PREOPERATIVE DIAGNOSIS: , Foreign body, right foot.,POSTOPERATIVE DIAGNOSIS: , Foreign body in the right foot.,PROCEDURE PERFORMED:, Excision of foreign body, right foot and surrounding tissue.,ANESTHESIA: , TIVA and local.,HISTORY:, This 41-year-old male presents to preoperative holding area after keeping himself n.p.o., since mid night for removal of painful retained foreign body in his right foot. The patient works in the Electronics/Robotics field and relates that he stepped on a wire at work, which somehow got into his shoe. The wire entered his foot. His family physician attempted to remove the wire, but it only became deeper in the foot. The wound eventually healed, but a scar tissue was formed. The patient has had constant pain with ambulation intermittently since the incident occurred. He desires attempted surgical removal of the wire. The risks and benefits of the procedure have been explained to the patient in detail by Dr. X. The consent is available on the chart for review.,PROCEDURE IN DETAIL: , After IV was established by the Department of Anesthesia, the patient was taken to the operating room via cart and placed on the operating table in a supine position with a safety strap placed across his waist for his protection.,A pneumatic ankle tourniquet was applied about the right ankle over copious amounts of Webril for the patient's protection. After adequate IV sedation was administered by the Department of Anesthesia, a total of 12 cc of 0.5% Marcaine plain was used to administer an ankle block. Next, the foot was prepped and draped in the usual aseptic fashion. An Esmarch bandage was used to

exsanguinate the foot and the pneumatic ankle tourniquet was elevated to 250 mmHg. The foot was lowered into the operative field and the sterile stockinet was reflected. Attention was directed to the plantar aspect of the foot where approximately a 5 mm long cicatrix was palpated and visualized. This was the origin and entry point of the previous puncture wound from the wire. This cicatrix was found lateral to the plantar aspect of the first metatarsal between the first and second metatarsals in a nonweightbearing area. Next, the Xi-scan was draped and brought into the operating room. A #25 gauge needles under fluoroscopy were inserted into the plantar aspect of the foot and three planes to triangulate the wire. Next, a #10 blade was used to make approximately a 3 cm curvilinear ""'S""-shaped incision. Next, the #15 blade was used to carry the incision through the subcutaneous tissue. The medial and lateral margins of the incision were undermined. Due to the small nature of the foreign body and the large amount of fat on the plantar aspect of the foot, the wires seemed to serve no benefit other then helping with the incision planning. Therefore, they were removed. Once the wound was opened, a hemostat was used to locate the wire very quickly and the wire was clamped. A second hemostat was used to clamp the wire. A #15 blade was used to carefully transect the fatty tissue around the tip of the hemostats, which were visualized in the base of the wound. The wire quickly came into visualization. It measured approximately 4 mm in length and was approximately 1 mm in diameter. The wire was green colored and metallic in nature. It was removed with

the hemostat and passed off as a specimen to be sent to Pathology for identification. The wire was found at the level of deep fascia at the capsular level just plantar to the deep transverse intermetatarsal ligament. Next, copious amounts of sterile gentamicin impregnated saline was instilled in the wound for irrigation and the wound base was thoroughly cleaned and inspected. Next, a #3-0 Vicryl was used to throw two simple interrupted deep sutures to remove the dead space. Next, #4-0 Ethibond was used to close the skin in a combination of simple interrupted and horizontal mattress suture technique. The standard postoperative dressing consisting of saline-soaked Owen silk, 4x4s, Kling, Kerlix, and Coban were applied. The pneumatic ankle tourniquet was released. There was immediate hyperemic flush to the digits noted. The patient's anesthesia was reversed. He tolerated the above anesthesia and procedure without complications. The patient was transported via cart to the Postanesthesia Care Unit.,Vital signs were stable and vascular status was intact to the right foot. He was given OrthoWedge shoe. Ice was applied behind the knee and his right lower extremity was elevated on to pillows. He was given standard postoperative instructions consisting of rest, ice and elevation to the right lower extremity. He is to be non-weightbearing for three weeks, at which time, the wound will be evaluated and sutures will be removed. He is to follow up with Dr. X on 08/22/2003 and was given emergency contact number to call if problems arise. He was given a prescription for Tylenol #4, #30 one p.o. q.4-6h. p.r.n., pain as well as Celebrex 200 mg #30 take two

p.o. q.d. p.c., with 200 mg 12 hours later as a rescue dose. He was given crutches. He was discharged in stable condition.