All City Family Healthcare Center
3632 Nostrand Ave.
Brooklyn, NY 11229
(718) 332-4409

Left Wrist Arthroscopy Operative Report

Patient Name:	Etienne, Shinda
Medical Record Number:	3278907
Date of Birth:	01/21/1977
Date of Procedure:	08/25/2022
Surgeon:	Upendra K. Sinha, MD.
Assistant:	David Davydov, P.A.
Preoperative Diagnoses:	Chondral damage, left wrist. Adhesions, left wrist.
Postoperative Diagnoses:	M65.849 Synovitis, left wrist. M24.032 Loose body, left wrist. S63.592A Triangular fibrocartilage partial tear, left wrist.
Operative Procedure:	29846 Arthroscopic surgical examination. 25118 Complete synovectomy. 25332 Arthroplasty, radius and scaphoid. 26080 Removal of loose body. 20605 Intraarticular cortisone injection.
Anesthesia:	Regional with IV sedation.
Estimated Blood Loss:	Minimal.
Complications:	None.
Instrumentation:	None.

Intraoperative Findings:
Extensive synovitis.
Chondral damage, grade III, scaphoid and radius.
Loose body.
Intact scapholunate ligament.
Partial tear of the TFC.
Mild to moderate De Quervain's disease.
Snapping tendon, third compartment.

Indications for Surgery:
Indications: The patient has been complaining of chronic pain in the left wrist. The patient failed conservative treatment. All the treatment options were discussed with the patient. The advantages and disadvantages, complications and recovery from surgery was discussed. The possibility of infection,

complication from anesthesia, possibility of neurovascular structure injury, blood clots after surgery, pulmonary embolism and need for further surgery were discussed. No guarantees were given.

The patient expressed an understanding of the risks and possible benefits of the procedure and was also made aware of the alternatives to surgery. An informed consent was obtained, and was checked immediately preop.

Description of Procedure:
The patient was brought to the operating room and placed supine on the table. Under regional anesthesia and IV sedation, the hand was suspended vertically with a traction device. Adequate traction was applied. Then after usual aseptic draping and prepping, a standard dorsal 3/4 viewing portal was created and a 4/5 working portal was established. Around 10 mL of saline was used to distend the joint. An 18-gauge needle was used to confirm the outflow of fluid.

The 3/4 portal was made in line with the radial border of the third metacarpal and the 4/5 portal was created in line with the mid axis of the fourth metacarpal. The 6R portal was not used. A 4/5 portal was made just proximal to the 3/4 portal because of the natural radial slope of the distal radius.

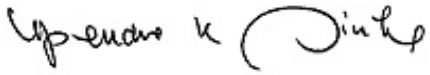
A small incision was made in the skin with a #11 blade at the intended portal site. A blunt dissection was carried out with a small curved hemostat. The joint capsule was perforated. Then the arthroscope with a blunt trocar was introduced into the wrist joint. A 4/5 portal was made as usual under direct visualization. the joint was irrigated.

Diagnostic arthroscopic examination was done. Examination revealed extensive synovitis of the wrist. A loose body was seen which was removed. The scapholunate ligament was intact. There was partial tear of the TFC. The patient had chondral damage of the radius and the scaphoid. Some loose bodies were also found, which were removed. The mid carpal joint was normal. Total synovectomy and debridement was performed up to a stable border. Copious irrigation was done followed by closure of the wound. Sterile dressing was applied.

Cortisone was injected intraarticularly into the wrist.

The patient tolerated the procedure well. A post op volar splint was applied. The patient was awakened from anesthesia and brought to the recovery room in a 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.



U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon