All City Family Healthcare Center
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Left Knee Arthroscopy Operative Report

PATIENT NAME:	Rollaing, Shaquan
MEDICAL RECORD NUMBER:	3303384
DATE OF BIRTH:	01/24/1978
DATE OF PROCEDURE:	08/17/2022
SURGEON:	Richard E. Pearl, MD.
ASSISTANT:	Angel M. Leal, PA-C
PREOPERATIVE DIAGNOSIS:	Internal derangement, left knee.
POSTOPERATIVE DIAGNOSES:	M22.40 Chondromalacia patella. M23.40 Loose body in knee. M23.90 Internal derangement of knee. S83.242A Medial meniscus tear, left knee. S83.282A Lateral meniscus tear, left knee. M12.569 Traumatic arthropathy of knee. M65.162 Synovitis, left knee. M24.10 Chondral lesion, left knee.
OPERATIVE PROCEDURE:	29874 Removal of loose body or foreign body. 29876 Synovectomy (major; 2 or more compartments). 29880 PMM and PLM. 20610 Arthrocentesis (aspiration and/or injection) of a joint. 29999 Coblation arthroplasty, patella/trochlea/MFC/LFC/LTP. 29884 Lysis of adhesions-anterior wall. 0232T PRP injection.
ANESTHESIA:	General.
POSITION:	Supine.
ESTIMATED BLOOD LOSS:	Minimal.
COMPLICATIONS:	None.

INTRAOPERATIVE FINDINGS:
MMT, posterior.
LMT, body.
Patella, grade 2 chondromalacia.

Trochlea, grade 1 chondromalacia.
LFC, grade 2 chondral lesion.
MFC, grade 2 chondral lesion.
LTP, grade 2 chondral lesion.
Loose fragments.
Medial plica.
Synovitis.
Adhesions- anterior wall.

INDICATIONS FOR SURGERY:
After failing a course of nonoperative therapy, the patient elected to undergo the above procedure. In the office, the risks and possible complications of the procedure were discussed in detail with the patient. The patient verbalized understanding and elected to have the procedure performed today.

Informed consent was obtained and checked immediately preoperatively.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, and placed supine on the operating table. The anesthesiologist administered appropriate anesthesia. All bony prominences were well-padded. The patient's left lower extremity was prepped and draped in the usual standard surgical fashion. A time out was done. The patient was given IV-antibiotic prophylaxis.

A stab incision was made in the left knee lateral portal site. A blunt cannula was passed from the lateral portal site into the patellofemoral joint paying careful attention to avoid damaging the articular surface. The arthroscope was placed and the patellofemoral joint was evaluated. The arthroscope was placed in the medial portal site. A spinal needle was placed through the medial portal site. The needle was visualized and a small stab incision was made. A blunt probe was placed in the medial portal site for further evaluation.

Major Synovectomy:
Using arthroscopic visualization, inflammatory synovitis was seen in multiple compartments. A synovectomy procedure was done using a full radius shaver and radiofrequency wand. This removed the inflammatory synovitis and provided for arthroscopic visualization. Hemostasis was well maintained. Pictures were taken.

Coblation Arthroplasty Medial and Lateral Condyle:
While evaluating the medial and lateral condyle, there was noted to be grade 2 chondral lesion as evaluated by arthroscopic visualization and a probe. This was debrided using the shaver; however, there were unstable margins remaining and a coblation arthroplasty had to be performed. Using an ArthroCare wand and its plasma field, we melded the unstable margins down to a smooth and stable surface with minimal damage to the surrounding tissue. The remaining chondral surface was probed and was stable. Hemostasis was well maintained. Arthroscopic pictures were taken.

Coblation Arthroplasty Patella/Trochlea:
While evaluating the patella and trochlea, there was noted to be grade 1-2 chondromalacia as evaluated by arthroscopic visualization and a probe. This was debrided using the shaver; however, there were unstable margins remaining and a coblation arthroplasty had to be performed. Using an ArthroCare wand and its plasma field, we melded the unstable margins down to a smooth and stable surface with minimal damage to the surrounding tissue. The remaining chondral surface was probed and was stable. Hemostasis was well maintained. Arthroscopic pictures were taken.

Coblation Arthroplasty Lateral Tibial Plateau:
While evaluating the lateral tibial plateau, there was noted to be grade 2 chondral lesion as evaluated by arthroscopic visualization and a probe. This was debrided using the shaver; however, there were unstable margins remaining and a coblation arthroplasty had to be performed. Using an ArthroCare wand and its plasma field, we melded the unstable margins down to a smooth and stable surface with minimal damage to the surrounding tissue. The remaining chondral surface was probed, and was stable. Hemostasis was well maintained. Arthroscopic pictures were taken.

Removal of Loose Bodies:
Using the arthroscope, there were several loose bodies seen in the knee compartments. These were carefully removed using standard arthroscopic technique. All compartments were evaluated again. The gutters were also evaluated and no loose bodies remained. Hemostasis was well maintained.

Medial Plica Excision:
Using arthroscopic visualization, there was noted to be a medial plica at the anterior wall. The plica was excised using a full radius shaver and a radiofrequency wand. Hemostasis was well maintained. Arthroscopic pictures were taken.

Lysis of Adhesions:
Using arthroscopic visualization, there was noted to be several adhesions at the anterior wall. The adhesions were excised using a full radius shaver and a radiofrequency wand. Hemostasis was well maintained. Arthroscopic pictures were taken.

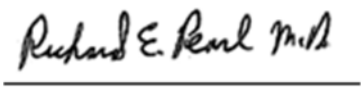
Bilateral Meniscectomy:
Using arthroscopic visualization and a probe, the full margins of the medial meniscus were evaluated. A tear was clearly seen and pictures were taken. The tear was probed. The tear was not in the red-red zone and a decision was made to perform a partial meniscectomy. The meniscectomy was started with meniscal biters. The remainder of the meniscectomy was completed with a full radius shaver. A radiofrequency wand was used to smooth out the edges. After the partial meniscectomy was complete, the periphery of the remaining meniscus was evaluated with the arthroscope and a probe. It was stable. Next, the lateral meniscus was evaluated and there was a tear seen. Arthroscopic evaluation was performed using visualization and a probe. Pictures were taken. In a similar fashion, a partial meniscectomy was performed on the lateral side. After the lateral meniscectomy, the remaining meniscus was

probed and was noted to be stable. Hemostasis was well maintained. Arthroscopic pictures were taken.

The knee was suctioned and placed through a range of motion of 0 to 90 degrees and tracked well. The arthroscope and shaver were carefully removed. The incisions were closed using nylon interrupted sutures. An intraarticular injection was given using 20 cc of 0.025% Marcaine. A sterile dressing was placed. The patient was then weaned from anesthesia, transferred to a postoperative stretcher and brought to the recovery room in satisfactory condition.

PHYSICIAN ASSISTANT:

During this procedure, I was assisted by Angel Leal, a licensed physician assistant in the State of New York. Mr. Leal assisted in positioning the patient on the operating room table, as well as transferring the patient from the operating room table to the recovery room stretcher. In addition, Mr. Leal assisted me during the actual operative procedure by positioning the patient´s extremity to allow for ease of arthroscopic access to all the areas of the joint. The presence of Mr. Leal as my operative assistant was medically necessary to ensure the utmost safety of the patient in the pre-, intra-, and postoperative periods.



Richard E. Pearl, MD