus split.,POSTOPERATIVE DIAGNOSES:, Left calcaneal valgus split.,PROCEDURES: ,1. Left calcaneal lengthening osteotomy with allograft.,2. Partial plantar fasciotomy.,3. Posterior subtalar and tibiotalar capsulotomy.,4. Short leg cast placed.,ANESTHESIA: , Surgery performed under general anesthesia.,TOURNIQUET TIME: , 69 minutes.,The patient in local anesthetic of 20 mL of 0.25% Marcaine plain.,COMPLICATIONS: , No intraoperative complications.,DRAINS: ,None.,SPECIMENS: , None.,HISTORY AND PHYSICAL: , The patient is a 13-year-old female who had previous bilateral feet correction at 1 year of age. Since that time, the patient has developed significant calcaneal valgus deformity with significant pain. Radiographs confirmed collapse of the spinal arch, as well as valgus position of the foot. Given the patient's symptoms, surgery is recommended for calcaneal osteotomy and Achilles lengthening. Risks and benefits of surgery were discussed with the mother. Risks of surgery include risk of anesthesia; infection; bleeding; changes in sensation in most of extremity; hardware failure; need for later hardware removal; possible nonunion; possible failure to correct all the deformity; and need for other surgical procedures. The patient will need to be strict nonweightbearing for at least 6 weeks and wear a brace for up to 6 months. All questions were answered and parents agreed to the above surgical plan.,DESCRIPTION OF PROCEDURE: , The patient was taken to the operating room and placed supine on the operating table. General anesthesia

was then administered. The patient received Ancef preoperatively. A bump was placed underneath the left buttock. A nonsterile tourniquet was placed on the upper aspect of the left thigh. The extremity was then prepped and draped in a standard surgical fashion. The patient had a previous incision along the calcaneocuboid lateral part of the foot. This was marked and extended proximally through the Achilles tendon. Extremity was wrapped in Esmarch. Tourniquet inflation was noted to be 250 mmHg. Decision was then made to protect the sural nerve. There was one sensory nervous branch that did cross the field though it was subsequently sharply ligated because it was in the way. Dissection was carried down to Achilles tendon, which was subsequently de-lengthened with the distal half performed down the lateral thigh. Proximal end was tacked with an 0 Ethibond suture and subsequently repaired end-on-end at length with the heel in neutral. Dissection was then carried on the lateral border of the foot with identification of the peroneal longus and valgus tendons, which were removed from the sheath and retracted dorsally. At this time, we also noted that calcaneocuboid joint appeared to be fused. The area between the anterior and middle facets were plicated on fluoroscopy for planned osteotomy. This was performed with a saw. After a partial plantar fasciotomy was performed, this was released off an abductor digiti minimi. The osteotomy was completed with an osteotome and distracted with the lamina spreader. A tricortical allograft was then shaped and subsequently impacted into this area. Final positioning was checked with

multiple views of fluoroscopy. It was subsequently fixed using a 0.94 K-wire and drilled from the heel anteriorly. A pin was subsequently bent and cut short at the level of the skin. The wound was then irrigated with normal saline. The Achilles was repaired with this tie. Please note during the case, it was noted the patient had continued significant stiffness despite the Achilles lengthening. A posterior capsulotomy of the tibiotalar and subtalar joints were performed with increased 10 degrees of dorsiflexion. Wound was then closed using #2-0 Vicryl and #4-0 Monocryl. The surgical field was irrigated with 0.25% Marcaine and subsequently injected with more Marcaine at the end of the case. The wound was clean and dry and dressed with Steri-Strips and Xeroform. Skin was dressed with Xeroform and 4 x 4's. Everything was wrapped with 4 x 4's in sterile Webril. The tourniquet was released after 69 minutes. A short-leg cast was then placed with good return of capillary refill to his toes. The patient tolerated the procedure well and was subsequently taken to the recovery room in stable condition.,POSTOPERATIVE PLAN: , The patient will be hospitalized overnight for elevation, ice packs, neurovascular checks, and pain control. The patient to be strict nonweightbearing. We will arrange for her to get a wheelchair. The patient will then follow up in about 10 to 14 days for a cast check, as well as pain control. The patient will need an AFO script at that time. Intraoperative findings are relayed to the parents.