**Aesthetic/Cosmetic**

Fleur de Lis Abdominoplasty Cuzzone

2-0 Ethibond buried figure of 8

2-0 PDS imbricating

Flex bed and trendelenverg while plicating (probably not necessary)

After raise flap and isolate umbilicus (use silk suture air knots to lift up), split upper flap up to xiphoid, get down to fascia. Decide what your vertical limbs will be. Undermine to these points. Make incisions and remove vertical limbs. Figure out how much horizontal you can take by using towel clamps. Mark and figure out laterally what else to take to avoid dog ear. Cuzzone insets umbo with just monocryls and then when running vertical, run one way from top to around umbo, then from bottom run but go the other half of umbo.

Cheng Thighplasty

Leave SCDs on. Circumferential prep of thighs. Down sheet. Stockingettes up to knees. Cut hole in stockingette and hook up SCD and cover with green towel wrap around and staple. Universal drape after towels. Lateral towels wide so they don’t restrict you. Anterior incision first. Get down and stay above Scarpas. Watch for greater saphenous vein and preserve it. Drop it down by bovie on top of it. Dissect flap posteriorly. Have medium automatic clip applier ready to clip large veins and branches. Pull up anteriorly with 3 penetrating towel clamps and pull superiorly as well to work out any knee excess (vertical lift).

Thompson/Faulkner double incision mastectomy FNG

Make superior incision, thickness is guided by half the pinch of the upper abdominal thickness to make consistent contour. For Faulkner, it’s all mastectomy plane. Get down to that thickness and raise your superior flap. Use rakes or roll flap with fingers and dissect over breast tissue. Start medially, get to fascia but not thru (not cancer case). Commit to inferior incision, make it a little higher than fold (want males to be higher). Can cut out your nipple prior and soak it (ellipse wider than long, about 26-28mm diameter). Faulkner uses 30cc syringe plunger for size.

Go straight to chest wall on bottom, begin taking off specimen above fascia. Take specimen with superior tail no need to mark (I think Faulkner does)

Obliterate IMF well. Use rake to lift and undermine to stick half length of your fingers in there. Radial score the scarpa’s fascia. Faulkner near fully excises IMF/scarpa’s here. Exparel, drains, hemoastasis. Tailor tack, sit up. Close with 2-0 PDS CT-1, 3-0 and 4-0 monocryl. Sit up again and mark nipples with glove paper. Draw circle and de-ep. De-fat your nipple grafts with hemostat just on the dermis and curved scissors. Suture in place with 5-0 plain guts circumferentially.

Faulkner - uses back of 30cc syringe to mark nipple shape. 4-0 silk at 8 points around FNG, in between 5-0 fast U stitch through graft dermis graft.

Cheng breast reduction

Make little triangle at triple point

After nipple marking, de-epitheliaize nipple bed and cruciate back cuts.

Cheng maneuver - draw IMF incision mirroring the medial aspect. Bring inferior flap up to this point so the incision is symmetrical to medial aspect. Imbricate the lateral aspect so incision first swings up laterally then down

3-0 stratafix deep dermal for IMF

4-0 stratafix for nipple. To end just run backwards a few bites

Aboude breast reduction.

Inferior pedicle. Drains if over 700cc resections. Infuse 100cc TXA per drain after deep dermals closed. 4g in 200cc NS is the concentration for TXA.

3-0 PDS for IMF deep dermals, buried triple point stitch. 3-0 monocryl for vertical limb and NAC deep dermals.

Running 4-0 monocryl for IMF and NAC/vertical.

Tegederm without biopatch for drains.

Breast Reduction - general

Make sure arms are wrapped with kerlix

Make sure patient is at flexion point of the bed

Make sure leads are most lateral as possible, need to prep out abdomen for lipo?

Staple outer edges of markings at transition points (will eventually lose your markings)

Paint the inner circle of the bigger side - this one is **42mm** - and mark nipple in center

Marker middle of breast and draw pedicle markings (go vertically)

Pedicle base should be about 8-10cm (smaller - bigger)

Hold up nipple and tie lap pad around base and clamp tightly with Kelly

Score your nipple, score the pedicle markings - should loop around nipple markings like a sling

Begin de-epithelializing (scissors or knife)

Cauterize along sides of pedicle, making sure to bevel out to protect the pedicle, to chest wall. Some go straight down. Do sides of pedicle first, then grasp and elevate to do distal edge.

Make other incisions and do the same to create your flaps. Debulk flaps (grasp w/ Allis)

Measure each sides’ weight in grams

If oncoplastic reduction, you want the side getting radiated to be a little bigger to account for the breast shrinking from XRT (will shrink ~10%)

Cheng maneuver

Line up medially first. Then do lateral and create lateral C shape then staple lateral side going medial. Lift inferior flap up over superior flap and staple down until reach edge of lateral C shape. Then chase out dog ear by inverting skin and tailor tacking. Will end up with an extra incision going inferiority at angle in exchange for that nice lateral shape.

Losken breast reduction and markings

Mark Midline, IMF, meridian, go parallel from inferior most point of IMF and mark this in center then go 3cm cephalad and this is top of your nipple position

Turn breast medially and laterally and mark 10cm each way, then connect to medial and lateral folds

Draw your nipple cut out using top of nipple as a guide

Surgery

Make all incisions first (score nipple/pedicle; make cuts nearly thru dermis on others so you don’t injure skin w bovie) and di-ep pedicle and isolate pedicle only go down about 7-8cm. Most important that it’s wide at the base, and you don’t undermine.

Do your C first, pull down hard with left hand and bevel to make a 2cm superior flap

Go down and do the V part next, same type of flap and aim up. Take off chest wall, isolate from pedicle, use as handle.

Do lateral part same thing.

Excise these sections from the pedicle

Go medial and cut straight down

Go straight down at IMF and take specimen off chest wall from medial to lateral

Hemostasis, excise excess where necessary

Staple from lateral, then get corners together, staple nipple, sit up, close

Losken breast amputation

Make all cuts

For vertical limb, cut your triangle but only take little bit of fat (like a skin flap about 2cm deep) at base of the triangle markings you will amputate everything below that. Stop when you get to base. Go medially and bevel inferiorly to save tissue (main thing Losken says is you don’t want to excise too much)

Then go laterally, go straight down (can afford to excise more here)

Committ to lower incision, go straight to chest wall and amputate.

Wedge excision of vertical limb breast tissue

Staple and tailor tack. If need to take more laterally release lateral staples and grab with Allis, excise breast and skin as needed.

Triangle of vertical limbs take a small 2cm flap (don’t go straight down). Go straight down medially and laterally. Make IMF cut go down to chest wall take it off medially to laterally off chest wall.

Losken Brachioplasty

Mark with pinch test

Intraop test if it will close with penetrating towel clamps

Grasp, invert tissue then grasp opposite

Remark so it will close appropriately

Make cuts, move tissue to opposite end to provide tension

Bevel out a little bit. Be careful of ulnar nerve and MABC. Take tissue superficially

Close SFS with 2-0 PDS, multiple, no fingers should fit between them.

3-0 monocryl deep dermal and running. Steri’s and 6” Ace wrap not too tight

Metcalfe lower blepharoplasty

Genteal and corneal protectors (NO!), inject lido w epi off field.

Start with lateral extension incision, create plane below orbicularis oculi to medial limbus. Cut skin and bevel towards cheek to leave some orbic down. Stay below orbic and above septum and dissect down toward rim and feel it.

Release ORL with bovie. Use demarre/blair

Create muscle flap by taking orbic off skin, control bleeders and be careful here.

Tack orbic laterally to lateral temporal fascia with 5-0 PDS to create the “youthful tarsal sling”

Split lateral excess tissue and trim excess skin laterally. Single hook to hold tissue and line up laterally and close with interrupted 6-0 prolenes

Trim inferior excess

Run infralid incision w 6-0 plain

BSS to eyes, erythromycin ointment to lid incision

Metcalfe augmentation-mastopexy (vertical)

38mm nipple sizer

Incision between markings, doesn’t matter where it’s coming out.

Go down to chest wall, elevate breast tissue mostly medially and just laterally past nipple.

Place sizers, tailor tack with mastopexy markings and determine nipple position

Insert implant sterile, close parenchyma with 2-0 running vicryl

Make incisions of new markings after tailor tacking and de-epithelialize. Consider excising skin of horizontal. Likely need to back-cut through dermis of vertical limbs nearly up to level of nipple, and at the superior-most portion of the vertical limbs (horizontal cut) to allow nipple to inset easily. Tailor tack and close with monocryls.

Earlobe Repair - Pediatric, Brady, Scottish

Usually from previous earring or laceration

Inject lido w epi into area

Wedge resect with an 11 blade

Cauterize majors and pressure for dermal bleeders

Deep dermal with 5-0 monocryl

Skin closure with 6-0 plain gut chromics

Dermabond posterior side first then anterior side

Otoplasty

Head drape

Methylene blue to target suture points

S-shaped incision behind ears, start posteriorly at superior portion. Bovie for hemostasis

Black handle scissors spread down to cartilage to dissect to methylene blue points

Clear 4-0 Nylons going in horizontal direction (posterior to anterior, and posterior to anterior) to reshape antihelix

Conceal-mastoid sutures 4-0 PDS in vertical orientation to tack back.

4-0 running chromic to suture skin (don’t close before contralateral side is done. Close both at very end.

Baci, Xeroform, cut 4x4s in middle convexly to make room for ear. Head wrap

Sethna rhinoplasty

3cc local - mix of 8cc 1%lido w epi, 1cc TXA, 1cc hyaluronidase. Only inject 3cc, don’t want to distort the nose.

Genteal then cover eyes with tegederm

2 afrin pledget per nose. Betadine and head wrap

Hair bearing and non hair bearing represents where the cartilage is. Use wide double prong skin hook and middle finger to help evert to show yourself. Incision is triangle in middle with sharp and wide angles and go 90 degrees

Curved iris and dissect through columella and open tissue with 15C blade

Micro double hook at columella and single hook inferiorly and begin dissection on top of cartilage with tips down to follow the crus going cephalad. Qtip to help with bleeding and dissection May need bovie. Wide double prong underneath lower cartilages , bovie tissue off cartilages and get into sub-SMAS plane and elevate to radix with curved iris scissors. Get into subperichondrial and subperiosteal plane with a Jake?

With lower lats exposed with single hooks and expose the interdomal ligament. Use adsom browns to grasp cartilage and bovie thru ligament

Place browns between cartilage and bovie down to caudal septum, dissect on one side. Get down with a Woodson first then a caudal then get a speculum in there and use the caudal to get to the floor.

Lateral Osteotomy - leave 3-4mm cuff above pyriform

If need multiple osteotomies, start medial first then lateral.

Miotto Facelift notes - general

Extension on ETT

Secure with dental floss to incisor/premolar and lace like drain

Xeroform in ears

Lubricant I’m eyes (Genteal tears)

Tape around head, wash with chlorhexidine

Pony tail hair including sideburns to make temporal brow incision easier

Harvest fat from belly or thighs first, inject tumescence towel out and just do with sterile gloves before draping

Prep face with betadine, dab on eyes

When closing upper bleph, place midpupillary interrupted 6-0 prolene and another at inflection point. When running subcuticular advance each bite and make sure you can floss at end

Miotto Facelift and Brow Lift Op Note

The patient was placed on the operating table and after confirming that pneumatic compression devices were on and active and that antibiotics had been infused the anesthesia team started induction of anesthesia. The endotracheal tube was secured with dental floss. Eye ointment was placed. After initial alcohol prep, local xylocaine, marcaine, TXA with epinephrine was injected into the incision sites. The facial area was then prepped and draped.

Brow Lift

The procedure began with the brow lift. Using a 15 scalpel a 2.5cm incision was made in the temporal scalp. An elevator was then placed through the lateral incisions on top of the deep temporal fascia.

The dissection started over the deep temporal fascia. Blunt dissection was performed on top of the DTF and in the subperiosteal plane in the lateral forehead. The temporal septum was sharply released and the lateral periorbital adhesions were also released with the elevator and scissors. The procedure was repeated on the other side. Then we used 3-0 Mersillene sutures to suspend the lateral brow into the deep temporal fascia in 3 points. We confirmed symmetry of brow position and closed the scalp incisions using 4-0 Nylon sutures.

Endoscopic Brow Lift

After initial alcohol prep, local anesthetic solution of 1% xylocaine, TXA and 0.25% Marcaine with epinephrine was injected into the forehead area. The procedure began with the endoscopic brow lift. Incisions were made just behind the hairline in the temporal areas.

The temporal fusion line was released and a subperiosteal plane was created in the superior half of the forehead, and then a 5mm endoscope with sheath protector was placed. Under endoscopic visualization, the transition zone at the temporal crest fusion line was completely released, and dissection carried down to the level of the supraorbital rims. The supraorbital nerves were identified and preserved. Using the elevator, the attachments in the area of the lateral orbital rim were released. The central forehead periosteum was also released.  The muscles were preserved. The entire surgical site was inspected under endoscopic visualization. Finding no bleeding, the endoscope was removed and suspension completed in the temporal area with 3-0 mersillene sutures These sutures were placed parallel to the supraorbital nerve path to limit the risk on impact on the nerve. After suspension, the skin layers were closed with 4-0 Nylon sutures.The supratrochlear and supraorbital nerves were blocked with the anesthetic solution, and the corneal protectors were removed. The patient tolerated the procedure well. Dressing was placed. No complications were noted. All counts were reported correct. The patient was extubated and taken to recovery room in stable condition.

Miotto mix

100cc saline

50cc Marciano 0.25%

50cc lidocaine 1%

1cc epi

1g TXA

Miotto Face/Neck Lift Op note

Dental floss to secure tube. Wrap a strand around tooth, then other strand around other side of tooth and tie down. Wrap around tube and secure like a drain. Cut long and tape it to tube/balloon port. Put tape around head and secure head wrap to tape with staples not scalp.

The face and neck were addressed. The lower face/neck were injected with a mixture of local NS, Xylocaine, Marcaine, Tranexamic acid with epinephrine. After allowing time for vasoconstrictive effects, the submental incision was opened with a #15 scalpel. The central neck skin flap was undermined with facelift scissors pointing down. Bovie/bipolar on 25 for neck. The platysma identified and dissected laterally. Deep fat was present and was removed with the electrocautery. The platysma was grasped and undermined with cautery on its deep surface. . Hypertrophic digastrics were identified and shaved. The platysmaplasty was performed with 3.0 PDS sutures. Platysma backcut and triangular resection was performed at the level of the hyoid bone. Then the lateral facelift incisions were done with a #15 scalpel in the retrotragal and pre-hairline fashion. Initial elevation of the flaps was completed with #10 scalpel then extended with scissors to the limit of the entrance of the deep plane. In the neck, the skin dissection was completed along the jawline to meet the opposite side in the midline and release the submandibular ligament.

Then laterally, the deep plane was elevated initially with a 10 scalpel for a few millimeters and then blunt dissection was carried out with facelift scissors in the deep plane right under the SMAS/platysma, dissection the platysma ligaments for about 4cm below the jaw line. The masseteric and zygomatic ligaments were disrupted using blunt dissection and electrocautery on 15. Throughout this elevation great care was taken to avoid proximity to key nerves. The buccal fat pads were bulging and were conservativelly resected using the electrocautery

Hemostasis was achieved with bipolar cautery when needed. Then we created the cuff for deep plane suspension. The face was suspended using 3-0 Mersillene sutures as 5 cables of suspension on each side. (U-stitch by going deep to superficial through SMAS, then superficial to deep, then anchoring stitch, tie and then swing knot anterior so it’s not palpated under incision) A platysma flap was created by muscle transection performed about 1cm below the jawline for about 3cm anteriorly and suspended in the anterior mastoid periosteum using 3-0 Mersillene sutures in the crevasse. With elevation complete, the entire area was inspected for hemostasis. The skin flaps were then advanced in a vertical fashion and tailor-tacked into position with no tension. Skin was then incised in front of the ear and key sutures of 6-0 Prolene placed above and below the tragus as well as superiorly. The remainder of the skin was sharply excised and closure was performed with 6-0 Prolene, 5-0 and 6-0 fast gut. Behind the ear the flap was advanced, marked, and the redundant scalp tissues were excised, taking care to bevel the incision to maximally preserve hair follicles. The scalp portion was then closed with 4-0 nylon and monocryl sutures. The retroauricular skin was then trimmed and closed with 4-0 Monocryl and running 5-0 fast. One 10F Blake drain was placed across the neck and a few Auersvald net sutures were placed in the neck and lateral face using 4-0 Nylon sutures. The submental incision was closed with 5.0 Monocryl sutures. The face was cleaned, a light head wrap dressing was applied.

The patient tolerated the procedure well. No complications were noted. All counts were reported correct. The patient was extubated and taken to recovery room in stable condition.

Neck lift - general steps

Submental incision

Creat skin flaps

Identify platysma laterally

Remove deep fat

Undermine platysma, keep posterior fascia intact.

Identify submandibular gland

Tease capsule off

Cauterize/bipolar slowly, avoid getting into feeding vessel. Take any bulging.

Remove slips of bulging hypertrophied digastrics Platysmaplasty w 3-0 PDS

Remove triangle of hyoid fascia with platysma back cut?\*\*\*

Miotto Facial fat grafting & Blepharoplasty

The patient was placed on the operating table and after confirming that pneumatic compression devices were on and active and that antibiotics had been infused, anesthesia team started the induction of anesthesia. The LMA was secured with tape. Corneal lubrication and protector were placed. After initial alcohol prep, local anesthetic solution of 1% xylocaine with epinephrine was injected into the forehead, temple, upper and lower eyelid area.

We proceeded with fat harvesting from the abdomen. After the area was injected with tumescent solution we used a 2.4mm Tonnard harvesting cannula with a 10cc syringe. A total of 18cc of fat was harvested as microfat. The fat was then injected using blunt 0.7 and 1.2mm cannulas as the following:

Temples: 2cc in the right and  2cc in the left in the subcutaneous plane

Forehead: 2cc into each side

Lower lid / lidcheek junction: 2.3 cc into each side

Upper eyelid: 3 ccs into each side

Lower Eyelids /SOOF - 2 cc each side

Marionette - 1cc into each

Chin - 1 cc each side

1cc of nanofat to upper lip

Millifat (2mm) - for deep compartments and bone loss. Harvested with 2.5mm diameter 12-hole cannula. Fat is processed (telfa vs. centrifuge, etc)

Microfat (1mm) - for superficial compartment fat loss above facial muscles. Processed as above but passed through 30 times with 2.0/2.4mm luer lock between two 10cc syringes

Nanofat (500 microns) - used intradermally & as biologic cream for topical application (after laser resurfacing). Pass between two 10cc syringes with 2.0/2.4mm filter for 60 passes

Miotto Upper Blepharoplasty

Then the upper lids were addressed. After injecting with local anesthetic the incisions were made and the resection of skin only was performed. The fat pads were not prominent and were not removed. The orbicularis oculi was cauterized to reinforce the crease

Once this was completed and hemostasis confirmed, closure was performed using 6-0 Prolene (intracuticular suture).

Clamp tail end with hemostat so doesn’t pull thru. Place 1 interrupted prolene at mid-incision around mid-pupillary line, and at flexion point laterally to align incision.

IMPORTANT - advance a little bit with bites as you place intracuticular suture! Test as you go to make sure suture “slides” through wound. Needs to slide in order to remove at 1 week postop. Otherwise, Miotto and patient will be mad and in pain.

Miotto Lower Blepharoplasty

Transconjunctival

A transconjunctival incision was made with the electrocautery right below the tarsal margin. The preseptal plane was entered and the lower orbital rim exposed. The septum was opened and all 3 fat pat pads were trimmed conservativelly with the electrocautery. Contour was checked and it was even with no hollowing or bulging. Hemostasis was confirmed with electrocautery.

Skin-only flap

Then the lower eyelids were addressed. A subcilliary incision was placed and a skin only flap created to the level of the orbito-malar ligament. Fat pads were not prominent and were not trimmed. Hemostasis was achieved. Then the lower lid skin excess was trimmed conservatively at the lash line. A lateral retinaculum suspension suture was placed in the lateral canthus using 4-0 PDS sutures. The incision was sutured with interrupted 5.0 fast gut sutures. A temporary tarsorraphy suture was placed bilaterally to avoid chemosis using a 6.0 Prolene. Steri-strips were placed over the incisions.

Skin-muscle flap

Corneal lubrication was placed. After initial alcohol prep, local anesthetic solution of maicaine, TXA,  xylocaine with epinephrine was injected into the flower eyelids. Then the lower eyelids were addressed. A subcilliary incision was placed and a skin muscle flap created to the level of the orbito-malar ligament. The tear trough ligament and ORL were released with electrocautery and Joseph elevator. The upper midface was undermined medially to create a pocket for fat transposition.

The fat pads were trimmed with electrocautery. The fat was transposed as grafts using 5.0 plain gut sutures (2 grafts each side). The suture was secured to the skin with tape. Then I performed a lateral canthopaxy using 4-0 PDS suture. The muscle was suspended to the lateral temporal fascia using 4-0 Vycril sutures.  Then the lower lid skin excess was trimmed conservatively at the lash line. The incision was sutured with interrupted 5.0 fast gut sutures and 6-0 Prolene sutures. A temporary tarsorraphy suture was placed bilaterally to avoid chemosis using a 6.0 Prolene. Steri-strips were placed over the incisions.

The patient tolerated the procedure well. No complications were noted. All counts were reported correct. The patient was extubated and taken to recovery room in stable condition.

Lip Lift

Then we proceeded with the lip lift. Using a #15 scalpel the excess upper lip was excised as the modified bullhorn markings. Orbicularis oris was preserved and SMAS dissection carried out for about a 1cm centrally and 2 centimeters laterally. Hemostasis was achieved with electrocautery. Deep interrupted sutures in key points were placed between the SMAS and the piriform ligament using 5-0 Monocryl. Then the skin was closed tension free with multiple 6-0 Nylon sutures.

Corner lift was performed in a elyptical fashion using the #15 scalpel. The incision was closed with deep 5.0 Monocryl and superficial 6-0 Prolene.

Miotto Abdominoplasty and flank liposuction

Markings were placed in the pre-operative area and reviewed with the patient prior to transport to the operating room.  The patient was placed on a stretcher and after confirming that pneumatic compression devices were on and active and that antibiotics had been infused she underwent induction of anesthesia.

The abdomen and flanks were prepped and draped. Small access incisions were made with a 15 blade.  Wetting solution containing epinephrine (but NO lidocaine) was then injected into the liposuction sites using the SAFE lipo technique.  Liposuction was then performed with PAL using a size 4 cannula with the endpoints defined by visual inspection, aspirate volume, and pinch test.  The inferior abdominoplasty incision was made as marked.  Elevation was performed with electrocautery leaving the loose areolar tissue attached to the fascia.  Elevation proceeded to the level of the umbilicus which was circumscribed and the inferior flap was split in the midline.  Additional elevation was performed superiorly to the level of the costal margin.  The patient did have a diastasis recti.  Diastasis was repaired in 2 layers of 1 and 3 PDS sutures.   She also had a very small superaumbilical hernia which consisted of pre-peritoneal fat which was reduced and the fascia repaired using 3.0 PDS sutures. Exparel which had been reconstituted to a total volume of 40 cc was then injected into the abdomen as a field block.  Several progressive tension sutures of Stratifix 1.0  and  2.0 Vicryl were then placed beginning at the superior midline tunnel.  The patient was placed in a slightly flexed position and the abdominal flap advanced and temporarily secured so that the umbilical position could be marked.  The umbilicus was then matured through an elliptical incision.  3.0 monocryl sutures secured the umbilicus in place close to the fascia. 3.0 Monocryl and 4.0 Monocryl interrupted sutures completed the umbilical closure. Additional interrupted progressive tension sutures were placed in the lower abdomen.  Once the final row of PTS was placed the abdominal flaps were marked and the excess tissue excised.  After confirming that there was meticulous hemostasis, the wound was closed with several interrupted 3.0 PDS sutures to the SFS with a 3-point fixation to the fascia followed by 3-0 deep dermal interrupted Monocryl sutures and 4.0 running intra-cuticular sutures.  Steri-strips were placed over the incisions. A light abdominal binder was placed.  The patient was extubated in the operating room and taken to the recovery room in stable condition.  All counts were reported correct.  There were no complications noted.

**Craniomaxillofacial**

Mandible - BioMet (good transbuccal trocar)

Orbital floor - Stryker (good implant)

KLS - good arch bars?

Synthes - has the arch bars that you can use as tension band.

Grady Clinic

Questions to ask patients: do you have insurance? Do you live in Fulton or Dekalb county? Do you have a Grady card? Do you have $70 to pay for preop appointment.

Arch bar removal

Ask for: needle driver, retractors, lido w epi, wire cutter, screw driver if hybrids, peridex, toothbrush, any pickup

Are they Traditional/Erich arch bars vs. Hybrid arch bars? Will need screwdriver for Hybrid

Brush teeth with peridex

Inject local into gums around screws

Removal screws with universal screw driver if Hybrid

Cut any wires with heavy needle driver to untwist and wire cutter (twist in opposite direction, cut, and pull)

Remove bars

Brush teeth again with peridex

Mandible fracture and MMF

Shoulder roll, turn bed 90, tuck arms, nasotracheal intubation and suture in with 0-silk (U-stitch thru septum and secure to ETT). Colorado tip bovie, Frazier tip suction.

Lido with epi, incise with cut first, change angle and go to bone, careful for mental nerve in between 1st and 2nd premolars.

Dissect soft tissue off bone with Molt 9 around mental nerve m, use toe-out to get underside of mandible

Establish occlusion

Place arch bars: ask for 25G wires

Hybrid: make sure overhangs are placed in direction you need them, secure with screws in between tooth roots. Mold the bar to just above the teeth and cut the excess.

Erich/Traditional: First bend it and size it up to teeth and cut off excess. Secure with 25G wires, go on top and below and twist down with heavy needle driver while pulling up. Bend after you cut.

Re-establish occlusion

Use the fishhooks to place in MMF, always loop and pull toward yourself, choke up on the instrument and twist and pull, twist and pull. Cut and bend

Mandible ORIF tips

Bite block, sweetheart for tongue, and Minnestoa retractor for cheek

For difficult fractures to reduce, don’t forget to use a bone reduction forceps (2 drill holes and clamp in place), will make your life a lot easier and gets number of hands out of the field.

Transbuccal trocar placement:

Stab incision w 15blade in cheek where your trajectory and angle is best, get through with a tonsil or hemostat. Place the trocar within the tract. Place the top device to hold it in place with the upside down U part over the intra-oral aspect, lift up the locking mechanism and lock in place. Screw in the drill guide. Drill with drill guide in. Take out drill guide to screw in. Use handle to angle, get one screw in, don’t screw in all the way, place second screw across fracture line screw this one in all the way, screw first screw all the way.

Orbital floor repair

Ask for: Q-TIPS! 1% lido w epi, 5-0 nylon, 6-0 plain and castro, corneal protectors w erythromycin ointment, BSS. Needle/Colorado tip, Frazier tip suction, Demar (big one) retractor, 0.5 forceps. Powered drill

Place corneal protectors off the field first. Betadine prep, head wrap, towel out, split drape.

Forced duction test, grasp at bottom of eyeball.

Inject 5cc local

Frost stitch nylon through gray line - bite, loop, bite, clamp w hemostat. Use Demar on skin to push it forward to make your incision easier, or finger traction on lower lid to distract skin away.

Make incision w cut cautery a few mm posterior to tarsal plate in conj (white and then turns pink, go a few mm’s behind this). Only make incision w cautery enough to release each side

Grasp posterior conjunctival with 0.5 forceps and bluntly sweep w Q-tip (push and roll) to get the orbicularis to sweet anteriorly/forward, find the septum just posterior to muscle (is white) and continue in this plane until orbital rim. Use a Demar to retract the orbic/tissue anterior to make your blunt dissection easier

Once at orbital rim and you’re sure there’s no skin in between, make your rim incision w cautery and take it medially and laterally.

Molt 9 elevator to strip periosteum and define fracture. Use malleables to doggy paddle entrapped fat/muscle out of fracture line. Get to medial and posterior edges and make sure something sturdy for plate to sit on. Trim/bend your plate. Insert and make sure the contents are still reduced and your plate is resting on sturdy bone (poke down on it with Molt 9 to check stability). Align the plate holes with a hemostat, drill, place your screw. Make sure contents still reduced and happy with your plate position.

Forced duction

Close conjunctival with buried 6-0 plain gut.

**Reconstruction**

STSG

Ask for: dermatome, mesher (1:1, 2:1, 3:1), nitrogen tank, mineral oil, 0.5%Marciane w epi,

Make sure dermatome available. Estimate width of blade you’ll need (4inch vs 2inch)

Set to 0.012” or 0.014 (Knaus) and decide if need to mesh or not? 1:1 or 1:2. Test dermatome blade width with a knife to ensure it’s at least 0.012”

Measure wound and approximate length you need to take, inject local to donor site.  
Slather mineral oil on donor site

Put through mesher, usually 1:2, make sure doesn’t wrap around mesher!

Put dermis side down (don’t lose track), suture in place with 3-0 chromics (run around edges)

“Ship to shore”

Make sure folds are sutured down

Donor site wound → inject marcaine w/ epi, xeroform, tegederm

Cut and shape xeroform over STSG, take xeroform off and cut VAC sponge around it and staple xeroform to the VAC so it stays, cover w/ strips

If bolstering, ask for 2-0 silks. Place circumferentially and TIE AIR KNOTS. Tie over cotton balls wrapped w Xeroform and mineral oil (can use scrub brush to gain more surface area, just take of bristles and get rid of soap). Use needle driver to hold down initial knots and secure.

For scalp - bolster. Xeroform sheet wrapped over kerlix. 3-0 Nylons circumferentially (8) and tie down air knots. Tie opposing strands over bolster with assistance of a hemostat to hold suture and tie down and remove. Stretch net to cover.

FTSG

De-fatting: small penetrating towel clamps x2 (or hemostats) to either end, wrap around empty 10cc syringe or bigger, use iris scissors to de-fat more than you think

Piecrust (15blade slits)

Inset with 5-0 chromics

Silk sutures on outside surrounding FTSG with air knots

Bolster = cotton ball with mineral oil wrapped in xeroform, tie down with 2-0 silks circumferentially, with air knots, pin with a needle driver. If large area to be covered Cheng says you can use a chlorhexidine scrub brush - take the bristles off, get the soap out, use it to obtain more real estate and place cotton balls around it

Losken breast recon DTI

Get ADM soaking. Cortiva

Ask for your drain to be ready. 15F Blake, drain stitch

Make note of mastectomy weight. Throw up a sizer, staple. Sit up. Decide on your implant size

While waiting for implant, get hemostasis and examine skin flaps.

Irrigate pocket with irrisept, place drain.

Prepare implant and wrap with ADM.

ADM preparation

Let soak in irrisept solution ASAP

Find dermal side and place this side up initially

Fenestrate first with Debakeys and large curved scissors. Cut 3 rows, pickup and cut slit. Then cut the tips off

Turn it over, place your implant on top

Fold over in 4 places, it will overlap on 2 opposite sides.

Pinch the bottom corners (the side that doesn’t overlap)  and sew 3-0 vicryl. Do top and bottom (or left/right, depends which side does not overlap). Then do your 4-point stitch (figure of 8 in the back, end on same side as you started). Back stitch is more important in NSM because you’re only tacking it in a few places, less important in SSM since tacking circumferentially

Then split the sides into two separate corners and sew these. This will create dogear, cut the dogear directly and close with 3-0 vicryl

Flip over and replace in implant box, add irrisept. You’re ready.

Prepare site with betadine, green towels, ioban

Cut slit in ioban with knife. Change gloves, place implant.

Secure ADM to chest wall - for NSM do in 2-3 places, for SSM tack circumferentially (exposure)

Staple and close. Tegederm bra while sitting up

Cheng immediate breast recon

Things to ask for at Grady: ADM availability, fill kit, SPY machine and kit, lighted retractor and light box, 15F Blake drain.

Hemostasis, check flaps, see if you need to SPY

If all good, irrigate out. Throw up a sizer or if going to use TEs just place your drain. Make sure drain goes out within bra line so covered, and more laterally so can’t be seen from front.

\*\*Recreate lateral breast border with 3-0/2-0 vicryls

Prepare the ADM (she uses two pieces of the alloderm that are football shaped) perforate it with small knife strikes, suture together running 3-0 vicryl so it looks like a tortilla.

Prepare tissue expander - deflate the expander so the inferior fold is flipped upward (not downward) as you deflate. Bring the butterfly and syringe up to head of bed and hook up butterfly and the syringe at the 3way stopcock, so ready to inflate a little bit before tacking ADM superiorly.

Tack ADM starting medially and working inferiorly along chest wall (3-8oclock on right, 9-4oclock L) bite thru ADM chest wall then ADM again.

Insert TE/implant with GAPS protocol - 4 towels and ioban, knife thru ioban, change gloves

When tacking in the tabs (2-0 vicryl) go as LOW as possible to IMF

\*\*\*Tack the lateral tab down to the chest wall before tacking down ADM

\*\*\*inflate TE about 100-200cc or whatever is appropriate (need to be able to drape ADM over it)

Use retractors (rich/armynavys/lighted) to expose and place your 3-0 vicryls superiorly and medially. Leave lateral for last. Bite thru adm then chest wall then thru ADM again. Pop off each and tie. Pull ADM so it’s tight but not too tight over implant/TE - you can excise if there’s too much so not bunching. Finish tacking down laterally.

If doing submuscular, first tack ADM to IMF medially to laterally (horizontal mattress interrupted) up to lateral border of pec. Place TE, and fill. Drape ADM over expander and trim appropriately. Run 3-0 vicryl from pec to ADM.

Let dwell with irrisept. Close mastectomy incision.

Faulkner immediate implant/expander

Setup - arms. Make sure arm boards are even. Place oval egg crate pad underneath elbow. Place blue blanket underneath the pink egg crate pad and roll up the lower segment and then upper segment draped over, secure with 2 inch clear tape wrapped around in 2 places.

If Rizzo, just use kerlix she doesn’t have room with the burrito roll

Thompson -  flat closure

Obliterate IMF for a few cm’s. Tailor tack starting medially and work laterally. Once hit the anterior axillary line do your Cheng maneuver and excise excess. 2-0 PDS for scarpas.

C-V flap

Mark while sitting up will look drastically different while on OR table as far as nipple position goes

Banner (bat wing) markings

Make sure inflow from subdermal plexus isn’t thru previous incision (although it can be)

Incise away from pedicle (in case you slip you won’t go thru pedicle)

Full thickness through dermis into fat want to include fat for the flap

Undermine with knife, go all the way to edge points near the pedicle and release to allow maximal mobility of each side of flap

If base (C) is too small arms will extend past, you can de epitheliaze the C to extend and allow arms to anchor down to dermis here.

3-0 monocryl deep dermal base of flap on either side

3-0 monocryl to get arm to C, see where it wants to land, do same for other arm, anchor in few more places

4-0 chromics to anchor top down, arms to each other and to base.

3-0 monocryl to close donor sites where there’s tension

Cheng runs 4-0 chromic to close donor sites

Cheng - bacitracin, nipple guard, cut off tips, tape down with steri’s in box formation. 4x4s and tape gently no bra.

Latissimus Dorsi Flap

Lateral decubitus position; need beanbag and axillary roll with arm board

2 drains in back, 1 in breast/recipient site

Start dissection superiorly to avoid lifting serratus. Can also grab and hook the muscle bluntly with your fingertips as it narrows towards its insertion and lift it up with a penrose drain to stay on top of serratus and dissect correct plane.

Micro tips

Clean off vessels by grasping with microdebakeys and peeling off tissue surrounding vessel. Gem clips on branches. Can mobilize with tenotomies to acquire length so not under tension

Flush with heparinized saline

Acland clamp on vessel, place your background

Get inside vessel with microdilator to assure you don’t back wall the stitch.

DIEP

Chest vessel dissection → split pectoralis at 3rd or 4th rib

Use Lonestar retractor superioly & medially, and Weitlaner’s to help expose for yourself

Periosteal elevator to dissect rib, remove rib with Rongeur

\*\*\*SIEV is located typically 5-7cm from midline

Location of SIEA compared to SIEV is unpredictable

Ligate the pedicle as far distally as possible

\*\*\*Once you cut the chest vessels you are committing to a DIEP, can’t go for a bail out pedicled TRAM since the TRAM will need to rely on the IMA

Dissection - like abdominoplasty, try to preserve SIEV/SIEA (4-7cm off midline). Cut “U” around umbilicus and preserve stalk.

Start dissection laterally, bovie on 35 until you get to Línea semiluminaris and lateral row perforators then switch to 20

Look for perforators - fascial rents, arborization, blue hues underneath fascia.

Once happy with your perforators (clamp other row and spy), finish dissection. Spy is 5cc ICG followed by 10cc flush. Lights down, Press red button. Have marking pen available.

Incise anterior sheath 2cm away from most superior perforator. Use tonsil instrument and cut cautery, swing around perforators.

Islandize perforators (release farther away from you so they retract toward you, instead of vice versa)

Cut into fascia on either side then connect. Tease away muscle from perforators and trace all of them down to Pedicle. Use microdebakey and bipolar. Use hooks to retract muscle out of way. Release as much of pedicle as you can. Watch for opposite row perforators where it will branch. Use sponge stick to push down and help yourself reveal pedicle at external iliac. Deaver to retract soft tissue.

Get TWO large clips on pedicle and cut with tenotomies.

Close fascial defect with interrupted figure of 8 1-0 Neurulon. Then bury with plication sutures with same stitch to bury (pull very tight!)

Abdomen closure with progressive tension sutures:

Barbed suture. Christmas tree pattern. Bites in anterior sheath, then take bite farther cephalad in scarpas, keep advancing in Christmas tree pattern and pull so you get some dimpling (will go away in 3-4 months or whenever PDS absorbs). Take 3 separate bites in fascia to end, cut with some tail.

Do same in lateral abdomen. Close skin in mid-dermis with 3-0 monocryl barbed/locking suture.

Goldilocks

0-vicryl to tack down inferior auto dermal flap to chest wall

15F Blake both sides, secured w 3-0 nylons

Measure total area of autodermal flaps

Big brown steric, ABDs, tube top

Miscellaneous:  
Nitro-BID dose is 45mg = 7.5cm on the measuring strip. Leave in place for at least 48hr

Pec flaps - Garcia

Make sure you do case in cardiac room in case something goes wrong. Prep out groin for cannulation if patient crashes.

Check status of IMA, abdominal surgeries.

Things needed: ioban, lighted retractor, extended bovie, deaver retractors, medium clip applier, 19/15F Blake drains, 0-PDS, 2-0 PDS, 3-0 monocryl, staples, xeroform/black sponge or Prevena.

Identify pec muscle on sternum, grasp with debakey and bovie on underside. Enter the right plane, use the ribs on one side to help you identify subpectoral plane. Watch out for internal mammary perforators, identify these and clip them before they bleed. Undermine up to clavicle and down to inferior pec border, identify anterior rectum fascia. Undermine to anterior axillary line, use cautery but also more blunt dissection with finger and bovie. Draw line from Cora void to xiphoid then draw a line at the mid-distal intersection of clavicle straight down and that’s the point of your thoracoacromial artery pedicle. There’s a fat pad surrounding this in the sub pec plane so watch out for it. Undermine on top of pec for just a few cm’s. Use rakes/catclaws to assist, pull on pec with Allis clamps. Irrigate. Hemostasis. Take cultures if haven’t. Place drains in subpec. Close pecs with 0-PDS figure of 8 sutures. Place 15F Blake in subQ space. Close scrapas with 2-0 PDS. Dermis with monocryl, staples, VAC. Sternal precautions. No arm abduction for 2 weeks. Drains/staples for 3 weeks. Beware restarting anticoag. Wait 6hrs prior to any DVT Ppx.

Thompson Gracilis

Always uses R leg if able since it’s more ergonomic (no one complains about driving after).

Interval is just posterior to adductor tendon. Pedicle is hands breadth from pubic tubercle origin. Incise go straight down to muscle, enter fascia. Define posterior border. Grasp with debakey the anterior edge and dissect anterior border. Bluntly dissect with fingers and get penrose around muscle belly. Dissect going distally with lighted retractor and use penrose to dissect around gracilis. Go as far as you can. Pull on penrose to determine where tendon is. Gracilis is only structure that is all tendon in this area. Incise and get weitlaner in. Feel for tendon while pulling on gracilis. Find tendon and bluntly get around it and get penrose around it. Dissect through distal incision with lighted retractor and meet in the middle - can bluntly dissect with your fingers to break up any attachements (tendon stripper method, wrap fingers around and pull down). Cut tendon as distally as you can. Grasp tendon with Allis clamp and deliver through tunnel. Dissect muscle proximally with care to know where your pedicle is. Can go fast posteriorly where there is no pedicle. Anteriorly use a right angle and dissect tissue and isolate pedicle. Dissect tissue around to release it more for more reach. Really only need to dissect distally to pedicle.

Tunnel - want to be just above bone. Dissect from the thigh stay on top of muscle and head straight to bone. Feel from perineal defect and get your fingers on top of bone. Should be able to get thru with cautery and bluntly. Dilate with your fingers to get 2 fingerbreadths through.  Pass gracilis through with Allis clamp.

Thigh closure - 15F Blake drain through tunnel (use tonsil clamp) and out through small distal incision.

Postop - strict bed rest x 48hrs, no sitting for 2 weeks. Can ambulate after 48hrs, no abduction or hip flexion, can shuffle while ambulating.

Abd wall recon w mesh

Vicryl mesh x2 sutured together w 3-0 vicryl

Fortiva (like ADM) and Pariotene mesh (macroporous polypropylene) sutured together

Place vicryl with assistance of malleable.

Then fortiva and pariotene

Suture fascia with 0-prolene

Thompson Ab wall (CAWR) - ask for mesh (strattice), provena, 15F Blake drains x2, #1 prolene on CTX needle. 0-looped PDS, 3-0 nylon for drains, possibly Mitek bone anchors if need to tack to pubic symphysis and drill.

Strattice mesh 30x30 usually if big abdominal surgery and bowel involved. Want ingrowth side away from bowel and facing up towards fascia.

See what comes together. Make sure you have lipocutaneous flaps and release external oblique aponeurosis. Measure your hernia defect. Want overlap of 4-5cm. Mark mesh with marking pen. Place moist blue towel on top of bowel to protect it.

If you need to tack to pubic symphysis, drill a hole in the bone. Place mitek anchor into hole and then remove. Flip the switch toward yourself and release the device from the suture threads, clamp the sutures with needles on. Take a bite through mesh for as much overlap as you need with both needles. At this point you can cut the needles off and tie down.

Place sutures north south east west. Pull up and check to make sure mesh is flat. North: take bite from one side of fascia to mesh to other side. Don’t tie down, tie at end. Work more difficult to easier area. Use malleable on mesh, Kocher on fascia, place prolene (clamp end with a hemostat) through ab wall, bite of mesh and back thru fascia, clamp and cut (get 2 uses out of these). Bisect and fill in gaps. Do other side, then tie but remove blue towel first. Close fascia that is able to come together with running 0-looped PDS. Irrigate and place drains above fascia. 2-0 PDS for SFS, 3-0 monocryl, staples. provena.

Radial Forearm Free flap

Raise subdermal skin flaps, find cephalic vein (can inflate tourniquet without Esmarch initially and elevate arm to mark out where the superficial veins are to help you)

Incise over marked skin paddle, note where FCR is

Raise from ulnarly to radially superficial to muscular fascial plane, keep paratenon on, go to FCR

Begin dissection on radial side, looking out for superficial branch of radial nerve, and identifying brachioradialis tendon, retracting this radially to expose radial artery

\*The radial artery lies just ulnar to the brachioradialis, and just radial to the FCR

\*Sometimesthe VC of the radial artery aren’t great caliber, so you should include cephalic vein

Divide cephalic vein distal to the draining branch

Can pursestring forearm wound to decrease wound burden. Skin graft. Cover with xeroform, VAC.

Ghareeb sutures muscle together over the FCR to promote skin graft take.

Reverse RFF

Do Allen’s test preoperatively to ensure intact arch (test palmar arch and digits with the test too)

Doppler out radial pulse to proximal forearm

Template defect with Esmarch bandage, use a lap pad as a tether to simulate your pedicle at the pivot point which is just proximal to the radial styloid to ensure you’ll be able to reach. Draw out your markings.

Make incisions around flap and distal pedicle, dissect through soft tissue with tenotomy and 15blade. When you come across superficial veins clip these with small automatic clip applier, smaller branches can be bipolar’d. Identify brachioradialis and FCR distally and spread them apart bluntly with Weitlaner retractor. Watch out for LABC- runs with the cephalic vein. Also beware of superficial branches of radial sensory nerve at the radial wrist. Pedicle will be here within fat. Lift flap ulnarly to FCR first. Get down to muscular fascia and incise it to bring it with the flap. Helpful if assistance pulls on other side of fascia with forceps. Leave any peritenon down. Identify septocutaneous perforators. Do the same from radially to BR - lots of muscular perforators here so watch out. Find pedicle proximally and ligate with multiple clips. Make sure distal pedicle is somewhat dissected out with knife/tenotomy/bipolar/clips. Lift the flap from proximal to distal. Make sure it will reach. Let the tourniquet down and let it bleed. Create a tunnel. Watch for superficial branch of radial sensory nerve here at radial wrist. Dilate tunnel with large hemostat or Kelly. Tunnel it through by grasping with hemostat and being gentle and make sure no kinking or twisting. If you bring it back through make sure it doesn’t get tethered around a sensory nerve branch and continues to be kinked. If any doubt just open up the tunnel skin - just watch for nerve branches. Inset flap with few staples and start with 3-0 chromics. Pursestring suture the donor site with a 3-0mono/PDS. Skin graft. Running 4-0 chromic. Xeroform, VAC. Mastisol. Xeroform on all incisions. Splint around it. Doppler and mark signal.

Exposing PT vessels

Incision 1cm posterior to tibia, dissect down to fascia, incise fascia and take muscle (soleus) off the bone and dissect carefully to define PT vessels

**Upper Extremity**

Distal Radius Fracture

Place tourniquet over arm stocking, place ten-tens on arm

Exsanguinate extremity with Esmarch bandage, put tourniquet to 250mmHg

Incision over FCR, retract ulnarly

Longitudinal radial incision in pronator quadratus to styloid, then go ulnarly, leave a cuff to suture to (close this with 2-0 vicryl figure of 8)

Volar slab splint → thermoplastic splint in clinic at 1 week

Flexor tenosynovitis

General anesthesia, culture swabs, 14G angio cath on 10cc syringe, saline solution, 3-0 chromics, ¼” iodoform packing.

Incision over A1 pulley, dissect longitudinally, incise sheath and open along its length. Send cultures.

Incise transversely at DIPJ, find sheath and open just a little bit

Need: 14G angio catheter on 10cc syringe. Flush sheath copiously with at least 50cc (5 times). Close loosely, can wick incisions.

Ghareeb cubital tunnel release

Prop elbow up on towels, bend at 90 degrees

Palpate medial epicondyle, olecranon. Boomerang type incision through these up to inter muscular septum of biceps/triceps

Spread w tenotomy. Identify nerve and release proximal and distal.

Bend arm to make sure you don’t need to transpose it. If it moves too much transpose it in subcutaneous position. If recurrent, submuscular.

Radial Forearm Free flap - Ghareeb

Raise subdermal skin flaps, find cephalic vein (can inflate tourniquet without Esmarch initially and elevate arm to mark out where the superficial veins are to help you)

Incise over marked skin paddle, note where FCR is

Raise from ulnarly to radially superficial to muscular fascial plane, keep paratenon on, go to FCR

Begin dissection on radial side, looking out for superficial branch of radial nerve, and identifying brachioradialis tendon, retracting this radially to expose radial artery

\*The radial artery lies just ulnar to the brachioradialis, and just radial to the FCR

\*Sometimesthe VC of the radial artery aren’t great caliber, so you should include cephalic vein

Divide cephalic vein distal to the draining branch

Can pursestring forearm wound to decrease wound burden. Skin graft. Cover with xeroform, VAC.

Ghareeb sutures muscle together over the FCR to promote skin graft take.

Reverse RFF - Knaus

Do Allen’s test preoperatively to ensure intact arch (test palmar arch and digits with the test too)

Doppler out radial pulse to proximal forearm

Template defect with Esmarch bandage, use a lap pad as a tether to simulate your pedicle at the pivot point which is just proximal to the radial styloid to ensure you’ll be able to reach. Draw out your markings.

Make incisions around flap and distal pedicle, dissect through soft tissue with tenotomy and 15blade. When you come across superficial veins clip these with small automatic clip applier, smaller branches can be bipolar’d. Identify brachioradialis and FCR distally and spread them apart bluntly with Weitlaner retractor. Watch out for LABC- runs with the cephalic vein. Also beware of superficial branches of radial sensory nerve at the radial wrist. Pedicle will be here within fat. Lift flap ulnarly to FCR first. Get down to muscular fascia and incise it to bring it with the flap. Helpful if assistance pulls on other side of fascia with forceps. Leave any peritenon down. Identify septocutaneous perforators. Do the same from radially to BR - lots of muscular perforators here so watch out. Find pedicle proximally and ligate with multiple clips. Make sure distal pedicle is somewhat dissected out with knife/tenotomy/bipolar/clips. Lift the flap from proximal to distal. Make sure it will reach. Let the tourniquet down and let it bleed. Create a tunnel. Watch for superficial branch of radial sensory nerve here at radial wrist. Dilate tunnel with large hemostat or Kelly. Tunnel it through by grasping with hemostat and being gentle and make sure no kinking or twisting. If you bring it back through make sure it doesn’t get tethered around a sensory nerve branch and continues to be kinked. If any doubt just open up the tunnel skin - just watch for nerve branches. Inset flap with few staples and start with 3-0 chromics. Pursestring suture the donor site with a 3-0mono/PDS. Skin graft. Running 4-0 chromic. Xeroform, VAC. Mastisol. Xeroform on all incisions. Splint around it. Doppler and mark signal.

Exposing PT vessels

Incision 1cm posterior to tibia, dissect down to fascia, incise fascia and take muscle (soleus) off the bone and dissect carefully to define PT vessels

Trigger finger - Ghareeb

Local at A1 pulley. Longitudinal incision over metacarpal head.

Retract with Ragnell retractors on either side, spread with tenotomy down to tendon sheath. Reposition Ragnells as you dissect, dissect a little proximal/distal to the pulley

Use 15 blade to incise sheath, any fluid is pathologic.

Get tenotomy scissors in your sheath, spread gently inside, and cut the sheath for full length of pulley, distally at least to base of digit. Get small side of Ragnell retractors around FDS and FDP, and pull/stretch the tendons and free up any adhesions.

Check for tendon catching by flexing digit to ensure adequate release

Pimp question - what else can you do if you still have triggering despite release? Take out a slip of FDS tendon (makes the contents inside of sheath smaller).