

OPERATIVE REPORT

Patient Name: xxxxx

Hospital No.: xxxxx

Date of Surgery: 09/26/2009

Admitting Physician: xxxxx

Surgeon: xxxxx

Preoperative Diagnosis: Right intertrochanteric femoral fracture.

Operative Procedure: Open reduction, internal fixation of right intertrochanteric femoral fracture with Depuy's sliding screw.

Anesthesia: General endotracheal.

Postoperative Diagnosis: Same.

INDICATIONS: The patient is a 69-year-old black female who fell, landing on her right hip. She was seen in the emergency room where physical exam and x-ray revealed an intertrochanteric right femoral fracture. She was admitted to Dr. xxxxx service. After an orthopedic consultation and preoperative clearance for surgery, she was taken for ORIF.

OPERATION IN DETAIL: After adequate preoperative evaluation, preoperative medication and signing the informed consent, the patient was taken to the operating room and administered a general endotracheal anesthetic with prominences well padded. She underwent an uneventful reduction and was placed on traction through a well-padded boot. Her left lower extremity was flexed and abducted at the hip. All bony prominences and the peroneal nerve were well padded. Fluoroscopy, AP and lateral images revealed a good reduction of her intertrochanteric femoral fracture. The right hip was administered IV preoperative antibiotics. A straight lateral approach to the proximal femur was made. Dissection was carried through the skin and subcutaneous tissue. Hemostasis was obtained with electrocautery. The fascia lata was divided in line with the skin incision. The fascia over the vastus lateralis was divided in line with the skin incision, and the vastus lateralis was divided in line with its fibers, revealing the lateral aspect of the proximal femur, which was retracted with the Bennet and Homan retractors without complication.

A guide pin was placed along the anterior neck to give the proper amount of anteversion. Using the 135 drill guide, a guide pin was placed through the lateral aspect of the proximal femur across the fracture site and into the center of the head and neck, as demonstrated by AP and lateral fluoroscopic C-arm images. This was then

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measured and 85 mm was found to be the appropriate length. The core was cut for the sliding screw without complication, using a preset reamer set at 85 mm. The tap was then used to tap the way for the proximal screw and an 85-mm sliding screw was inserted across the fracture site into the head and neck without complication. A four-hole 135-degree side plate was then attached. We slid it over the DePuy sliding screw and attached it to the proximal femur using a Lowman turkey-claw clamp.

With the fixation in place, AP and lateral fluoroscopic images throughout the fracture site and hardware position confirmed good reduction and good placement of the hardware. At this point, the side plate was then secured to the proximal femur using the 3-2 drill bit to drill a hole measuring approximate length with the depth gauge and placing 4 to 5 cortical screws of the appropriate length without complication. At this point, the compression screw was inserted. All traction was left off, and the compression screw was tightened, impacting the fracture nicely. All screws were then tightened with the screwdriver. The Lowman was removed, as was all hardware. Multiple views in the AP and lateral plane of the fracture site and hardware for placement confirmed good reduction and good hardware placement for her intertrochanteric femoral fracture.

With open reduction, internal fixation complete, the wound was copiously irrigated with antibiotic solution. Hemostasis was obtained with electrocautery. The fascia over the vastus lateralis was closed with a running suture of 0 Vicryl. A Hemovac drain was left between the fascia lata and the vastus lateralis, connected to a separate stab wound. The fascia lata was closed with a running suture of 0 Vicryl with a few interrupted sutures. Care was taken to make sure that the drain was not sutured into the wound. The subcutaneous tissue was closed with staples. A sterile dressing was applied and the patient was returned to the recovery room via stretcher.

The patient tolerated the procedure well. There were no complications. Blood loss was negligible. No replacement. Lap, needle and sponge count was correct x 2, and she returned to the recovery room in good condition where she was neurovascularly intact.

xxxxx, M.D.

CD:ld

D: 09/26/2009

T: 09/27/2009