PREOPERATIVE DIAGNOSES: History of breast cancer, status post

bilateral mastectomies and loss of left breast tissue expander.

POSTOPERATIVE DIAGNOSES: History of breast cancer, status post

bilateral mastectomies and loss of left breast tissue expander.

PROCEDURE: Left breast reconstruction with placement

of tissue expander.

ASSISTANT: Ambika Menon .

ANESTHESIA: General endotracheal anesthesia.

IV FLUIDS: See Anesthesia record.

EBL: 50 cc.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Womble is a 56-year-old woman who

previously underwent bilateral mastectomy with loss of left breast

reconstruction due to infection. She now presented in delayed fashion for

reconstruction and placement of tissue expander. The risks, benefits,

alternatives, and possible complications of the procedure were discussed with

her, obtaining written and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating

room, placed under general anesthesia in supine position on the operating table

without complication. She was identified with appropriate time-out.

Preoperative antibiotics were administered. Chest was prepped with ChloraPrep

and draped in the usual sterile fashion. We began by first incising along the

inframammary incision and dissecting using a scalpel, followed by Bovie

electrocautery down to the chest wall. We then proceeded to re-elevate the

mastectomy skin flaps off the pectoralis muscle using Bovie electrocautery

dissection under direct visualization with a lighted retractor. I did

encounter some bleeding at the upper outer quadrant along the pectoral border

and spent some time obtaining hemostasis here and applied Surgicel gauze. Once

I was happy with the pocket, we radially scored the pocket to allow for

expansion. Finally, there was some severely attenuated scar along the border

of the mastectomy skin flap, and so we advanced the inferior mastectomy skin or

upper abdomen skin cephalad and marked an area that could be excised with

minimal tension on closure. We copiously irrigated the pocket with IrriSept

and confirmed hemostasis and then placed a drain laterally through a separate

incision with a 15-French Blake drain that was secured with a 2-0 nylon suture.

Finally, I selected a 14 cm wide tissue expander and filled this with 100 cc of

air and then secured this into the pocket with a 2-0 Vicryl along the lateral

tab. We de-epithelialized the attenuated scar portion of the mastectomy skin

flap and then closed with 3-0 Monocryl deep dermal sutures, followed by 4-0

Monocryl running subcuticular. Biopatch Tegaderm dressing was placed on the

drain site and Steri-Strips on the breast. The patient was then extubated,

transferred to Recovery in good condition. All needle and sponge counts were

correct at the end of the procedure.

DRAINS: 15-French Blake x1.

SPECIMENS: None.

FINDINGS: Dense scarring from previous infection.

COMPLICATIONS: None.

PREOPERATIVE DIAGNOSIS: Bilateral breast reconstruction deformity.

POSTOPERATIVE DIAGNOSIS: Bilateral breast reconstruction deformity.

PROCEDURES:

1. Removal of intact bilateral breast implants.

2. Placement of smaller bilateral breast implants.

3. Bilateral capsulorrhaphy.

4. Bilateral breast fat grafting (right 22, left 20 cc).

ASSISTANT: Dr. Philip McCarthy.

ANESTHESIA: General endotracheal.

INTRAVENOUS FLUIDS: See anesthesia record.

ESTIMATED BLOOD LOSS: Minimal.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Elenkova is a 65-year-old woman who previously

underwent bilateral implant exchange, but developed several areas of deformity

and was too large and requested smaller implants. The risks, benefits,

alternatives, possible complications of the procedure were discussed with her,

obtaining written and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating room, placed

under general anesthesia in supine position on the operating table without

complication. She was identified with appropriate time-out. Preoperative

antibiotics were administered. Her chest and abdomen were prepped with

ChloraPrep and draped in the usual sterile fashion. We made a small incision

along the previous scar on her abdomen, injected tumescent solution throughout

the abdomen and then attention was directed toward the breasts. We reopened

her previous mastectomy incision bilaterally using a 15 blade scalpel followed

by Bovie electrocautery dissection through the capsule. The implant was

intact and removed on both sides. We then performed extensive capsulotomy

medially and superiorly to move her implants and then laterally did a strip

capsulorrhaphy without resecting this segment but cauterizing the intervening strip. We

then closed this using 2-0 PDS sutures. On the right side, I also did sutures

along the inframammary fold to redefine her crease and make her nipple to IMF

distance more symmetric. We then selected a 450 cc sizer to be placed on both

sides as she requested. Noted that the right side still appeared bigger and

so I changed down to a 430 cc sizer and sat her up to examine for symmetry.

On the abdomen, I harvested fat using a 60 cc syringe and a Mercedes tip Tulip

cannula and then strained the fat. The fat was then transferred into 10 cc

syringes with a Mercedes tip Tulip cannula. With the sizers in position, I

carefully injected the fat along predominantly the lower half of the nipple-

areolar complex bilaterally to avoid a step-off deformity and then also

inferiorly where the mastectomy skin flap was significantly thinner. On the

right side, I injected 22 cc, the left side 20 cc. Once the fat was injected,

the sizers were removed and pockets were irrigated with IrriSept to confirm

hemostasis. We then placed 3-0 Vicryl sutures as our parachuting sutures and

secured those with hemostats along the capsule and then repainted the skin on

both sides with Betadine. We started with the right side and changed gloves,

placed the Mentor MemoryGel Boost moderate plus profile 430 cc implant, serial

number 9990916-001; and on the left side, we placed a same style, but 450 cc

implant, serial number 9992811-022. With the implants positioned of both

sides, we closed the capsule using the 3-0 Vicryl sutures by tying them down

and then did undermine slightly just to release the skin edge from the scar to

avoid a dimpling deformity before closing the skin using 3-0 Monocryl deep

dermal sutures and 4-0 Monocryl running subcuticular. Finally, attention was

directed toward the left lateral chest where she had some skin excess, so we

did a direct excision of some of that skin excess with a wedge using a 15

blade scalpel followed by Bovie electrocautery and then closed this using 3-0

Monocryl deep dermal sutures and 4-0 Monocryl running subcuticular as well.

Sylke tape dressing was applied followed by 5-0 fast in the umbilicus and then

ABD pads and a surgical bra were placed. The patient was extubated and

transferred to the recovery room in good condition. All needle and sponge

counts were correct at the end of the procedure.

DRAINS: None.

SPECIMENS: Bilateral breast implants for gross.

FINDINGS: Intact bilateral breast implants 600 cc.

COMPLICATIONS: None.

PREOPERATIVE DIAGNOSES:

1. Bilateral breast reconstruction with tissue expanders.

2. History of breast cancer.

POSTOPERATIVE DIAGNOSES:

1. Bilateral breast reconstruction with tissue expanders.

2. History of breast cancer.

PROCEDURE: Bilateral tissue expander and implant exchange.

ASSISTANT: Dr. Philip McCarthy

ANESTHESIA: General endotracheal anesthesia.

IV FLUIDS: See Anesthesia record.

ESTIMATED BLOOD LOSS: Minimal.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Rayburn is a 54-year-old with previous

bilateral skin sparing mastectomy and expander based reconstruction. She now

presented for second-stage expander and implant exchange. The risks,

benefits, alternatives, and possible complications to the procedure were

discussed with her, obtaining written and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating room ad placed

under general anesthesia in supine position without complication. She was

identified with an appropriate time-out and preoperative antibiotics were

administered. Her chest was prepped with ChloraPrep and draped in usual

sterile fashion. We began by reopening the inframammary portion of her scar

and dissected using a scalpel followed by Bovie electrocautery through the

capsule. We then ruptured and deflated her expanders and extracted these from

the pocket. We tried a series of sizers Mentor Boost High-Profile and

Moderate Plus on both sides ranging from 530 to 635 cc and sat her up several

times to achieve symmetry, and ultimately chose to proceed with High-Profile

both sides with the right being 635 cc and the left being 585 cc. We

irrigated the pocket with IrriSept and placed 3-0 Vicryl sutures in a

parachuting fashion on the capsule and then we painted the skin with Betadine

and changed gloves before introducing the implant. On the right side serial

#9938628-054, left side serial #9875508-034. Once the implant was in

position, we closed the capsule using Vicryl sutures and tying them down, and

then closed the skin using 3-0 Monocryl deep dermal sutures and 4-0 Monocryl

running subcuticular. Silk tape dressing was applied and then followed by

ABDs and a bra. The patient was extubated and transferred to the recovery

room in good condition. All needle and sponge counts were correct at the end

of the procedure.

DRAINS: None.

SPECIMENS: None.

FINDINGS: Well-positioned breast expanders.

COMPLICATIONS: None.

PREOPERATIVE DIAGNOSIS: Bilateral breast reconstruction deformity.

POSTOPERATIVE DIAGNOSIS: Bilateral breast reconstruction deformity.

PROCEDURE: Bilateral breast fat grafting (right 70, left 50cc).

ASSISTANT: Dr. Philip McCarthy.

ANESTHESIA: General endotracheal anesthesia.

INTRAVENOUS FLUIDS: See anesthesia record.

ESTIMATED BLOOD LOSS: Minimal.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Wingo is a 73-year-old woman with a history of

complex bilateral breast reconstruction with severe capsular contracture and

attenuated mastectomy skin flaps. The risks, benefits, alternatives, and

possible complications of the procedure were discussed with her, obtaining

written and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating room, placed

under general anesthesia in the supine position on the operating table without

complication. She was identified by appropriate time-out. Preoperative

antibiotics were administered. Her chest, abdomen, and thighs were prepped

with ChloraPrep and draped in usual sterile fashion. We began by making a

small access incision along the flanks and inner medial thighs and injecting a

liter of tumescent solution. We then waited 15 minutes before we harvested

fat manually with a Mercedes tip Tulip cannula and 60 cc syringe. The fat was

strained and then transferred to 10 cc syringes, which were then injected with

a long tip Coleman cannula. I made on the right breast 5 access incisions and

then on the left breast two and then injected fat into the lower pole where

she had very attenuated skin flaps. On the right side, I injected a total of

70 cc, on the left side a total of 50 cc. The access incisions were then

closed with 5-0 fast and the patient was extubated and transferred to the

recovery room in good condition. All needle and sponge counts were correct at

the end of the procedure.

DRAINS: None.

SPECIMENS: None.

FINDINGS: Very thin mastectomy skin flaps bilaterally.

COMPLICATIONS: None.

PREOPERATIVE DIAGNOSIS: Right ear keloid.

POSTOPERATIVE DIAGNOSIS: Right ear keloid.

PROCEDURE: Excision of right ear keloid (2.5 cm).

ASSISTANT: Dr. Phil McCarthy

ANESTHESIA: General endotracheal.

INTRAVENOUS FLUIDS: See anesthesia record.

ESTIMATED BLOOD LOSS: Minimal.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Brown is a 17-year-old who came with her

mother for excision of right ear keloid. The risks, benefits, alternatives,

and possible complications of this procedure were discussed with her mom and

obtaining written and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating room, placed

under general anesthesia in the supine position on the operating table without

complication. She was identified by appropriate time-out and preoperative

antibiotics were administered. Her right ear was prepped with Betadine and

draped in the usual sterile fashion. We made a curvilinear incision along the

keloid scar along its base using a 15 blade scalpel followed by dissection

using Iris scissors and double hooks. We did encounter some sebum consistent

with trapped debris from the sinus tract from her piercing at this location.

Once the mass was removed, it was sent to Pathology. We then obtained

hemostasis using Bovie electrocautery and closed using 5-0 nylon deep followed

by 5-0 fast simple interrupted sutures. We did evert the sinus tract and

trimmed this and then closed this in a similar manner with interrupted suture.

Bacitracin dressing was applied. The patient was extubated and transferred to

the recovery room in good condition. All needle and sponge counts were

correct at the end of the procedure.

DRAINS: None.

SPECIMENS: Right ear mass.

COMPLICATIONS: None.

FINDINGS: Sebaceous debris within a sinus tract.

PREOPERATIVE DIAGNOSES: History of right breast cancer and failed implant

reconstruction.

POSTOP DIAGNOSIS: History of right breast cancer and failed implant

reconstruction.

PROCEDURES:

1. Right breast reconstruction with full TRAM (transverse rectus abdominus

muscle) flap.

2. Spy angiography.

ASSISTANT: Dr. Gabby Garcia Nores.

RESIDENTS: Dr. Gabby Glassman, Dr. Erica

Smearman and Dr. Troy Marxxen.

ANESTHESIA: General endotracheal anesthesia.

IV FLUIDS: See anesthesia record.

EBL: 100 cc.

URINE OUTPUT: See anesthesia record.

INDICATIONS FOR PROCEDURE: Ms. Oliver is a 71-year-old with previous history of

right breast reconstruction site. Previous history of failed right breast

reconstruction with implant and radiation. She now presented in delayed

fashion for right DIEP flap reconstruction. The risks, benefits, alternatives,

and possible complications procedure were discussed with her, obtaining written

and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken operating room, placed under general

anesthesia in supine position on the operating table without complication. She

was identified with appropriate time-out and. Preoperative antibiotics were

administered. Her chest and abdomen were prepped with ChloraPrep and draped in

usual sterile fashion. On the chest, we reopened the transverse mastectomy

incision using a scalpel followed by Bovie electrocautery dissection down to

the pectoralis and latissimus muscle. We then proceeded to elevate recreate

the mastectomy pocket cephalad using Bovie electrocautery and then finally were

able to identify the 4th cartilaginous rib. Split overlying muscle to expose

the cartilaginous rib fully scored with the Bovie electrocautery and then using

#9 peeled the anterior perichondrium off circumferentially. We then we used a

rongeur forceps to remove the cartilaginous rib to the sternal junction. We

opened the posterior perichondrium, resected the intercostal muscles to the rib

above the rib below to expose the internal mammary vessels. We had a larger

internal mammary vein laterally and a smaller caliber vein medially. We then

used small medium clips to divide the vessels distally and placed green Acland

clamps proximally and then divided the vessel and then cleaned these under the

microscope and flushed with heparinized saline in preparation for microvascular

anastomosis. I did inject 10 cc of 0.5% Marcaine as an intercostal and tap

block. I then placed a separate drain a 15-French Blake with a separate

incision laterally and secured this with 2-0 nylon suture.

On the abdomen, we made the cephalic incision 1st just above the umbilicus and

dissected using Bovie electrocautery down to the anterior rectus sheath and

dissected cephalad toward the xiphisternum. We then brought her flexed

position confirmed. We closed the lower incision and readjusted this up

slightly 1 cm. We then admitted the lower incision and identified the sied of

both sides and followed this down for approximately 6 cm before we clipped and

divided it. We then split the flap down the midline and freed the umbilicus on

the stalk using a 15 blade followed by Bovie electrocautery dissection. We

then dissected the lateral to medial using Bovie electrocautery until we were

over the rectus muscle and then slowed down to identify perforators. On the

right hemi abdomen, we then dissected the medial to lateral as well and noted

we had our 2 strongest perforators were the medial and lateral cephalad

perforator. I could not find a corresponding signal to the more periumbilical

perforators, but could find a skin paddle signal to the lateral row

perforators. On the left hemi-abdominal flap all the perforators were

exceptionally diminutive and would not be feasible for Diep flap, so at this

point, we elected to convert this to full TRAM.

We opened the fascia just lateral to the lateral perforators, dissected this

down to the pedicles origin and then finished freeing the rectus muscle

circumferentially. We transected the muscle distally 1st and proximally using

Bovie electrocautery and then clipped and divided the pedicle. The flap was

flushed with heparinized saline and brought to the chest and using the

microscope, we performed a venous anastomosis with a 3.0 coupler and then

trimmed the artery and performed the arterial anastomosis using a double Acland

clamp and 8-0 nylon sutures. The clamps were released with good flow and the

2nd vena com was clipped. Good strip test was noted on the vein and the spy

angiography was performed demonstrating good inflow and outflow after 20

minutes. The distal part of the flap that did not perfuse well on spy was

trimmed using Bovie electrocautery. We then proceeded to inset the flap with

the more medial aspect laterally as the flap was flipped 180. The skin paddle

signal was identified and marked with a 5-0 nylon suture. We did excise a rim

of mastectomy skin along the cephalad border after making a slit toward the

axilla to remove the previously radiated and scarred tissue. The skin was sent

to Pathology. We then carefully de-epithelialized the buried portion of the

flap using Metzenbaum scissors and then proceeded to inset the flap using 3-0

Monocryl deep dermal sutures along the cephalic edge. Ultimately, I chose to

excise the previous latissimus skin paddle as I could not inset this with the

previous skin paddle and finished insetting the lower edge also with 3-0

Monocryl deep dermal sutures and 4-0 Monocryl running subcuticular. On the

abdomen, we selected the piece of Parietex mesh as an inlay and then closed the

fascia overlying with 2-0 PDS sutures and then brought the patient in a flexed

position and stapled the skin shut and proceeded to mark the new position of

the umbilicus was inverted V. Scarpa's fascia was reapproximated with 2-0 PDS

and then skin was closed using 3-0 Stratafix running intradermal suture. The

umbilicus was inset using 3-0 Monocryl deep dermal sutures of 5-0 nylon simple

interrupted sutures. We did place 2 drains in the abdomen, brought these out

through the mons pubis. Secured these with 2-0 nylon sutures. Biopatch and

Tegaderm was placed on the drain site. Silk tape followed by Primapore was

placed on the abdominal incision. Xeroform and Primapore were placed on the

umbilicus. Bacitracin with Xeroform and ABD pad was placed on the breast. We

did also inject 20 cc of half-strength Marcaine into each hemiabdomen as a tap

block prior to closure. At this point, the patient was noted to be hypothermic

and so we did not immediately extubate and brought in multiple Bair huggers,

bottles of warm saline, and warm blankets with fluid warmer to brace her body

temperature prior to extubation. All needle and sponge counts were correct at

the end the procedure.

DRAINS: 15-French Blake x3.

SPECIMENS: Right mastectomy skin.

FINDINGS: Well-perfused flap.

COMPLICATIONS: None.

PREOPERATIVE DIAGNOSES:

1. Hidradenitis of the right breast.

2. Hidradenitis of right lateral chest.

3. Hidradenitis of right mons and inguinal region.

4. Hidradenitis of right buttocks.

5. Fat necrosis of abdominal scar.

POSTOPERATIVE DIAGNOSES:

1. Hidradenitis of the right breast.

2. Hidradenitis of right lateral chest.

3. Hidradenitis of right mons and inguinal region.

4. Hidradenitis of right buttocks.

5. Fat necrosis of abdominal scar.

PROCEDURE:

1. Excision of right breast hidradenitis (6 cm)

2. Excision of right lateral chest hidradenitis (7 cm)

3. Excision of right inguinal/mons pubis hidradenitis.

4. Excision of 2 right gluteal hidradenitis lesions (4 cm each)

5. Excision of fat necrosis of abdominal wall (2 cm)

ASSISTANT: Dr. Kendall Brooks and Dr. Gabby Glassman.

ANESTHESIA: General endotracheal anesthesia.

IV FLUIDS: See Anesthesia record.

ESTIMATED BLOOD LOSS: 50 cc.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Born is a 48-year-old woman with diffuse

hidradenitis and a previous panniculectomy. She now presented for further

excision of areas of refractory disease as well as a firm area of fat necrosis

on the abdominal scar. The risks and benefits, alternatives, and possible

complications to procedure were discussed with her, obtaining written and

verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken operating room and placed under

general anesthesia in supine position after appropriate time-out procedure.

She was then turned in the left lateral decubitus position and prepped with

ChloraPrep and draped in usual sterile fashion. We began with direct excision

of the right lateral chest lesion with a 15 blade scalpel followed by Bovie

electrocautery and then closure using 3-0 Monocryl deep dermal sutures and 2-0

nylon interrupted simple sutures. We then directed attention toward the right

buttocks where she had a lesion along the gluteal crease as well as the gluteal

cleft, and both were excised in elliptical fashion and closed in a similar

manner. Finally, attention was directed toward the right breast inframammary

fold where we also designed an elliptical incision to excise the tissue. This

was sent to pathology. The last area that was addressed was the right inguinal

and abdominal region where a large ellipse of tissue was removed. The incision

was extended along the previous panniculectomy incision to excise the fat

necrosis. Once all areas had been excised and hemostasis confirmed, they were

all closed in a similar manner with 3-0 Monocryl deep dermal sutures and then

simple and/or horizontal mattress 2-0 nylon sutures. We then covered these

with 4x4s and ABD pad with Medipore tape. The patient was extubated and

transferred to recovery in good condition. All needle and sponge counts were

correct at the end of the procedure.

DRAINS: None.

SPECIMENS:

1. Right breast.

2. Right lateral chest.

3. Right gluteal cleft.

4. Right gluteal crease.

5. Right inguinal skin.

COMPLICATIONS: None.

FINDINGS: Fibrotic tissue consistent with fat necrosis in the right lower

quadrant abdominal wall.

PREOPERATIVE DIAGNOSIS: Rectovaginal fistula.

POSTOPERATIVE DIAGNOSIS: Rectovaginal fistula.

PROCEDURE: Left gracilis flap.

ASSISTANT: Dr. Gabby Glassman

ANESTHESIA: General endotracheal anesthesia.

IV FLUIDS: See Anesthesia record.

ESTIMATED BLOOD LOSS: 50 cc.

URINE OUTPUT: See Anesthesia record.

INDICATIONS FOR PROCEDURE: Ms. Evans is a 30-year-old woman who previously

sustained a rectovaginal tear during childbirth and failed previous repair.

She now presented for repair with Dr. Northington, and accompanying request for

a gracilis flap to help with the repair. The risks, benefits, alternatives,

and possible complications of the procedure were discussed with her, obtaining

written and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating room by Dr.

Northington for repair of the rectovaginal fistula. For further details,

please see her operative dictation.

I entered the operating suite after the preliminary dissection was complete,

and proceeded to incise directly over the gracilis muscle in the left inner

thigh using a 15 blade scalpel, followed by Bovie electrocautery. I dissected

through the fascia until I was directly over the muscle, and then proceeded to

finish exposing the gracilis muscle medially more cephalad and then more

distally dissected bluntly. We carefully opened the space between the adductor

longus and the gracilis muscle. We identified the pedicle and dissected this

proximally toward its origin. We circumferentially freed it. Once I had it

fully identified, I also divided the obturator nerve using bipolar forceps.

Small and medium clips were used to divide the muscular branches to free the

pedicle. Finally, we made a small counter incision just proximal to the knee

medially, and dissected using a 15 blade scalpel, followed by Bovie

electrocautery to identify the tendinous insertion of the gracilis muscle, then

divided that using Bovie electrocautery after isolating it with a right angle.

We then finished the dissection to disinsert the muscle and bring it

proximally. I then completed it using a Dever, disinsertion proximally of the

gracilis muscle using Bovie electrocautery.

Dr. Northington came back into the room, so that we could develop a

subcutaneous plane to deliver the muscle flap into position. Once we were

happy with this, I slit the muscle clockwise 180 degrees, passed the tendinous

insertion, and delivered that through the tunnel into the defect. I used 2-0

PDS to tack the muscle original proximal end distally to the adductor longus to

protect the pedicle which was transposed with no kinking and minimal tension.

We then placed a 15-French Blake drain through a separate incision and secured

this with 2-0 nylon suture. We proceeded to close the fascia using 2-0 PDS,

followed by skin closure using 2-0 Monocryl deep dermal sutures and 4-0

Monocryl running subcuticular. A silk tape dressing was applied. Biopatch and

Tegaderm were placed on the drain site, and finally at the end, an ABD pad was

placed on the thigh.

The distal flap was carefully inset by Dr. Northington, so I left the

procedure.

COUNTS: All needle and sponge counts were correct at the end of the procedure.

DRAINS: A 15-French Blake x1.

SPECIMENS: None for my operation.

FINDINGS: Healthy vessels and muscle flap.

PREOPERATIVE DIAGNOSIS: Bilateral breast reconstruction deformity.

POSTOPERATIVE DIAGNOSIS: Bilateral breast reconstruction deformity.

PROCEDURE: Bilateral breast fat grafting (right 46, left 37 cc).

ASSISTANTS: Dr. Gabby Glassman and Dr. Kendall Brooks.

ANESTHESIA: General endotracheal anesthesia.

IV FLUIDS: See anesthesia record.

ESTIMATED BLOOD LOSS: Minimal.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Butler is a 35-year-old woman who previously

underwent bilateral breast reconstruction with implants and had a significant

rippling deformity. The risks, benefits, alternatives, and possible

complications were discussed with her, obtaining written and verbal consent

preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating room and placed

under general anesthesia in supine position on the operating table without

complication. She was identified with appropriate time-out and preoperative

antibiotics were administered. Her chest, abdomen, and thighs were prepped

with ChloraPrep, draped in usual sterile fashion. We made an access incision

in the medial thigh as well as the umbilicus and injected tumescent solution

totaling 1 L. After waiting 20 minutes, we harvested fat manually with a

Mercedes tip Tulip cannula and a 60 cc syringe. The fat was then strained

carefully through Telfa and then transferred to 10 cc syringes to be injected

with a Coleman cannula tip. We made small access incisions on the breast in

old scars and injected into areas focusing on the superomedial quadrants of

both breasts and a little bit in the lateral breast and inferolaterally on the

right side. A total 46 cc was injected on the right and 37 cc was injected on

the left. Access incisions were closed with 5-0 fast. We set her up twice to

make sure we were happy with the final contour and then she was extubated and

transferred to recovery room in good condition. All needle and sponge counts

were correct at the end of the procedure.

DRAINS: None.

SPECIMENS: None.

FINDINGS: Well-healed breast reconstruction.

COMPLICATIONS: None.

PREOPERATIVE DIAGNOSIS: Excess abdominal skin.

POSTOPERATIVE DIAGNOSIS: Excess abdominal skin.

PROCEDURES:

1. Panniculectomy.

2. Abdominoplasty with umbilical transposition.

ASSISTANT: Dr. Charlie Frank.

ANESTHESIA: General endotracheal anesthesia.

INTRAVENOUS FLUIDS: See anesthesia record.

ESTIMATED BLOOD LOSS: Minimal.

URINE OUTPUT: No Foley.

INDICATIONS FOR PROCEDURE: Ms. Spaulding is a 41-year-old woman with excess

abdominal skin after weight loss. The risks, benefits, alternatives, and

possible complications of this procedure were discussed with her, obtaining

written and verbal consent preoperatively.

PROCEDURE IN DETAIL: The patient was taken to the operating room, placed

under general anesthesia in the supine position on the operating table without

complication. She was identified with appropriate time-out and preoperative

antibiotics were administered. Her abdomen was prepped with ChloraPrep and

draped in the usual sterile fashion. I began by freeing the umbilicus as an

oval incision using a 15 blade scalpel followed by Bovie electrocautery

dissection of the stalk. We then made the caudal incision just below her

previous Pfannenstiel incision and completed that using a 15 blade followed by

Bovie electrocautery until we dissected down to the rectus sheath. We then

dissected cephalad and split the flap down the middle to reach the umbilicus

where we finished dissecting the stalk and then continued the dissection in a

limited epigastric fashion toward the xiphisternum. The patient was then

brought into the flexed position and then we marked the excess skin to be

trimmed and completed this and the specimen was sent to Pathology. We then

confirmed hemostasis, noted that she had minimal diastasis, and then proceeded

to close using 2-0 Stratafix running progressive tension sutures to

reapproximate the abdominal skin to the anterior rectus sheath. We did inject

15 cc of 0.25% Marcaine as a pseudo TAP block and finished closing the final

layer of skin using 3-0 Monocryl deep dermal sutures and 4-0 Monocryl running

subcuticular. The new position of the umbilicus was excised as an inverted V

and then the umbilicus was delivered into position and inset with 3-0 Monocryl

deep dermal sutures and 5-0 nylon simple interrupted sutures. The umbilicus

was covered with Xeroform, 2 x 2 and Tegaderm. The abdominal incision was

covered with Sylke tape dressing. The patient was then extubated and

transferred to the recovery room in good condition. All needle and sponge

counts were correct at the end of the procedure.

DRAINS: None.

SPECIMENS: Lower abdominal skin.

FINDINGS: No rectus diastasis.

COMPLICATIONS: None.

PREOPERATIVE DIAGNOSIS: History of breast cancer, status post bilateral

mastectomy.

POSTOPERATIVE DIAGNOSIS: History of breast cancer, status post bilateral

mastectomy.

PROCEDURE: Left breast reconstruction with left deep inferior epigastric artery

perforator flap.

CO-SURGEON: Dr. Abdl-Rawf Al-Nowaylati.

ASSISTANTS: Dr. Phillip McCarthy, Dr. Iman Khan.

ANESTHESIA: General endotracheal.

INTRAVENOUS FLUIDS: See anesthesia record.

ESTIMATED BLOOD LOSS: 300 cc.

URINE OUTPUT: See anesthesia record.

INDICATIONS FOR PROCEDURE: Ms. Pettus is a 46-year-old woman with a history of

breast cancer, status post failed expander-based reconstruction. She now

presented in delayed fashion for autologous reconstruction with abdominal

tissue. The risks, benefits, alternatives, and possible complications of this

procedure were discussed with her, obtaining written and verbal consent

preoperatively.

PROCEDURE IN DETAIL: Patient was taken to the operating room, placed under

general anesthesia in supine position on the operating table without

complication. She was identified with appropriate time-out. Preoperative

antibiotics were administered. Her chest and abdomen were prepped with

ChloraPrep and draped in the usual sterile fashion.

I began work on the left breast by reopening the mastectomy incision using a

scalpel followed by Bovie electrocautery to recreate the mastectomy defect. We

then deflected the 4th rib and split the pectoralis muscle overlying, including

the underlying capsule from the previous subpectoral implant. Once we exposed

the perichondrium, we dissected this free using a #9 circumferentially and then

removed the cartilage with a rongeur and then removed the posterior

perichondrium and intercostal muscles to expose the internal mammary artery and

vein. We did have a pair of vena comitans that were a little on the smaller

side on the left chest so I squirted some papaverine on this and placed a moist

Ray-Tec in the chest. We then injected 10 cc of 0.25% Marcaine as a pectoralis

and intercostal block and placed a 15-French Blake drain and secured this with

2-0 nylon suture.

On the abdomen, I made the incision transversely just above the umbilicus and

then dissected using a scalpel followed by Bovie electrocautery down to the

anterior rectus sheath in limited epigastric fashion toward the xiphisternum.

We brought the table into a flexed position and made a small adjustment to the

central portion of the flap marking at the caudal aspect and bringing it up

approximately a centimeter. I then proceeded to dissect the left hemi-

abdominal flap. I was able to identify and dissect the SIED for a few

centimeters before I clipped and divided it. I then dissected in a lateral to

medial direction, identifying 2 lateral perforators and then relatively smaller

3 medial row perforators. Dopplers signals were strongest on the lateral

perforators, so I decided to dissect a flap based on this and opened the fascia

using Bovie electrocautery followed by bipolar dissection through the muscle

and clips were used to divide smaller branches as well as small-medium clips to

divide intramuscular branches.

I then dissected the pedicle until there was adequate length and caliber and

then placed clamps on the medial perforators SPY angiography confirmed that the

flap was adequately perfused on the lateral perforators. We then proceeded to

clip and divide the medial row perforators. I clipped and divided the medial

division. We then finished dissecting the flap and clipped and divided the

pedicle using a large vascular clip.

The flap was flushed with heparinized saline and brought up to the left chest,

where I then performed microvascular anastomosis using a 2.5 mm coupler

followed by using a double Acland with 8-0 nylon simple interrupted sutures.

Right before the first anastomosis clamp was released, I noticed an area where

the artery was actually damaged, and so I trimmed it back and re-did the

arterial anastomosis a 2nd time.

Clamps were removed, and a good flow was noted with positive strip test.

Pedicle was gently laid into position, and the flap was tacked into the pocket

and secured with skin staples. At this point, we closed the fascia with #1

Nurolon figure-of-eight sutures in interrupted fashion followed by a 2nd

running layer to bury the sutures. I also injected 20 cc of Exparel as a TAP

block in the left hemi abdomen.

For further details of the right breast flap, please see separate dictation by

Dr. Al-Nowaylati, noting that I did assist them on the extensive revision that

was necessary with vein graft to establish the flap.

Once that was completed, we sewed a piece of Strattice mesh then to the replaced

fascia that was harvested on the muscle-sparing TRAM on the right side and

secured this with 2-0 PDS horizontal mattress sutures.

I then brought the patient into a semi-flexed position and proceeded to close

using 2-0 Stratafix running progressive tension sutures to reapproximate the

anterior abdominal wall to the anterior rectus fascia. I then did place a few

2-0 PDS sutures to suspend the Scarpa fascia on the lower tissue and then

finished closing the skin using 3-0 Stratafix running intradermal suture. We

inset the position of the umbilicus with an inverted V and then brought this

out, secured this with 3-0 Monocryl deep dermal sutures and 5-0 nylon simple

interrupted sutures.

At this point on the breast, we made several adjustments of the pockets, then

made relaxing incision along the axillary tail and excised a portion of the

mastectomy skin for the inset as it was quite tight due to the previous

radiation. This skin was sent to Pathology.

We then noted a good Doppler signal on the skin paddle, which was marked with a

5-0 nylon suture, and repeated the SPY, showing good inflow and outflow. We

marked and de-epithelialized the buried portions of the flap and then proceeded

to de-epithelialize that. We finished closing using 3-0 Monocryl deep dermal

sutures and 4-0 Monocryl running subcuticular.

At this point, attention was directed toward helping Dr. Al-Nowaylati with

multiple revision anastomoses and followed this with a vein graft on the right

flap, and we finished completing the surgery. Silk tape was applied to the

abdominal incision. Xeroform and Primapore were applied to the umbilicus as

well as Primapore to the abdominal incision. The breast was covered with

bacitracin, Xeroform, ABD pad, and Biopatch and Tegaderm were placed on the

drain site. Patient was extubated and transferred to recovery room in stable

condition. All needle and sponge counts were correct at the end of the

procedure.

DRAINS: 15-French Blake in each breast.

SPECIMENS: Mastectomy skin.

FINDINGS: Well-perfused left breast flap on SPY.

COMPLICATIONS: Please see separate dictation by Dr. Al-Nowaylati regarding

right breast flap.

PREOPERATIVE DIAGNOSIS: Symptomatic macromastia.

POSTOPERATIVE DIAGNOSIS: Symptomatic macromastia.

PROCEDURE PERFORMED: Bilateral breast reduction.

ANESTHESIA: General.

INDICATIONS: The patient presents with a history of symptomatic macromastia

with back, neck, and shoulder stress pain, and failed conservative treatment,

and we elected to proceed with the above.

PROCEDURE IN DETAIL: Her breasts had been prepped and draped in the usual

fashion. SCDs were placed, and IV antibiotics were given. The right nipple

was incised with a knife and the standard Wise pattern markings were cut. An

inferior pedicle was de-epithelialized, and we removed 735 g of breast tissue

and skin from around the inferior pedicle. Adjustments in size and shape were

made. Hemostasis was obtained. The pocket was irrigated and sprayed with

Arista, and the horizontal, vertical, and periareolar incision was then closed

in layers with Monocryl after Insetting the nipple. We did the exact same

procedure on the left-hand side, removing 731 g of tissue from around the

inferior pedicle, and similarly irrigating and closing her breast mound. She

was transferred stable to the PACU.

PREOPERATIVE DIAGNOSIS: Symptomatic macromastia.

POSTOPERATIVE DIAGNOSIS: Symptomatic macromastia.

PROCEDURE PERFORMED: Bilateral breast reduction.

ANESTHESIA: General.

INDICATIONS: The patient presents with a history of back, neck, and shoulder

strap pain. This was despite conservative management, and we elected to

proceed with the above.

PROCEDURE IN DETAIL: Her breasts had been prepped and draped in the usual

fashion. The right nipple was incised with a knife, and the standard Wise

pattern markings were cut. A superomedial pedicle was de-epithelialized, and

we resected 596 g of tissue from around the pedicle. Adjustments in size and

shape were made. Hemostasis was obtained. The pocket was sprayed with Arista,

and the horizontal, vertical, and periareolar incision was closed in layers

with Monocryl. The exact same procedure was done on the left-hand side,

removing 724 g of tissue, and similarly irrigating and closing. She was

transferred stable to the PACU.

Fat Grafting

The patient was brought to the operating room and was placed on the operating table in the supine position. All bony prominences appropriately padded, perioperative antibiotics were infused at least 30 minutes prior to skin incision, and sequential compressive devices were placed on the bilateral lower extremities. Prior to anesthetic induction, an anesthesia timeout was performed verifying the patient, procedure, location and all parties were in agreement. General anesthesia was then induced, and an endotracheal intubation was performed without complication. The patient was then prepped and draped in the usual sterile fashion. Prior to skin incision, a surgical timeout was performed again verifying the patient, procedure, location, and all parties were in agreement.

We began infiltrating the abdomen with tumescent solution (1L NS and 1 ampule of epinephrine) to allow sufficient time for hemostasis. After allowing sufficient time for hemostasis, we began harvesting fat from her supraumbilical abdomen using the typical blunt tipped cannula. \*\*\*cc total of fat was harvested using her old laparoscopic access sites. This fat was processed via decantation on white telfa gauze and transferred into 10cc syringes.

The fat was then transferred into the superior poles of bilateral breasts after creating stab incisions with an 18-gauge needle. A total of \*\*\*cc was transferred to \*\*\* breast, after which we sat the patient up to ensure there were no residual areas of hollowing that could benefit from lipofilling.

Fat grafting access sites were closed with 5-0 plain gut.

Steri-strips were applied to all incisions, and the patient was placed in a light compressible surgical bra.

The patient was awakened from anesthesia without complication and taken to the PACU in stable condition.

DATE OF PROCEDURE: @DATE@

PREOPERATIVE DIAGNOSIS:

1. \*\*\*

POSTOPERATIVE DIAGNOSIS: Same

OPERATIVE PROCEDURE:

1. Free anterior lateral thigh flap for \*\*\*.

ATTENDING SURGEON: \*\*\*

RESIDENT SURGEON: @ME@

ASSISTANTS: \*\*\*

ANESTHESIA: General anesthesia

ESTIMATED BLOOD LOSS: \*\*\*

REPLACEMENT: \*\*\*

SPECIMENS: None

DRAINS: 1 JP in \*\*\* thigh, 1 JP in \*\*\*

COMPLICATIONS: None.

INDICATIONS: \*\*\* is a \*\*\* year old \*\*\*

FINDINGS: \*\*\*

TECHNIQUE:

The patient was identified in the preoperative holding area where verbal and written consent was confirmed. He was then taken to the OR and placed in supine positioning. Perioperative antibiotics were administered and SCDs were placed. He underwent intubation. The \*\*\* and \*\*\* lower extremity were prepped and draped in standard fashion. Prior to surgical start- a surgical time out was performed.

The left upper extremity wound vacuum was removed and the wound explored. Intra operative fluoroscopy was used to better characterize the bony defect which measured 5 cm. The previous DRUJ pin was removed and the external fixator pins in the second metacarpal were removed. The external fixation system was revised and placed into the third metacarpal shaft. The left upper extremity was then irrigated with copious amounts of saline.

Attention was then directed to the preparation of a free anterolateral thigh flap for reconstruction of the left upper extremity soft tissue defect. A lenticular-shaped skin island was designed along the left thigh centered at the location of two dominant skin perforators along the anterolateral septum, which were found with an arterial pencil doppler probe. The anterior incision was made, and dissection was carried sharply through the subcutaneous tissue to the level of the muscular fascia. The fascia was incised, and a subfascial elevation of the flap was performed proceeding in a lateral direction towards the anterolateral septum. The skin perforators were identified and traced to the descending branch of the lateral femoral circumflex vessels in the interval between the rectus femoris and the vastus lateralis. The origin of the vascular pedicle off the profundus vessels was identified and skeletonized. Dissection of the perforator vessels and the pedicle was completed both a retrograde and anterograde direction. The lateral incision was made, and the remainder of the flap elevation was completed along the subfascial plane proceeding in an anteromedial direction.

We then proceeded with the preparation of the left upper extremity vessels for free tissue transfer. The radial artery and vena comitans were selected for use as the recipient vessels. The artery and vena comitans were each skeletonized at the level of the planned microanastomosis along the middle/distal third of the left forearm. Each of the vessels was clipped and transected. The vessels were further prepared under high loupe magnification by flushing with heparinized saline, freshening the vessel ends sharply, dilating the vessel lumens, and excising excess adventitia.

After confirmation of the readiness of the recipient vessels, the flap pedicle vessels were each isolated, ligated, and transected. The flap was brought to the left upper extremity operative site. Under magnification, the flap vessels were prepared by using the same technique as for the recipient vessels.

Attention was directed to the microsurgery. The first venous microanastomosis was performed in an end-to-end orientation with a 2.5 mm vessel coupler using standard microsurgical technique. The arterial microanastomosis was performed in an end-to-end orientation with simple interrupted 9-0 nylon sutures using standard microsurgical technique. Following the release of the microclamps, the microanastomoses were noted to be patent, and the flap was observed to regain perfusion briskly.

Attention was directed to the flap inset and closure. The flap was provisionally inset with the use of a stapler and the tailor tacking technique. The inset was performed using interrupted 3-0 Monocryl sutures in the deep dermis, followed by a 3-0 Prolene suture. A split thickness skin graft was taken from \*\*\* and placed.

A 15-French Blake drain was placed along the subcutaneous plane exiting a remote skin site. The incision sites were dressed with Xeroform and ABD pads. The left upper extremity was elevated with the assistance of a pink carter pillow.

At the end of the case, the Doppler signals were robust, and the flap had a viable and perfused appearance. The left thigh donor site was closed in layers using interrupted inverted 0 and 2-0 PDS figure-of-eight sutures along the superficial fascia, followed by interrupted, inverted 3-0 Monocryl sutures in deep dermis, followed by staples. A dressing of gauze, ABDs, and ACE wrap was placed.

The patient was awakened from anesthesia without difficulty. He had tolerated the procedure well. He was transported directly to the ICU for q1hr flap checks in stable condition.

\*\*\*

DATE OF PROCEDURE: @TODAYDATE@

PREOPERATIVE DIAGNOSIS:  Mandibular fracture

POSTOPERATIVE DIAGNOSIS: Mandibular fracture

OPERATIVE PROCEDURE:

1. Maxillary \*\*\* arch bar removal (20670)
2. Mandibular \*\*\* arch bar removal (20670)

ATTENDING SURGEON: Eric Elwood, MD

RESIDENT SURGEON:

@ME@

ANESTHESIA:

{Anesthesia type:25237}

ESTIMATED BLOOD LOSS:  2cc

DRAINS:  None

SPECIMENS:  None

IMPLANTS:  None

COMPLICATIONS:  None apparent.

FINDINGS: Intact mandibular and maxillary arch bars.

DISPOSITION:  {dispo post op:31781}

INDICATIONS:  The patient is a @AGE@ @SEX@ , who sustained a mandibular fracture that was previously treated with operative fixation with application of maxillomandibular fixation. They have completed their course of treatment and now required arch bar removal.

The patient was seen and evaluated in clinic and removal in the operating room was recommended. Informed consent was obtained from the patient after discussion of material risks, benefits, alternatives.

TECHNIQUE:  The patient was brought to the operating room and remained supine on the transport stretcher. A timeout was performed with all necessary staff. Sedation was administered by the anesthesia team. The teeth and hardware were washed with peridex. The oral cavity was inspected for loose and or fractured hardware. The maxillary arch bar was then removed by removal of \*\*\* screws/ cutting and removing the wires. The mandibular arch bar was removed by removal of \*\*\* screws/ cutting and removing the wires. The hardware and screws/wire were intact and removed in its eternity. A finger sweep of the buccal gingiva was made to insure complete removal of all hardware. The teeth were again brushed with peridex. Hemostasis was confirmed. The patient tolerated the procedure well, was awakened from anesthesia, and then brought to the post-anesthesia care unit in good condition.

\*\*\*

**Operative Note**

**DATE OF PROCEDURE: @TODAYDATE@**

**Pre-operative Diagnosis:**@ORDXCPRE@

**Post-operative Diagnosis:** {condition:17813}

**Procedure:**

1. \*\*\* carpal tunnel release.

**Surgeon:** @ORSURROLE@

**ANESTHESIA:**

1. Monitored anesthesia care.

**ESTIMATED BLOOD LOSS:** 5cc

**DRAINS:** None

**SPECIMENS:** None

**IMPLANTS:** None

**COMPLICATIONS:** None

**FINDINGS:**

1. \*\*\* carpal tunnel release.

**INDICATIONS:** This patient is a @AGE@ @SEX@ with \*\*\* carpal tunnel syndrome. The patient is scheduled for the above-mentioned procedure. The planned procedures were discussed with the patient including the associated risks. The patient voiced understanding and agreed to proceed as planned.

**DESCRIPTION OF PROCEDURE:** The patient brought to the operating, placed on the operating table in supine position. All pressure points were adequately padded. Systematic compression devices were applied to bilateral lower extremities and activated. Monitored anesthesia care was induced by anesthesia. Antibiotics were deferred due to low-risk procedure type. The patient's \*\*\* upper extremity was outstretched on a hand table and prepped and draped in the usual sterile manner. A time-out was performed in which the patient, medical record number, procedure, laterality were confirmed by those present in the room.

The patient underwent skin markings with palpation of the pisiform and the hook of the hamate. This was then used to establish Kaplan cardinal line between the 1st web space and the hook of the hamate. The patient's ring finger was then flexed toward the palm after skin crease was selected for a proximal palm incision site.

Prior to incision, the patient underwent anesthetization with lidocaine 1% with epinephrine as a field block in the median nerve block at the wrist level. An Esmarch bandage was then used to exsanguinate the hand to the forearm level then used as a makeshift tourniquet. Total tourniquet time was less than 10 minutes.

The scalpel was then used to perform the skin incision which was then deepened down to subcutaneous tissue. Bipolar electrocautery was used to control subcutaneous vessels. The palmar aponeurosis was then longitudinally incised. The palmaris brevis was brushed off the ulnar aspect of the transverse carpal ligament. The transverse carpal ligament underwent a focal venting incision with a 15 blade scalpel. The freer elevator was then passed directly underneath the transverse carpal ligament and a distal directed release was performed at the level of the sentinel fat pad. The Freer elevator was then reversed in its course and a proximal directed release was performed at the proximal extent of skin incision at the proximal extent of the skin incision, retractors were then placed. Tenotomy scissors were then used to spread the antebrachial fascia to the distal volar forearm. With the Freer elevator protecting the underlying carpal tunnel contents, a tenotomy scissor was then used to divide the proximal leaf of the transverse carpal ligament to the level of the distal wrist flexion crease.

The transcarpal ligament was moderately thickened. The Esmarch bandage tourniquet was then removed. Another round of hemostasis was then obtained with bipolar electrocautery. The wound was then repaired in a single layer 3-0 Monocryl deep dermal interrupted suture followed by skin glue and Steri-Strips. This was then allowed to dry. This was then covered with 4 x 4 gauze, Webril, and an Ace wrap to secure a bulky gauze dressing.

The patient tolerated well, was awakened from anesthesia and brought to the postanesthesia care in good condition.

Orr Shauly, MD  
PRS

**Operative Note**

**DATE OF PROCEDURE: @TODAYDATE@**

**Pre-operative Diagnosis:**@ORDXCPRE@

**Post-operative Diagnosis:** {condition:17813}

**Procedure:**

1. \*\*\* distal radius fracture.

**Surgeon:** @ORSURROLE@

**ANESTHESIA:**

1. Monitored anesthesia care.

**ESTIMATED BLOOD LOSS:** 5cc

**DRAINS: \*\*\***

**SPECIMENS:** None

**IMPLANTS:** None

**COMPLICATIONS:** None

**FINDINGS:**

1. \*\*\* distal radius open reduction and internal fixation with volar plate fixation.

**INDICATIONS:** This patient is a @AGE@ @SEX@ with \*\*\* distal radius fracture. The patient is scheduled for the above-mentioned procedure. The planned procedures were discussed with the patient including the associated risks. The patient voiced understanding and agreed to proceed as planned.

**DESCRIPTION OF PROCEDURE:** Prior to the procedure, the anesthesia team placed a regional block of the \*\*\* arm. The patient was taken to the operating room as scheduled for surgery. After a call to order \*\*\* anesthesia was induced. A tourniquet was placed on the upper arm. The operative site was prepped and draped in the standard fashion. Exsanguination was performed using the Esmarch bandage, and the tourniquet was inflated to 250 mmHg.

An extensile incision was made along the volar wrist centered over the flexor carpi radialis tendon utilizing a modified Henry approach. The incision was carried through the subcutaneous tissue and the floor of the FCR tendon sheath. The distal origins of the flexor pollicis longus musculature were released from the radius. The pronator quadratus was incised along the radial and distal margins. A subperiosteal elevation was performed to expose the fracture site. The fracture pattern was noted to be \*\*\*. The insertion of the brachioradialis tendon was sharply released from the radial styloid. Fracture reduction was performed using direct manipulation and distraction. Fixation was performed with using an \*\*\* Acumed Acu-loc distal radius \*\*\* plate, initially stabilized with K-wires distal and proximal. Plate was fixated with 5 distal locking screws distal and 3 bi-cortical non-locking screws proximally on the shaft. The K-wire pins were removed, and final fluoroscopic image was then performed with PA, lateral, and oblique, with adequate reduction of the distal fragment segment and adequate placement of the pins. The tourniquet was then deflated for a total time less than one hour. Hemostasis was obtained with bipolar electrocautery and manual pressure. The wound was then repaired in layers using 3-0 Monocryl deep dermal interrupted followed by 3-0 nylon interrupted for skin. A Xeroform gauze, 4 x 4, and ABD were used as our sterile dressing followed by a short-arm splint (forearm based, wrist neutral, and MCP joints free) was then placed. The patient tolerated the procedure very well. At the end of the case, she was brought to the PACU for postoperative monitoring.

Orr Shauly, MD  
PRS

**Operative Note**

**DATE OF PROCEDURE: @TODAYDATE@**

**Pre-operative Diagnosis:**@ORDXCPRE@

**Post-operative Diagnosis:** {condition:17813}

**Procedure:**

1. \*\*\*

**Surgeon:** @ORSURROLE@

**ANESTHESIA:**

1. Monitored anesthesia care.

**ESTIMATED BLOOD LOSS:** 5cc

**DRAINS: \*\*\***

**SPECIMENS:** None

**IMPLANTS:** None

**COMPLICATIONS:** None

**FINDINGS:**

1. \*\*\*

**INDICATIONS:** This patient is a @AGE@ @SEX@ with \*\*\*. The patient is scheduled for the above-mentioned procedure. The planned procedures were discussed with the patient including the associated risks. The patient voiced understanding and agreed to proceed as planned.

**DESCRIPTION OF PROCEDURE:** The patient was identified in the holding area and correct operative site was identified by marking. Informed consent was obtained. The patient was then brought to the operating room and transferred to the operating table in supine position. Time-out was then performed at which point the surgeon, nursing staff, and anesthesia staff all confirmed the correct identification.

After adequate anesthesia was obtained \*\*\*

The patient was then awakened, extubated, and transferred over to their hospital bed. The patient was then transported to recovery room in stable condition. There were no intraoperative or immediate postoperative complications. All counts were reported as correct.

Orr Shauly, MD  
PRS

DATE OF PROCEDURE: @TODAYDATE@

PREOPERATIVE DIAGNOSIS:  \*\*\* mandibular \*\*\* fracture

POSTOPERATIVE DIAGNOSIS: \*\*\* mandibular \*\*\* fracture

OPERATIVE PROCEDURE:

1. Open reduction internal fixation of \*\*\* mandibular \*\*\* fracture

ATTENDING SURGEON: \*\*\*

RESIDENT SURGEON:

@ME@

ANESTHESIA:

{Anesthesia type:25237}

ESTIMATED BLOOD LOSS:  \*\*\* cc.

DRAINS:  \*\*\*

SPECIMENS:  \*\*\*

IMPLANTS:  \*\*\*

TOURNIQUET TIME:  \*\*\*

COMPLICATIONS:  None apparent.

FINDINGS: \*\*\*

DISPOSITION:  {dispo post op:31781}

INDICATIONS:  The patient is a @AGE@SEX@ who was involved in \*\*\* and sustained a \*\*\* mandibular \*\*\* fracture. Patient presented with obvious malocclusion. After discussion of the risks and benefits of surgery, patient elected to proceed with surgical intervention.  Informed consent was obtained from the patient.

TECHNIQUE:  The patient was taken to the OR and placed in supine positioning. administered perioperative ABX and SCDs were placed. He underwent \*\*\* intubation. He was prepped and draped in standard fashion. Prior to surgical start- a surgical time out was performed.

The \*\*\* mandibular body fracture was accessed with an intra-oral approach. Care was taken to identify and preserve the mental nerve. We then dissected to bone and proceeded with subperiosteal dissection. The fracture site was identified and thoroughly debrided.

We then turned out attention to the \*\*\* mandibular \*\*\* fracture which was accessed with an intra-oral approach. The dissection was carried down to bone and with subperiosteal dissection. The fracture site was thoroughly debrided.

The patient was then placed into maxillomandibular fixation (MMF) with \*\*\* arch bars on the mandible and maxilla.We then plated the \*\*\* with a \*\*\* mm inferior border plate - of which a total of 6 screws were placed bicortically, 3 on each side of the fracture. The \*\*\* fracture was plated with a \*\*\* mm inferior border plate - of which a total of 6 screws were placed bicortically, 3 on each side of the fracture.The patient was then released from MMF to ensure centric relation and then placed in MMF again.

Prior to closure of the intraoral incision, the mentalis was re suspended with 3-0 vicryl suture. The mucosa was aligned with 3-0 vicryl sutures in a simple interrupted fashion. The patient tolerated the procedure well and was taken to the PACU in stable condition.

The patient tolerated the procedure well, was awakened from anesthesia, and then brought to the post-anesthesia care unit in good condition.

\*\*\*

**Operative Note**

**DATE OF PROCEDURE: @TODAYDATE@**

**Pre-operative Diagnosis:**@ORDXCPRE@

**Post-operative Diagnosis:** {condition:17813}

**Procedure:**

1. \*\*\* metacarpal fracture open reduction and internal fixation.
2. \*\*\*

**Surgeon:** @ORSURROLE@

**ANESTHESIA:**

1. Monitored anesthesia care.

**ESTIMATED BLOOD LOSS:** 5cc

**DRAINS: \*\*\***

**SPECIMENS:** None

**IMPLANTS:** None

**COMPLICATIONS:** None

**FINDINGS:**

1. \*\*\* metacarpal fracture open reduction and internal fixation with intramedullary screw fixation.
2. \*\*\*

**INDICATIONS:** This patient is a @AGE@ @SEX@ with \*\*\* metacarpal shaft fractures. The patient is scheduled for the above-mentioned procedure. The planned procedures were discussed with the patient including the associated risks. The patient voiced understanding and agreed to proceed as planned.

**DESCRIPTION OF PROCEDURE:** Prior to the procedure, the anesthesia team placed a regional block of the \*\*\* arm. He was then taken to the OR and placed in supine positioning. General anesthesia was administered perioperative ABX and SCDs were placed. He underwent LMA\*\*\* placement without complications. The patient was prepped and draped in standard fashion. Prior to surgical start a surgical time out was performed. A tourniquet was placed on the upper arm. The operative site was prepped and draped in the standard fashion. Exsanguination was performed using the Esmarch bandage, and the tourniquet was inflated to 250 mmHg.

Under fluoroscopy guidance, an approximately 1cm extensile incision was made on the dorsal aspect of the \*\*\* metacarpal bone over the fracture line and osteotome facilitated open reduction achieved. A guidewire was placed percutaneously in anterograde direction through the phalanges into the intramedullary canal, and then guided out of the phalanges in retrograde fashion. An incision was made at the guidewire entry point. A \*\*\*mm cannulated screw was advanced over the guidewire. Using the same technique, an additional \*\*\*mm cannulated screw was placed for the \*\*\* metacarpal bone. Final imaging with fluoroscopy demonstrated stable reduction and screw fixation of the fracture. Passive intraoperative range of motion was normal of all digits.

Closure of the skin was performed using simple interrupted 4-0 nylon sutures. Xeroform gauze was applied over the suture lines. A well-padded \*\*\* splint was fabricated and applied.The patient was aroused from anesthesia and taken to the PACU in stable condition. The patient tolerated the procedure well.

Orr Shauly, MD  
PRS

**OPERATIVE NOTE**

DATE OF PROCEDURE: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Bilateral symptomatic macromastia.

POSTOPERATIVE DIAGNOSIS: Bilateral symptomatic macromastia.

OPERATIVE PROCEDURE: Bilateral reduction mammoplasty.

ATTENDING SURGEON: \*\*\*

RESIDENT SURGEON: @ME@

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: 150 mL.

REPLACEMENT: Per anesthesia.

URINE OUTPUT: \*\*\* mL.

SPECIMENS: Bilateral breast tissue.

DRAINS: None.

COMPLICATIONS: None.

INSTRUMENT COUNT: Correct.

INDICATIONS: @NAME@ is a @AGE@ @SEX@ with symptomatic macromastia who desired surgical reduction to improve her symptoms. The risks,

benefits, alternatives, and possible complications of the surgery were

discussed with her obtaining written and verbal consent preoperatively after all questions were answered and she was marked.

FINDINGS: Normal breast tissue.

TECHNIQUE: The patient was brought to the operating room and placed under general anesthesia in the supine position on the operating table without complication. She was identified with an appropriate time-out and preoperative antibiotics were administered. Sequential compression devices were placed, and a Foley catheter was inserted without complication. The chest was then prepped with ChloraPrep solution and draped in the usual sterile fashion. We used a \*\*\*mm sizer to mark the nipple-areolar complex on the \*\*\* breast, and then designed an 8cm wide \*\*\* based

pedicle and then a Wise pattern incision was scored. The pedicle on the \*\*\* side was de-epithelialized and then Bovie electrocautery was used to dissect out the pedicle as well as removing the breast tissue and elevating skin flaps. The total specimen removed was \*\*\* grams. The wounds were then copiously irrigated and inspected for hemostasis. The breast was then covered with topical surgicel powder.

Attention was then directed to the \*\*\* breast, where the specimen was resected from the \*\*\* side of the breast by the breast oncology team. A \*\*\*cm wide \*\*\* based pedicle was designed to fill the defect, and the wise pattern was incised and scored. The pedicle was then de-epithelialized and then Bovie electrocautery was used to dissect out the pedicle as well as removing any residual issue on the \*\*\* side of the breast. The total specimen weight including the oncologic specimen was \*\*\* grams.

Then, skin edges were tailor tacked in position with staples, and the patient was brought upright in a seated position to examine for symmetry. The new position of the nipple-areolar complex was then marked with a \*\*\*mm nipple marker and the area was scored and then de-epithelialized. The dermis was opened in a cruciate pattern to allow delivery of the nipple-areolar complex. The nipple was then secured with 3-0 Monocryl interrupted deep dermal sutures followed by 3-0 Monocryl running subcuticular from the vertical incision along the periareolar region. The inframammary incision was also closed with 3-0 Monocryl deep dermals followed by 3-0 Monocryl running subcuticular. Benzoin and Steri-Strips were then applied as well as ABD pads and then a surgical bra.

The patient was extubated and transferred to the recovery room in good condition. All needle and sponge counts were correct at the end of the procedure.

\*\*\*

**Grady Memorial Hospital**

**PATIENT:** @NAME@

**MRN:** @MRN@

**SEX:** @SEX@

**DOB:** @DOB@ **AGE:** @AGE@

**SERVICE:** Burn Surgery

**DATE OF PROCEDURE:** @TODAYDATE@

**ADMISSION DATE:** @ADMITDT@

Date Of Surgery: @TODAYDATE@

Pre-Operative Diagnosis: \*\*\*

Post-Operative Diagnosis: \*\*\*

Procedure Performed: Split thickness skin graft to \*\*\*.

Surgeon: \*\*\*

Resident: \*\*\*

EBL: \*\*\*

Fluids: Per anesthesia.

Urine Output: Per anesthesia.

Specimens: \*\*\*

Complications: \*\*\*

Indications for Surgery: The patient is a @AGE@ year old @SEX@ that is brought to the operating room for split thickness skin graft to \*\*\*.

Details of Procedure:

After consent was obtained as stated above, the patient was brought to OR \*\*\* at Grady Memorial hospital on \*\*\*. The patient was transferred over to the OR table with great care as to avoid dislodgement of any catheters/drains/IVs/etc.  All bony prominences were padded appropriately. The patient was sedated by anesthesia personnel. An underbody warming device was placed.  A time-out was performed in accordance with hospital policy and national standards. The peri-operative antibiotic \*\*\*, was administered within 30 minutes of the start of the procedure. The \*\*\* was examined and the wounds were excised by sharp debridement using Humby and Gulian knives to the depth of subcutaneous tissue.  Approximately \*\*\* sq cm area was excised and prepared for skin grafting. The excised wounds were inspected, adequate hemostasis was achieved. Once this was accomplished, the skin was harvested from the \*\*\* at 0.014 inch with a dermatome. This was meshed \*\*\*:1 and then stapled into position on the wounds. The total area on the excised wound that was covered with the meshed, split-thickness skin graft was \*\*\* sq cm. The wounds were then dressed with gent/telfa, covered with xeroform, and was stapled into position covered with Kerlix and stapled into position with ACE bandages.The patient tolerated the procedure well and returned to the ICU in stable condition. All sponge, needle and instrument counts were correct x 2.

The patient was \*\*\*tubated and taken to \*\*\* in stable condition.

The Family was updated after the case by Dr. \*\*\*

\*\*\*

PLASTIC AND RECONSTRUCTIVE SURGERY

OPERATIVE NOTE

DATE OF PROCEDURE: 03/12/25

PREOPERATIVE DIAGNOSIS: Left gluteal lipoma

POSTOPERATIVE DIAGNOSIS: same

OPERATIVE PROCEDURE: Lipoma Excision, 4cm, left buttock, subcutaneous

ATTENDING SURGEON: Elwood MD

RESIDENT SURGEON:

Matthew Noel Marturano, MD

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: Minimal mL.

SPECIMENS: Lipomatous lesion

DRAINS: None.

COMPLICATIONS: None.

INSTRUMENT COUNT: Correct.

INDICATIONS: Elaine Denise Young is a 59 y.o. female with the above condition. They were therefore indicated for the procedure. The risks, benefits, alternatives, and possible complications of the surgery were discussed with her obtaining written and verbal consent preoperatively after all questions were answered and she was marked.

FINDINGS: Lipomatous lesion measured 4x4cm. Poorly circumscribed

TECHNIQUE: The patient was brought to the operating room and placed under general anesthesia in the right lateral decubitus on the operating table without complication. They were identified with an appropriate time-out and preoperative antibiotics were administered. We infiltrated lido/marcaine with epi mixture in left buttuck field block. This was allowed to set up. We made an incision over the lesion in an elliptical fashion. We identified the lesion superficially. We resected the lesion in toto. It was poorly circumscribed. We closed the skin with inverted 3-0 monocryl and closed the epidermis with 3-0 monocryl suture running baseball suture. Dermabond was used for dressing.

OPERATIVE NOTE

DATE OF PROCEDURE: 03/12/25

PREOPERATIVE DIAGNOSIS: Bilateral ischial wounds s/p posterior thigh fasciocutaneous flaps with partial dehiscence

POSTOPERATIVE DIAGNOSIS: same

OPERATIVE PROCEDURE:

11043 Wound debridement,

15650 Lift and re-advance posterior thigh flap

ATTENDING SURGEON: Elwood MD

RESIDENT SURGEON:

Matthew Noel Marturano, MD

Philip McCarthy DO

Ryon Arrington MD

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: 25 mL.

SPECIMENS: cultures from both wound beds

DRAINS: None.

COMPLICATIONS: None.

INSTRUMENT COUNT: Correct.

INDICATIONS: Oyeyemi A Adesina is a 42 y.o. male with the above condition. They were therefore indicated for the procedure. The risks, benefits, alternatives, and possible complications of the surgery were discussed with her obtaining written and verbal consent preoperatively after all questions were answered and she was marked.

FINDINGS: defect is 8x3x3cm right buttock

TECHNIQUE: The patient was brought to the operating room and placed under

general anesthesia in the prone position on the operating table without

complication. They were identified with an appropriate time-out and preoperative

antibiotics were administered.

We started by identifying the locations that were partially dehisced as detailed on the previous progress notes. We cute the prolene sutures to free up the superior portion of the flaps. We then lifted both flaps. There was no signs of infection on either flap. There was a smooth layer of granulation. We used a curette and electrocautery to rough up both the flap side and wound bed. We obtained hemostasis. We then re-advanced the posterior thigh flap cranially. On the left side, wound edges were freshened up with curved iris scissors. This was repeated on the right. We then used 2-0 PDS suture to sew an intermediate layer catching what felt like superficial fascia. On the left side, this came together on all sides. On the right, there was a small defect remaining as detailed above. We then closed epidermis with 0 prolene suture in a combination of vertical mattress, figure of 8, and simple interrupted suture. There was no tension on the closure. We left both existing 19f blake drains. Patient was awakened and brought to the recovery room.

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| **OPEN TREATMENT, FRACTURE, NASOETHMOID COMPLEX Procedure Note**      **Diagnosis**  Pre-op Diagnosis: type III NOE fractures    Post-op Diagnosis: type II NOE fracture    **Procedures**  Procedure(s) (LRB):  OPEN TREATMENT, FRACTURE, NASOETHMOID COMPLEX (Bilateral)    **Surgeons**    **Anesthesia:**    **Staff:**    Operative Report    Fernando Hackett  5/21/1988  101057551    Date of Surgery: 3/12/2025    Attending Surgeon: Dr. Eric Elwood MD    Assistant: Philip McCarthy, DO, MPH; Matt Marturano, MD    Pre-operative Diagnosis:   1. Type III NOE fracture     Post-operative Diagnosis:   1. Type II NOE fractures bilaterally     Operative Procedure:   1. ORIF of type II Naso-orbito-ethmoidal fracture     Indications:  The patient presented with the above diagnosis. After a thorough discussion of the risks and benefits, the patient elected to proceed with the above operation.    Specifically, he fell off a scooter while intoxicated and landed on his face. He had a type II NOE fracture bilaterally. Sutured in the ED and planned fixation today    Operative findings:   1. Type II NOE fractures bilaterally extending down onto bilateral maxilla. 2. Nasal cartilage fractured. Upper lats in three pieces. Nasal bones in one piece. 3. Bilateral canthal tendons intact     Complications: None  Specimens: none  Drains: none  IV Fluids: See anesthesia log  Blood loss: 50 cc  Implants: will detail below  Tourniquet time: none  Anesthesia: general orotracheal intubation    Operative Technique:    The patient was identified, consented, and marked prior to surgery. The patient was taken back to the operating room and placed supine on the operating room table. A call to order was held identifying patient, procedure, and laterality, and all were in agreement. Anesthesia was induced, and the operative site was prepped and draped in the standard sterile fashion.    The procedure was begun by infiltrating 20 mL of 1% lidocaine into the surgical sites. Started by marking out the nasal radix where we would make the incision. This incision included the previous large laceration that extended down onto his left medial eye just medial to the medial canthus, to make it an L shape incision. We then opened the prior incision and then made the radix incision with 15 blade scalpel. We then used combination of blunt and sharp dissection to expose the NOE fractures. The bilateral nasal bones were in one piece. The upper lateral cartilages were detached. The left upper lat was in two pieces. We were also able to expose the ethmoid bone that had the medial canthus and it was clearly well attached.    We then exposed the maxillary portion of the fracture bilaterally through an upper oral sulcus incision. Blunt and sharp dissection were used with the #9. We protected the infraorbital nerve the entire tim bilaterally. Both were intact, though the left was involved in the fracture line.    We then started plating. We started with the nasal bones and placed two 4 hole plates with 4 screws each. We then repaired the cartilage with a small 3 hole plate and two screws and a single 3-0 PDS suture. We then placed a 6 hole plate across the medial ethmoidal fracture onto the frontal bone with 5 screws and included a small fragment into it. We ensured that there was good alignment of the maxillary fracture portions as well. We then plated the right maxillary medial buttress with a 5 hole plate with 4 screws. We then plated the left maxillary buttress with a 5 hole plate with a span and 4 screws. At this point, fixation was complete and it was well reduced.    Forced duction test was performed bilaterally and was negative for any entrapment.    The wounds were repaired on the forehead and nose with 3-0 monocryl to repair the muscle, 5-0 monocryl for the dermis and 5-0 fast for the skin. The gingiva was closed with 3-0 chromic suture. Small right upper eye lid laceration was closed with 5-0 fast    Bacitracin was applied to his incisions and abrasions.    Sterile dressings were applied. The patient was aroused from anesthesia and taken to the PACU in stable condition. The patient tolerated the procedure well. |

**Procedures**

Procedure(s) (LRB):

ORIF, FRACTURE, ULNA, SHAFT (Right)

**Surgeons**

**Anesthesia:**

**Staff:**

**Intraoperative Local Anesthetic:**

None

**Anesthesia:**

Regional and General

**Specimens sent to Pathology:**

None

**Implants**

Synthes

**Drains/Wound Vac:**

None

**Estimated Blood Loss:**

20 ml

**Tourniquet time:**

None

**Complications:**

None

**Findings:**

Consistent with postoperative diagnosis

**Postoperative Plan:**

**Weight bearing:** NWB x6 weeks

**Immobilization:** None

**Chemical DVT prophylaxis**: LMWH inpatient

**Postoperative Antibiotics**:None

**Drains:** N/a

**Imaging:** Postoperative radiographs

**Follow up:** 2 weeks

**Attending Comments**:

I was present for the key portion(s) of this procedure(s), which were reduction/fixation, and was available for all non-key portions of the procedure(s).

**Operative indications:**

The patient is indicated for surgery for the diagnosis above. Risks, benefits, and alternatives of surgery were discussed. General operative risks include, but are not limited to, risk of anesthesia, venous embolism, death, infection, damage to vessels and nerves, stiffness, treatment failure, and potential need for additional surgeries. The patient expressed an understanding of the risks and benefits and consented to proceed. All questions were answered

**Procedure:**

The patient was identified preoperatively and the surgical site was marked. In the operating room a time out was performed, confirming side, site, and procedure(s). General anesthesia was performed. The patient was positioned supine on the OR table, ensuring that bony prominences were well padded. The operative area was prepped and draped in a sterile fashion. Intravenous cefazolin was administered prior to incision.

A direct ulnar approach to the ulna was performed. The fracture, which was highly comminuted, was exposed and reduced using clamps and k-wires. 2.7 mm positional screws and a 3.5 mm plate was placed. Reduction and implant placement was confirmed using fluoroscopy. The wound(s) were irrigated using normal saline. 1g of vanco/tobra antibiotic puddy was applied to the plate. The wound(s) were closed in a layered fashion, including the: deep fascia, subcutaneous, dermis. The dermis was closed with a running subcuticular. The arm compartments were soft and compressible. Sterile dressings were applied. All counts were correct.

**Preoperative Decision Making**

Please see recent consult / history and physical note for additional evaluation and management detail. Briefly:

58M who has several days if not weeks of severe infection in his right hand and long finger extending proximal to the MP. He is indicated for ray resection

**Description of Procedure**

The patient was positioned supine on the operating table.

Bony prominences were padded.

Serial compression devices were placed on the calves.

general anesthesia was established.

Prohylactic antibiotics were given.

A well padded tourniquet was placed around the limb.

The limb was prepped and draped to create a sterile field.

A surgical timeout confirmed the treatment plan.

#1 The long finger was exceptionally swollen and infected. Cultures were taken. The limb was exsanguinated and the tourniquet was inflated to 250mmHg. A tennis racket shaped incision was made over the long finger. Bleeding points were stopped now and throughout with electrocautery. A combination of blunt and sharp dissection was used to expose the dorsal metacarpal. The extensor tendon was cut. I made a bone cut at the base taking care to be distal to the insertion of ECRB. I then made the volar skin incision and located and performed traction neurectomies of the digital nerves. I removed the finger. I used 2-0 PDS to repair the intermetacarpal ligament and bring to gether the 2nd and 4th metacarpal after the 3d was resected.

The tourniquet was let down and hemostasis was assured. The entire hand became warm and well perfused. The skin was closed with exposed nylon sutures. The operative site was protected with sterile soft dressing material.

The patient was awoken and transferred to the PACU in good condition.

Operative Report

Pamela Baynes

1/16/1962

6104989

Date of Surgery: 3/3/2025

Attending Surgeon: Dr. Angela Cheng MD

Assistant: Philip McCarthy, DO, MPH; Matt Marturano, MD; Charlie Frank, MD

Pre-operative Diagnosis:

1. Bilateral DCIS

Post-operative Diagnosis:

1. same

Operative Procedure:

1. Goldilocks breast reconstruction with adjacent tissue transfer of 200 sq cm bilaterally

Indications:

The patient presented with the above diagnosis. After a thorough discussion of the risks and benefits, the patient elected to proceed with the above operation.

Specifically, she had bilateral DCIS requiring mastectomy. Patient wished to have no implants and hopes for an autologous breast reconstruction in the future.

Operative findings:

1. Bilateral mastectomies performed by Dr. Okolis team.
2. Healthy perfused flaps bilaterally. Able to commit to goldilocks breast reconstruction
3. Right mastectomy weight 384 left 554 g

Complications: None

Specimens: left and right total mastectomy

Drains: bilateral 19 F JP drains

IV Fluids: See anesthesia log

Blood loss: 50 mL for our portion

Implants: none

Tourniquet time: none

Anesthesia: general

Operative Technique:

The patient was identified, consented, and marked prior to surgery. The patient was taken back to the operating room and placed supine on the operating room table. A call to order was held identifying patient, procedure, and laterality, and all were in agreement. Anesthesia was induced, and the operative site was prepped and draped in the standard sterile fashion.

The procedure was begun by de-epitheliazing the upper portion of the wise pattern which bled well and was well perfused. We then committed to doing the same for the lower portion. It was tacked and ensured that the shape was good. We then made the back cut on the lateral side. The medial side was left intact in order to help with more cleavage. We then ensured good hemostasis and placed a 19 F blake drain in the chest coming out laterally. At this point the autodermal flap was 20 x 10 cm on each side. This was then shaped into a breast mound and tacked to the chest wall with 3-0 vicryl sutures. We then sat her up to make sure the symmetry was good. The vertical and horizontal limbs were closed with deep 3-0 monocryl and running with 3-0 monocryl. The same procedure was performed on both sides.

Sterile dressings were applied. The patient was aroused from anesthesia and taken to the PACU in stable condition. The patient tolerated the procedure well.

**OPERATIVE REPORT**

**Pre-operative diagnosis:** L dysvascular index finger s/p attempted revascularization following a chainsaw accident

**Post-operative diagnosis:** same

**Procedure(s):**

Left IF amputation at the level of the proximal phalanx (26951)

**Surgeons**

**Surgeon(s):**

**Anesthesia:**

**Staff:**

Anesthesia Type: general

Implants: None

Tourniquet Time:

Total Tourniquet Time Documented:

Arm (Left) - 45 minutes

Total: Arm (Left) - 45 minutes

Urinary Catheter: none

Wound Classification: **Class I : Clean (Not infected or inflamed and free from entry into respiratory, alimentary or GU tract)**

**OPERATIVE INDICATIONS**

This is a 34 y.o. male patient with a history of chainsaw injury to his L hand. He previously underwent L LF amputation and L IF revascularization on 02/24/25. Unfortunately, the IF showed signs of progressive necrosis in his distal tip. We had a very lengthy discussion about the options for managing this problem moving forward. We discussed both various conservative and surgical options ranging from nonoperative care to surgical management. We decided together that the most reasonable option would be revision L IF amputation. They were advised of the risks of infection, bleeding, damage to surrounding structures, and need for reoperation. We also stressed in particular the chance of need for further surgery. Ultimately they decided they wanted to proceed with surgery. Consents were freely signed. No guarantees were made.

**OPERATIVE PROCEDURE**

The patient was met and identified in the preoperative holding area where the operative extremity was confirmed to be marked. Consent was reviewed and verified. The patient was taken back to the operating room.

The patient was positioned supine on the operating table. Bony prominences were padded. Serial compression devices were placed on the calves. General anesthesia was administered by our anesthesia colleagues. Prohylactic antibiotics were given. A well padded tourniquet was placed around the limb.

The limb was prepped and draped to create a sterile field. A surgical timeout confirmed the treatment plan.

The limb was exsanguinated and the tourniquet was inflated to 250mmHg. We examined the IF; there was clear necrosis from the tip to the level of the oblique laceration that extended proximal to the DIP crease. The prior sutures were removed. The K-wires were removed and the FDS transected proximal to the repair site. The radial digital nerve was resected to the level of the palm. The ulnar digital artery interposition was clotted off proximal to the level of the proximal anastomosis, with narrowing of the distal native ulnar digital artery. This was excised and cauterized proximally in the level of the palm.

We then circumferentially excised the necrotic tissue and left viable skin flaps for our closure. The digit was sent to pathology. We noted we would be able to obtain good coverage of the remaining proximal phalanx. The wound was irrigated with copious NS. We then proceeded to sharply excise redundant skin and close in a dorsal to volar direction, making sure to leave a good webspace and as much length as possible. We also brought some of the redundant skin ulnarly in order to obtain soft tissue coverage. Skin was approximated with #4-0 Nylon sutures. There was no tension in the skin edges.

The LF stump was also examined; there was prominence of the skin folds near the webspaces which were causing maceration; these were excised with a blade and skin reapproximated with #4-0 Nylon radially and ulnarly.

The tourniquet was deflated at the above indicated time and hemostasis obtained with the use of bipolar electrocautery. The limb became warm and well perfused. The operative site was protected with sterile soft dressing material.

The patient was awoken and transferred to the PACU in good condition.

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| |  | | --- | | **Operative Note**    **DATE OF PROCEDURE: 02/21/25**    **Pre-operative Diagnosis: Right open tib-fib fracture**    **Post-operative Diagnosis:** same    **Procedure:**   1. Right lower extremity open fracture coverage with pedicled medial soleus muscle 15738 2. Split thickness skin graft, 140 cm sq, meshed. 15100 15101 3. VAC dressing, > 50 cm sq. 97606     **Surgeon:** Surgeons and Role:    **ANESTHESIA:**  1. Monitored anesthesia care.    **ESTIMATED BLOOD LOSS:** 5cc    **DRAINS: Wound vac device**    **SPECIMENS:** None    **IMPLANTS:** None    **COMPLICATIONS:** None    **FINDINGS:**   1. Pedicled medial soleus muscle to anterior left lower extremity wound (complex right leg wound involving bone and soft tissue.     **INDICATIONS:** This patient is a 24 y.o. male with open right tib-fib fracture with spacer in place and no overlying soft tissue. The patient is scheduled for the above-mentioned procedure. The planned procedures were discussed with the patient including the associated risks. The patient voiced understanding and agreed to proceed as planned.    **DESCRIPTION OF PROCEDURE:** The patient was identified in the holding area and correct operative site was identified by marking. Informed consent was obtained. The patient was then brought to the operating room and transferred to the operating table in supine position. Time-out was then performed at which point the surgeon, nursing staff, and anesthesia staff all confirmed the correct identification.    After adequate anesthesia was obtained the open wound on the left distal extremity was extended about 8cm proximally and 4cm distally to connect to the distal medial wound. A subcutaneous plane was developed to identify the medial soleus muscle in the superficial posterior compartment. The posterior aspect of the medial gastrocnemius was separated from the deeper soleus. The plantaris tendon and muscle was visualized and left in place. A plane was then made on the anterior surface of the medial soleus muscle to separate it from the deep posterior compartment fascia.    The distal soleus tendon was divided at the level of the achilles, and then medial soleus and a part of the lateral soleus was elevated off the achilles muscle, taking half of the lateral soleus to ensure adequate width to cover the defect noted to be 8x8cm.    Dissection along the median raphe of the soleus was then performed distal to proximal, separating the two heads of the soleus. The medial soleus and the distally divided lateral soleus was dissected proximally up toward the level of the pedicle. Dissection was stopped once the muscle could be easily rotated into the soft tissue defect, fully covering the exposed spacer within the tibial shaft. The donor site was minimally approximated, but decision was made to close under minimal tension, so the incision distally was left open and covered per below. The proximal most 2cm of incision was closed in layers with 3-0 PDS and 3-0 monocryl.    The muscle was then inset in the recipient wound bed with deep 3-0 PDS in the superficial fascia followed by deep dermal 3-0 monocryl. Next a STSG was harvested from the left thigh using a dermatome with a 4 inch guard to a length of 14cm. Approximately 140 cm sq of STSG was harvested from the left thigh which was then meshed using a 2:1 mesher. The STSG was inset over the soleus muscle as well as over the entire right lower extremity wound with interrupted chromic suture. A wound vac was applied over the skin graft to aid in take. The right thigh donor site was covered with a tegaderm. A wound vacuum was then placed on the skin graft to 125mmHg suction with good seal noted at the closure of the case.    The patient was then awakened, extubated, and transferred over to their hospital bed. The patient was then transported to recovery room in stable condition. There were no intraoperative or immediate postoperative complications. All counts were reported as correct. | |

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| |  | | --- | | **DEBRIDEMENT, SKIN, FASCIA, MUSCLE, AND BONE, OPEN FRACTURE SITE Procedure Note**      **Diagnosis**  Pre-op Diagnosis: right soft tissue defect with exposed distal femur    Post-op Diagnosis: same    **Procedures**  Procedure(s) (LRB):  DEBRIDEMENT, SKIN, FASCIA, MUSCLE, AND BONE, OPEN FRACTURE SITE (Right)  FLAP PROCEDURE, MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS, LOWER EXTREMITY (Right)    **Surgeons**  **Anesthesia:**    **Staff:**    **Operation:**   1. STSG to RLE >100 cm square 2. Medial gastrocnemius muscle rotational flap right lower extremity     **Findings:**  Right lower extremity burn wound with approximately 40 cm squared of exposed distal femur    **EBL**: 50 mL    **Complications:** None apparent    **Specimen Removed:** None    **Indications:** 64 y.o. female s/p TBSA 8% burn to BLE from space heater (1/23/25) with third degree burns to R distal thigh requiring removal of necrotic patella and further serial debridements with burn surgery. Plastic and orthopedic surgery consulted for exposed distal femur with loss of extensor mechanism. Plan for reconstruction of extensor mechanism with medial gastrocnemius muscle along side with orthopedics. Booked for the OR.    **Technique:** Patient was seen and examined in the pre operative holding area. Patient was marked and consented. Patient understood the risks and benefits of the procedure. The patient was brought to the OR and transferred to the operating room table. Patient was placed under general anesthesia and the airway was securred with an ETT. Both legs were prepped and draped. The operation started with washout and debridement of the wound. Approximately 4 x 10 cm of exposed distal femur was appreciated. The totality of the wound was much larger, measuring approximately 300 square cm with healthy granulation tissue in place. The right leg was placed in a frog leg position. A lazy S shaped incision was made from the distal aspect of the wound to approximately 7 cm above the medial malleolus along the anterior border of the medial gastrocnemius. Dissection was performed to the fascia with electrocautery along the length of the incision. The fascia was incised along the totality of the incision. The anterior edge of the medial gastrocnemius was separated from the deeper soleus. The plantaris tendon and muscle was visualized and left in place. The distal gastrocnemius tendon was divided at the level of the achilles. Dissection along the median raphe of the gastrocnemius was performed distal to proximal, separating the two heads of the gastrocnemius. The medial gastrocnemius was dissected proximally up toward the level of the pedicle. Dissection was stopped once the muscle could be easily rotated into the soft tissue defect, fully covering the exposed bone. Next orthopedics assisted to inset the muscle belly / tendon in an effort to stabilize the knee joint and reconstruct the extensor mechanism. Please see orthopedics op note for details. Once the muscle was inset the donor site was closed over a 15 Fr drain with deep 2-0 PDS in the superficial fascia followed by deep dermal 3-0 monocryl and staples. Next a STSG was harvested from the left thigh using a dermatome with a 4 inch guard. Approximately 500 cm sq of STSG was harvested from the left thigh which was then meshed using a 2:1 mesher. The STSG was inset over the gastrocnemius as well as over the entire right lower extremity wound with interrupted chromic suture. A wound vac was applied over the skin graft to aid in take. The left thigh donor site was covered with xeroform and a tegaderm. Next orthopedics concluded the operation by placing an external fixator. The patient was extubated and brought to the PACU in stable condition. The patient will have a NPW in place for 7 days. The patient will be non weight bearing for approximately 2 weeks. | |