Operative Note

Facility: Phoenix Orthopedic Surgery Center, AZ
Date of Surgery: 09/15/2025
Surgeon: Dr. Andrew Thompson, MD – Orthopedic Surgery
Assistant: Sarah Patel, PA-C
Anesthesiologist: Dr. Michael Rivera, MD

Procedure Performed:

Arthroscopic Right Anterior Cruciate Ligament (ACL) Reconstruction using hamstring autograft
Diagnostic Arthroscopy of Right Knee
Preoperative Diagnosis:
Complete tear of the right anterior cruciate ligament
Postoperative Diagnosis:
Same as preoperative

Anesthesia:

General anesthesia with regional femoral nerve block

Indications for Surgery:
Lisa Wilson, a 43-year-old female, sustained a right ACL tear while exercising. She complained of instability and pain during activity. Conservative management failed to restore knee stability; thus, ACL reconstruction was recommended and consent obtained.

Procedure Description:
After informed consent and site verification, the patient was brought to the OR and placed supine on the operating table. General anesthesia was induced, and a right lower extremity tourniquet was applied. The leg was prepped and draped in sterile fashion.

A standard anterolateral and anteromedial portal was established. Diagnostic arthroscopy revealed a complete rupture of the ACL with intact PCL and menisci. Articular cartilage was smooth and intact. No loose bodies were identified.

Attention was turned to graft harvesting. A small incision was made over the pes anserinus. The semitendinosus and gracilis tendons were identified, harvested, and prepared as a quadruple-stranded autograft, measuring 8.5 mm in diameter.

Tibial and femoral tunnels were created in anatomic positions using standard guides. The graft was passed through the tunnels and fixed with bioabsorbable interference screws (8 × 25 mm femoral, 9 × 25 mm tibial).

The knee was cycled through full flexion and extension to ensure stable fixation and absence of impingement. Lachman and pivot shift testing under anesthesia confirmed a stable reconstruction. The portals and incision were irrigated and closed with absorbable sutures. Sterile dressing and knee immobilizer were applied.

Estimated Blood Loss: <50 mL
Complications: None
Specimens: None
Implants: Bioabsorbable interference screws (Arthrex)
Drains: None

Postoperative Condition: Stable – transferred to PACU awake and alert.

Postoperative Plan:

Weight-bearing as tolerated with crutches
Knee immobilizer in extension for ambulation
Ice and elevation for pain and swelling
Begin passive range of motion 0–90° at 1 week post-op
Outpatient physical therapy to start at 4 weeks post-op (per current PT evaluation dated 10/15/2025)

Follow-up in 10–14 days for wound check and suture removal

Surgeon Signature:
Dr. Andrew Thompson, MD
Orthopedic Surgery
NPI: 1589643127
(Electronically Signed 09/15/2025)