All City Family Healthcare Center
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Left Wrist Arthroscopy Operative Report

PATIENT NAME:	Nicaj, Peter
MEDICAL RECORD NUMBER:	3303743
DATE OF BIRTH:	07/01/1971
DATE OF PROCEDURE:	08/17/2022
SURGEON:	Richard E. Pearl, MD.
ASSISTANT:	Angel M. Leal, PA-C
PREOPERATIVE DIAGNOSIS:	Traumatic internal derangement, left wrist.
POSTOPERATIVE DIAGNOSES:	M67.832 Hypertrophic synovitis, medial and lateral compartments, left wrist. S63.592A Triangular fibrocartilage complex tear, left wrist. M94.23 Traumatic chondromalacia scaphoid, left wrist. M94.242 Traumatic chondromalacia radius, left hand.
OPERATIVE PROCEDURE:	29846 Arthroscopic surgical examination. 25118 Complete synovectomy. 29846 Extensive debridement of the TFCC/radial floor. 0232T PRP injection.
ANESTHESIA:	Interscalene block with sedation.
ESTIMATED BLOOD LOSS:	None.
SPECIMEN:	None.
DRAINS:	None.
CLOSURE:	Nylon sutures.
FLUIDS:	See anesthesia sheet.
ANTIBIOTICS:	Ancef 2 g.
COMPLICATIONS:	None.

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 correctly identified in the holding area and the left wrist was marked with the surgeon's initials. The patient was transported to the operating room and placed in the supine position. General anesthesia was obtained. A preop orthopedic exam of the left wrist revealed no instability and no stiffness. The left upper extremity was prepped and draped in the standard surgical fashion and the hand was then put in the spider traction device. The anatomical structures were outlined with a skin marker and 1% lidocaine with epinephrine was injected into the #2 and #4 portals.

At this point, the hand was put into 15 pounds of traction and a #15 blade was used to make a stab incision at the #2 portal and then spread with a SNAP. The trocar was introduced and the NanoScope was then placed into the trocar and water was turned on. Visualization of the wrist joint revealed hypertrophic synovitis of the medial and lateral compartments as well as traumatic chondromalacia grade 2 of the radius.

At this point, an 18-gauge needle was used to establish the #4 position. Once this was established, a #15 blade was used to make a stab incision. The incision was made, a SNAP was used to open the portal and then a 2.9-mm shaver was inserted and a complete synovectomy of the medial and lateral compartments was performed and completed.

Next, the shaver was taken, and a chondroplasty of the radial floor was performed and completed. All loose chondral flaps were debrided down to a stable rim. At this point, the scope was used to visualize the medial compartment. The TFCC was visualized and it was shown to be torn but not unstable. At this point, the shaver was taken and extensive debridement of the TFCC was performed and completed down to a stable rim.

The wrist joint was then irrigated with 300 cc of sterile saline. Closure was instituted with 3-0 nylon. A PRP injection was performed into the wrist via an arthroscopically placed needle under direct visualization. A sterile dressing was applied consisting of 4 x 4, xeroform, Webril, and Ace wrap.

Sponge and needle counts at the close of the case were correct. The patient was awoken without incident and transferred to the recovery room in stable condition having tolerated the procedure well. The patient will follow up in the office in one week.

The attending surgeon was scrubbed and present throughout the critical portions of the case including all the intraarticular arthroscopic procedures.

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

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