PREOPERATIVE DIAGNOSIS: , Congenital myotonic muscular dystrophy with bilateral planovalgus feet.,POSTOPERATIVE DIAGNOSIS: , Congenital myotonic muscular dystrophy with bilateral planovalgus feet.,PROCEDURE: , Bilateral Crawford subtalar arthrodesis with open Achilles Z-lengthening and bilateral long-leg cast.,ANESTHESIA: , Surgery performed under general anesthesia. The patient received 6 mL of 0.25% Marcaine local anesthetic on each side.,TOURNIQUET TIME: ,Tourniquet time was 53 minutes on the left and 45 minutes on the right.,COMPLICATIONS: , There were no intraoperative complications.,DRAINS:, None.,SPECIMENS: , None.,HARDWARE USED: , Staple 7/8 inch x1 on each side.,HISTORY AND PHYSICAL: ,The patient is a 5-year-4-month-old male who presents for evaluation of feet. He has been having significant feet pain with significant planovalgus deformity. The patient was noted to have flexible vertical talus. It was decided that the patient would benefit by subtalar arthrodesis, possible autograft, and Achilles lengthening. This was explained to the mother in detail. This is going to be a stabilizing measure and the patient will probably need additional surgery at a later day when his foot is more mature. Risks of surgery include risks of anesthesia, infection, bleeding, changes in sensation and motion of the extremity, hardware failure, need for other surgical procedures, need to be nonweightbearing for some time. All questions were answered and the mother agreed to the above plan.,PROCEDURE NOTE: , The patient was taken to the

operating room, placed supine on the operating room, general anesthesia was administered. The patient received Ancef preoperatively. Bilateral nonsterile tourniquets were placed on each thigh. A bump was placed underneath the left buttock. Both the extremities were then prepped and draped in standard surgical fashion. Attention was first turned towards the left side. Intended incision was marked on the skin. The ankle was taken through a range of motion with noted improvement in the reduction of the talocalcaneal alignment with the foot in plantar flexion on the lateral view. The foot was wrapped in Esmarch prior to inflation of tourniquet to 200 mmHg. Incision was then made over the left lateral aspect of the hind foot to expose the talocalcaneal joint. The sinus tarsi was then identified using a U-shaped flap to tack muscles, and periosteum was retracted distally. Once the foot was reduced a Steinman pin was used to hold it in position. This position was first checked on the fluoroscopy. The 7/8th inch staple was then placed across the sinus tarsi to maintain the reduction. This was also checked with fluoroscopy. The incision was then extended posteriorly to allow for visualization of the Achilles, which was Z-lengthened with the release of the lateral distal half. This was sutured using 2-0 Ethibond and that was also oversewn. The wound was irrigated with normal saline. The periosteal flap was sutured over the staple using 2-0 Vicryl. Skin was closed using 2-0 Vicryl interrupted and then with 4-0 Monocryl. The area was injected with 6 mL of 0.25% Marcaine local anesthetic. The wound was cleaned and dried, dressed with Steri-Strips,

Xeroform, and 4 x 4s and Webril. Tourniquet was released after 53 minutes. The exact same procedure was repeated on the right side with no changes or complications. Tourniquet time on the right side was 45 minutes. The patient tolerated the procedure well. Bilateral long-leg casts were then placed with the foot in neutral with some moulding of his medial plantar arch. The patient was subsequently was taken to Recovery in stable condition.,POSTOPERATIVE PLAN: , The patient will be hospitalized overnight for pain as per parents' request. The patient is to be strict nonweightbearing for at least 6 weeks. He is to follow up in the next 10 days for a check. We will plan of changing to short-leg casts in about 4 weeks postop.