SURGICARE OF BROOKLYN

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Right Knee Arthroscopy Operative Report

Patient Name:	Fernandez, Miguel
Medical Record Number:	16044
Date of Birth:	10/13/1992
Date of Procedure:	10/06/2022
SURGEON:	Richard E. Pearl, MD.
ASSISTANT:	Angel M. Leal, PA-C.
Preoperative Diagnosis:	Internal derangement, right knee.
Postoperative Diagnoses:	M22.40 Chondromalacia patella. M23.40 Loose body in knee. M23.90 Internal derangement of knee. S83.241A Medial meniscus tear, right knee. S83.281A Lateral meniscus tear, right knee. M65.161 Synovitis, right knee. M24.10 Chondral lesion, right knee.
Operative Procedure:	29874 Removal of loose body or foreign body. 29875 Plica resection. 29876 Synovectomy (major; 2 or more compartments). 29880 PMM and PLM. 20610 Arthrocentesis (aspiration and/or injection) of a joint. 29999 Coblation arthroplasty, patella, MFC, MTP. 29884 Lysis of adhesions-anterior wall. 0232T PRP injection.
ANESTHESIA:	General.
POSITION:	Supine.
ESTIMATED BLOOD LOSS:	Minimal.
COMPLICATIONS:	None.

Intraoperative Findings:
MMT, anterior.
LMT, posterior.
Patella, grade 1 chondromalacia.

MFC, grade 1 chondral lesion.
MTP, grade 1 chondral lesion.
Loose fragments.
Medial plica.
Synovitis.
Adhesions- anterior wall.

Indications for Surgery:
After failing a course of non-operative therapy, the patient elected to undergo the above procedure. The risks and possible complications of knee arthroscopy were discussed in detail with the patient. These risks include but are not limited to continued pain, lack of motion, infection, vascular injury, DVT/PE, nerve injury including peroneal nerve dysfunction, reflex sympathetic dystrophy, compartment syndrome, unforeseen medical and/or anesthesia complications, limb loss, and even death. The patient expressed an understanding of the risks and possible benefits of the procedure, and is also aware of the alternatives to surgery.

An informed consent was obtained, and was checked immediately pre-op.

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 right 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 right 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 Femoral Condyle:
While evaluating the medial femoral condyle, there was noted to be grade 1 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:
While evaluating the patella, there was noted to be grade 1 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 Medial Tibial Plateau:
While evaluating the medial tibial plateau, there was noted to be grade 1 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.

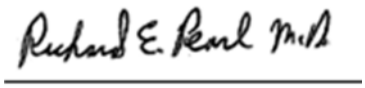
Bilateral Meniscectomy:
Using arthroscopic visualization and a probe, the full margins of the medial meniscus were evaluated. A tear was clearly seen and pictures were taken. The tear was probed. The tear was not in the red-red zone and a decision was made to perform a partial meniscectomy. The meniscectomy 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.

PRP Injection:
Blood was drawn from the patient's arm and processed in the centrifuge. The PRP was injected intraarticularly into the patient's right knee after the surgical incisions were closed, with the patient still in the operating room. 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:
Throughout the procedure, I was assisted by physician assistant, licensed in the State of New York. He 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. He assisted me during the actual procedure with positioning of the patient's extremity to allow for ease of arthroscopic access to all areas of the joint. The presence of physician assistant as my operating assistant was medically necessary to ensure the utmost safety of the patient in the operative, interim and postoperative period.



Richard E. Pearl, MD