PREOPERATIVE DIAGNOSIS: , Tailor's bunion, right foot.,POSTOPERATIVE DIAGNOSIS: ,Tailor's bunion, right foot.,PROCEDURE PERFORMED: , Removal of bone, right fifth metatarsal head.,ANESTHESIA: ,TIVA/local.,HISTORY: , This 60-year-old male presents to ABCD Preoperative Holding Area after keeping himself n.p.o., since mid night for surgery on his painful right Tailor's bunion. The patient has a history of chronic ulceration to the right foot which has been treated on an outpatient basis with conservative methods Dr. X. At this time, he desires surgical correction as the ulcer has been refractory to conservative treatment. Incidentally, the ulcer is noninfective and practically healed at this date. The consent is available on the chart for review and Dr. X has discussed the risks versus benefits of this procedure to the patient in detail.,PROCEDURE IN DETAIL: , After IV was established by the Department of Anesthesia, the patient was taken to the operating room, placed on the operating table in supine position and a safety strap was placed across his waist for his protection. A pneumatic ankle tourniquet was applied about the right foot over copious amount of Webril for the patient's protection. After adequate IV sedation was administered by the Department of Anesthesia, a total of 10 cc of 1:1 mixture of 1% lidocaine and 0.5% Marcaine plain were administered into the right fifth metatarsal using a Mayo type block technique. 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 in the

operating field and a sterile stockinet was reflected. The Betadine was cleansed with saline-soaked gauze and dried. Anesthesia was tested with a one tooth pickup and found to be adequate. A #10 blade was used to make 3.5 cm linear incision over the fifth metatarsophalangeal joint. A #15 blade was used to deepen the incision to the subcutaneous layer. Care was taken to retract the extensor digitorum longus tendon medially and the abductor digiti minimi tendon laterally. Using a combination of sharp and blunt dissection, the medial and lateral edges of the wound were undermined down to the level of the capsule and deep fascia. A linear capsular incision was made with a #15 blade down to the bone. The capsular periosteal tissues were elevated off the bone with a #15 blade. Metatarsal head was delivered into the wound. There was hypertrophic exostosis noted laterally as well as a large bursa in the subcuteneous tissue layer. The ulcer on the skin was approximately 2 x 2 mm, it was partial skin thickness and did not probe. A sagittal saw was used to resect the hypertrophic lateral eminence. The hypertrophic bone was split in half and one half was sent to Pathology and the other half was sent to Microbiology for culture and sensitivity. Next, a reciprocating rasp was used to smoothen all bony surfaces. The bone stock had an excellent healthy appearance and did not appear to be infected. Copious amount of sterile gentamicin impregnated saline were used to flush the wound. The capsuloperiosteal tissues were reapproximated with #3-0 Vicryl in simple interrupted technique. The subcutaneous layer was closed with #4-0

Vicryl in simple interrupted technique. Next, the skin was closed with #4-0 nylon in a horizontal mattress suture technique. A standard postoperative dressing was applied consisting of Betadine-soaked Owen silk, 4x4s, Kerlix, and Kling. The pneumatic ankle tourniquet was released and immediate hyperemic flush was noted at the digits. The patient tolerated the above anesthesia and procedure without complications. He was transported via cart to the Postanesthesia Care Unit with vital signs stable and vascular status intact to the right foot. He was given a postop shoe and will be full weightbearing. He has prescription already at home for hydrocodone and does not need to refill. He is to follow up with Dr. X and was given emergency contact numbers. He was discharged in stable condition.