SURGICARE OF BROOKLYN

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Left Knee Arthroscopy Operative Report

Patient Name:	Seabrook, Marian
Medical Record Number:	17176
Date of Birth:	05/21/1955
Date of Procedure:	10/20/2022
Surgeon:	Upendra K. Sinha, MD.
Assistant:	Gennadiy Shamalov, P.A.
Preoperative Diagnosis:	Internal derangement, left knee.
Postoperative Diagnoses:	M22.40 Chondromalacia patella. 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. M93.262 Osteochondral lesion, left knee.
Operative Procedure:	29876 Synovectomy (major; 2 or more compartments). 29877 Debridement (chondroplasty), MFC, patella. 29880 PMM and PLM. 20610 Arthrocentesis (aspiration and/or injection) of a joint. 29999 Coblation arthroplasty, patella, LFC, MTP, notch. 29884 Lysis of adhesions/suprapatellar pouch/anterior wall. 29999 Debridement of ACL. 0232T PRP injection.
Anesthesia:	Regional with IV sedation.
Position:	Supine.
Estimated Blood Loss:	Less than 10 mL.
Complications:	None.

Intraoperative Findings:

MMT.
LMT.
Partial tear of the ACL: 20%.
Patella, grade 3 chondromalacia.
Trochlea, grade 2 chondromalacia.
LFC, grade 2 chondral lesion.

MFC, grade 3 chondral lesion.
LTP, grade 2 chondral lesion.
MTP, grade 4 chondral lesion.
Medial plica.
Synovitis.
Adhesions- anterior wall/suprapatellar pouch.
Prognosis is guarded.
The patient may require TKR in the near future.

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 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.

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.

Debridement of ACL:
Using arthroscopic visualization and a probe, the anterior cruciate ligament was evaluated. A partial synovectomy was completed overlying the ACL to remove inflammatory synovitis and for better

visualization. There was a partial tear. The ACL was debrided to smooth margins using a full radius shaver and radiofrequency wand. The ACL was then reevaluated with the arthroscope and a probe. It was stable. Hemostasis was well maintained. Arthroscopic pictures were taken.

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.

Chondroplasty Medial Femoral Condyle:
While evaluating the medial femoral condyle, there was noted to be grade 3 chondral lesion as evaluated by arthroscopic visualization and a probe. A chondroplasty procedure was completed using a full radius shaver and a radiofrequency wand, done to smooth margins. The remaining chondral surface was probed and was stable. Hemostasis was well maintained. Arthroscopic pictures were taken.

Coblation Arthroplasty Lateral Femoral Condyle:
While evaluating the lateral femoral 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 and Trochlea:
While evaluating the patella and trochlea, there was noted to be grade 2-3 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 4 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.

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.

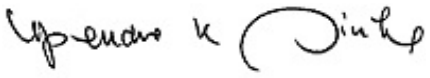
Lysis of Adhesions:
Using arthroscopic visualization, there was noted to be several adhesions at the anterior wall and suprapatellar pouch. The adhesions were excised using a full radius shaver and a radiofrequency wand. Hemostasis was well maintained. Arthroscopic pictures were taken.

Chondroplasty Patella and Trochlea:
While evaluating the patella and trochlea, there was noted to be grade 2-3 chondromalacia as evaluated by arthroscopic visualization and a probe. A chondroplasty procedure was completed using a full radius shaver and a radiofrequency wand, to debride the loose fimbriated and fragmented chondral edges and to smooth the margins. The remaining chondral surface was probed and was 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 left 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.



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