PREOPERATIVE DIAGNOSIS: , Achilles tendon rupture, left lower extremity.,POSTOPERATIVE DIAGNOSIS: , Achilles tendon rupture, left lower extremity.,PROCEDURE PERFORMED:, Primary repair left Achilles tendon.,ANESTHESIA: , General.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: , Minimal.,TOTAL TOURNIQUET TIME: ,40 minutes at 325 mmHg.,POSITION:, Prone.,HISTORY OF PRESENT ILLNESS: ,The patient is a 26-year-old African-American male who states that he was stepping off a hilo at work when he felt a sudden pop in the posterior aspect of his left leg. The patient was placed in posterior splint and followed up at ABC orthopedics for further care.,PROCEDURE:, After all potential complications, risks, as well as anticipated benefits of the above-named procedure were discussed at length with the patient, informed consent was obtained. The operative extremity was then confirmed with the patient, the operative surgeon, Department Of Anesthesia, and nursing staff. While in this hospital, the Department Of Anesthesia administered general anesthetic to the patient. The patient was then transferred to the operative table and placed in the prone position. All bony prominences were well padded at this time.,A nonsterile tourniquet was placed on the left upper thigh of the patient, but not inflated at this time. Left lower extremity was sterilely prepped and draped in the usual sterile fashion. Once this was done, the left lower extremity was elevated and exsanguinated using an Esmarch and the tourniquet was inflated to 325 mmHg and kept up for a total of 40 minutes. After all bony and soft tissue

land marks were identified, a 6 cm longitudinal incision was made paramedial to the Achilles tendon from its insertion proximal. Careful dissection was then taken down to the level of the peritenon. Once this was reached, full thickness flaps were performed medially and laterally. Next, retractor was placed. All neurovascular structures were protected. A longitudinal incision was then made in the peritenon and opened up exposing the tendon. There was noted to be complete rupture of the tendon approximately 4 cm proximal to the insertion point. The plantar tendon was noted to be intact. The tendon was debrided at this time of hematoma as well as frayed tendon. Wound was copiously irrigated and dried. Most of the ankle appeared that there was sufficient tendon links in order to do a primary repair. Next #0 PDS on a taper needle was selected and a Krackow stitch was then performed. Two sutures were then used and tied individually _____ from the tendon. The tendon came together very well and with a tight connection. Next, a #2-0 Vicryl suture was then used to close the peritenon over the Achilles tendon. The wound was once again copiously irrigated and dried. A #2-0 Vicryl sutures were then used to close the skin and subcutaneous fashion followed by #4-0 suture in the subcuticular closure on the skin. Steri-Strips were then placed over the wound and the sterile dressing was applied consisting of 4x4s, Kerlix roll, sterile Kerlix and a short length fiberglass cast in a plantar position. At this time, the Department of anesthesia reversed the anesthetic. The patient was transferred back to hospital gurney to the

Postanesthesia Care Unit. The patient tolerated the procedure well. There were no complications.