HONORHEALTH SCOTTSDALE SHEA MEDICAL CENTER
9400 E. Shea Blvd.
Scottsdale, AZ 85260

Patient Name:	RABO, KADIN	DOB:	05/30/2002
Attending Physician:	SHELDEN L MARTIN, MD	Sex:	M
Med Rec #:	5472809	PT Class:	O
CSN#:	134837017	ADM:	06/04/2019
Location:	SS PIPOR SSMC PIPER SURGERY POOL POOL	DIS:	
Primary Care Phys:	NEIL AARON, MD	DOS:	06/04/2019
Referring Physician:			

OPERATIVE REPORT

DATE OF SERVICE: 06/04/2019

SURGEON:
SHELDEN L MARTIN, MD

ASSISTANT:
Matthew Joseph Pavelek, PA

ANESTHESIA:
1. General.
2. Right adductor canal saphenous nerve block.

PREOPERATIVE DIAGNOSIS:
Right knee anterior cruciate ligament tear.

POSTOPERATIVE DIAGNOSES:
1. Right knee anterior cruciate ligament tear.
2. Medial plica.

PROCEDURES:
1. Right knee examination under anesthesia and diagnostic arthroscopy.
2. Anterior cruciate ligament reconstruction with semitendinosus autograft.
3. Medial plica resection.

COMPLICATIONS:
None.

EBL:
Minimal.

TOURNIQUET TIME:
102 minutes.

IMPLANTS:
Arthrex RT femoral TightRope and tibial TightRope and button.

Patient Name: RABO, KADIN Date Of Birth: 05/30/2002

INDICATION FOR PROCEDURE:
Patient is a 17-year-old athletic male who sustained an ACL tear. We discussed nonoperative and surgical treatment options, discussed all risks, benefits, outcomes, postop management and alternatives of an ACL reconstruction. We discussed graft options, pros and cons, and he elected to proceed with hamstring autograft.

DESCRIPTION OF PROCEDURE:
Patient was seen in the preoperative holding bay. Right knee initialed. Consents were signed. An adductor canal saphenous nerve block was performed. He was taken to the operating room, where general anesthesia, IV antibiotics and time-out were administered. Exam of the right knee on the operating table revealed full range of motion symmetric to his left knee and mild effusion. There was a 1+ Lachman with firm endpoint. There was a 1+ pivot shift. He was stable to varus and valgus stress. Normal posterior drawer test. No posterolateral rotatory instability. A tourniquet was applied to the right thigh. Leg was prepped, draped and exsanguinated, and tourniquet inflated to 250 mmHg. A longitudinal incision centered over the pes tendons was utilized, carried down to the sartorius fascia. Incision between the gracilis and semi-T was performed. The semitendinosus was isolated, harvested off the proximal tibia, whipstitched and then harvested in full continuity. It was prepared on the back table by my assistant, saving 30 minutes of operative time using GraftLink all-inside technique.

Arthroscopic portion procedure ensued. An anterolateral portal was established and the arthroscope inserted. An accessory anteromedial portal was made. Medial compartment was pristine with no meniscus tear or chondromalacia of the femur or the tibia. ACL showed some stretching with probing and small cyclops area with hematoma in the distal portion of the ACL insertion. Lateral compartment showed no chondromalacia on the femoral condyle or the tibial plateaus, normal lateral meniscus. Patellofemoral compartment showed a medial plica, but normal cartilage on the patella and the trochlea.

The medial plica was resected with the ArthroCare and shaver. The ACL ligament was resected from the intercondylar notch. A standard wallplasty and notchplasty were performed with a bur. The graft was sized to a 10 mm femoral-sided and 10 mm tibial-sided tunnel. The knee was hyperflexed, and through the medial portal a guidewire was placed with the over-the-top guide through the femur bicortically. A 10 mm low-profile cannulated reamer was used to ream a 30 mm socket. Passing suture was placed. Bone debris was removed. The ACL tibial guide was placed, and the 10 mm FlipCutter was advanced up into the knee in the center of the ACL insertion. The cutter was used to ream a 40 mm socket. All bone debris was removed and passing suture placed. The passing suture was brought out the medial portal, used to shuttle the graft first in the femur, getting cortical fixation with flipping of the button on the far lateral cortex, and then advanced the graft down to the tibia. The knee was cycled while tensioning the tibial side, and then at 20 degrees of knee flexion with posterior drawer the tibial side of the graft was fixated over the button and all sutures were tied over the graft. This normalized the Lachman and the pivot shift maneuvers. Pictures of the graft were obtained with excellent tension on it and anatomic positioning. No impingement over the PCL or with full extension in the roof of the intercondylar notch.

The knee was evacuated under suction. The sartorius fascia was closed with 0 Vicryls, subcu tissue was closed with 2-0 Vicryl, skin with 3-0 Monocryl; 3-0 nylon was placed in the portals. Sterile dressing and a hinged knee brace locked in full extension was applied. The tourniquet

Patient Name: RABO, KADIN Date Of Birth: 05/30/2002

was let down 102 minutes. The patient was awoken, extubated, and transferred to the recovery room in stable condition. All counts were correct at the end of the case.

SHELDEN L MARTIN, MD
Dictated By: SHELDEN L MARTIN, MD

DD: 06/04/2019 01:22pm
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Confirmation/Job #: 271648

cc: Neil Aaron, MD
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HONORHEALTH SCOTTSDALE SHEA MEDICAL CENTER
9400 E. Shea Blvd.
Scottsdale, AZ 85260

Patient Name:	RABO, KADIN	DOB:	05/30/2002
Attending Physician:	SHELDEN L MARTIN, MD	Sex:	M
Med Rec #:	5472809	PT Class:	O
CSN#:	141252274	ADM:	02/04/2020
Location:	SS PIPOR SSMC PIPER SURGERY POOL POOL	DIS:	02/04/2020
Primary Care Phys:	NEIL HOWARD AARON, MD	DOS:	02/04/2020
Referring Physician:			

OPERATIVE REPORT

DATE OF SERVICE: 02/04/2020

SURGEON:
SHELDEN L MARTIN, MD

ASSISTANT:
Matt Pavelek, PA.

ANESTHESIA:
1. General.
2. Right adductor canal saphenous nerve block.
3. Local.

PREOPERATIVE DIAGNOSES:
1. Failed right knee anterior cruciate ligament reconstruction.
2. Recurrent anterior cruciate ligament graft tear.
3. Medial meniscus tear.

POSTOPERATIVE DIAGNOSES:
1. Failed right knee anterior cruciate ligament reconstruction.
2. Recurrent anterior cruciate ligament graft tear.
3. Medial meniscus tear.
4. Lateral meniscus tear.
5. Full-thickness medial femoral condyle cartilage lesion.

PROCEDURES:
1. Right knee exam under anesthesia and diagnostic arthroscopy.
2. Arthroscopic medial meniscal repair.
3. Arthroscopic lateral meniscal repair.
4. Microfracture, medial femoral condyle.
5. Revision, anterior cruciate ligament reconstruction with patellar tendon-bone autograft.
6. Deep hardware removal.

IMPLANTS:

1. Arthrex BTB TightRope.
2. BioComposite interference screw size, 10 mm x 20 mm.
3. 4.75 mm SwiveLock.
4. Mitek Truespan all-inside meniscal repair sutures x5 (3 in the medial meniscus, 2 in the lateral meniscus).

INDICATIONS FOR PROCEDURE:
Patient is a 17-year-old male for whom I performed an ACL reconstruction with hamstring autograft in June 2019. He was progressing appropriately and rehabbing. About 8 months out, he was in physical therapy doing supervised box jumps with perturbations when he landed awkwardly, felt a pop, and was unable to bear weight. His MRI was consistent with recurrent tear of his ACL graft, as well as medial meniscus tear. We discussed management, and we elected, with him and his parents, to proceed with a revision ACL reconstruction and medial meniscal repair versus partial meniscectomy. We discussed the potential for other associated injury, including cartilage lesion, discussed appropriate management of that and appropriate postoperative therapy. We discussed the pros and cons of the graft options and elected to proceed with a bone-patellar tendon-bone autograft.

DESCRIPTION OF PROCEDURE:
Patient was seen in the preop holding bay, and the adductor canal saphenous nerve block was performed. He was taken to the operating room, where general anesthesia, IV antibiotics, and time-out were administered. An exam of his right knee revealed a 2+ Lachman with a soft endpoint. He did have a 2+ pivot shift with large effusion. He was stable to varus and valgus stress. He had a normal posterior drawer test and no patellar instability. A tourniquet was applied to the right thigh. The leg was prepped, draped, exsanguinated, and tourniquet inflated to 250 mmHg. A midline incision was utilized for patellar tendon harvest. This was carried down to the paratenon. The paratenon was incised centrally. An 11 mm double-blade 10 blade scalpel was used to incise the central third of the patellar tendon creating an 11 mm wide soft tissue graft. The tibial bone block was then harvested to a width of 11 mm by about 20-25 mm in length using the oscillating saw. The curved osteotome was used to complete the harvest. A similar technique was then used on the patellar bone block with the oscillating saw and a curved osteotome, again harvesting an 11 mm wide by about 20-25 mm length bone block. This was then prepared on the back table by my assistant. Bone plugs were drilled and passing sutures placed, as well as the femoral bone block being loaded onto the BTB TightRope. This saved approximately 45 minutes of operative time and required my assistant who is skilled in preparation of these complex grafts.

Meanwhile, I proceeded with the arthroscopic portion. I first repaired the patellar tendon defect with 0 Vicryl suture and closed the paratenon with 2-0 Vicryl, leaving the bone harvest sites open for later bone grafting. An anterolateral peripatellar portal, the same as from his previous surgery, was utilized. The arthroscope was inserted. The same medial peripatellar portal was used from his previous surgery. Arthroscopic findings showed no significant chondromalacia in the patellofemoral compartments. The intercondylar notch showed a complete rupture of his previous ACL hamstring graft. The intercondylar notch was completely empty and devoid of any graft. It was still attached distally and scarred to the fat pad. The medial compartment showed a vertical tear at the junction of the middle and peripheral thirds in the posterior aspect of the meniscus over a distance of about a centimeter and a half with an intact posterior horn. This was a repairable tear. It was rasped to induce bleeding. I placed 3 Mitek Truespan all-inside

vertical mattress sutures across the tear, getting a nice stable anatomic repair. The lateral compartment showed a complex tear of the posterior portion of the lateral meniscus around the area of the popliteal hiatus and extending medially, but not into the posterior horn. Although this was a complex tear, given his young age, I felt that an attempt at repair was reasonable. I rasped the tear. Again, there was tearing at multiple levels. I placed 2 vertical mattress Mitek Truespan all-inside sutures across the tear, getting a reasonable repair. There was some inner border tearing of the white-white zone that I resected with a basket resector that was not repairable. The posterior horn and remaining body and anterior portion of the meniscus were intact. The cartilage was intact on the lateral femoral condyle, although there was some softening and generalized mild fibrillation that was gently debrided with a shaver off the lateral femoral condyle, and tibial plateau cartilage was in good condition. There was a full-thickness small cartilage lesion on the weightbearing surface of the medial femoral condyle. I would come back at the end, after the ACL reconstruction, to perform microfracture on this.

The suture material and graft were removed from the femoral tunnel. Sequential reamers through the medial portal were placed, and I reamed up to a 10 mm. Passing suture was placed. I then proceeded to ream the tibial tunnel, placed a guidewire up through the pre-existing tunnel as his femoral and tibial tunnels were in appropriate position from his previous surgery. I used full-length antegrade reamers up to a size 11 in the tibial tunnel and was able to remove all of the pre-existing graft and suture material, as well as the tibial button. I then passed the graft up into the femoral side, getting cortical purchase of the BTB TightRope button. The graft was advanced up into the femoral tunnel and bottomed out with the bone block filling the tunnel nicely. While then manually tensioning the graft on the tibial side, I cycled the knee 10-15 times. The knee was flexed over a bump to about 20 degrees with a posterior drawer force while I placed the 10 mm x 28 mm BioComposite interference screw, getting a nice secure fixation of the tibial bone block. I then backed this up by placing the sutures in a 4.75 mm SwiveLock on the tibia. He had full range of motion of the knee, and this stabilized his Lachman and pivot shift maneuvers to normal. The graft was visualized arthroscopically to be very robust and appropriately tensioned with probing and anatomically positioned with no impingement in full extension and no impingement over the PCL in flexion.

I then completed the procedure by preparing the medial femoral condyle lesion with cartilage ringed curettes to a final size of about 5 mm medial and lateral and 7 mm superior to inferior. I placed 1 microfracture hole using a microfracture awl centrally in the lesion with escape of marrow and fat elements and blood. The bone from the reamings and preparation of bone blocks was then placed back and grafted into the patellar and tibial donor sites. The fascia was closed over both sites. The incisions were all closed in layers with 2-0 Vicryl in the subcu layer and 3-0 Monocryl in the skin. 3-0 nylons were placed in the portals. 20 cc of 0.5% Marcaine was placed into the knee and the wounds. The tourniquet was let down at 139 minutes. Patient was awoken, extubated, and transferred to the recovery room in stable condition. All counts were correct at the end of the case. A hinged knee brace was applied in full extension locked.

Postoperatively, patient received 2 g of Ancef IV in the PACU postoperatively. He will remain nonweightbearing with his hinged knee brace locked in full extension, with crutches, and will begin physical therapy postop day 2, per my appropriate meniscal repair and microfracture and ACL protocols.

Patient Name: RABO, KADIN Date Of Birth: 05/30/2002

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